Methods.—In Vellore, 132 patients with active disease were studied at 0 and 6/12 after therapy with steroids plus mycophenolate. In Lucknow, 46 patients were assessed at 0 and < 12/12 after therapy with steroids plus methotrexate or azathioprine while TADS (Takayasu Damage Score) was also used to assess development of damage.

Results.—In Vellore, ITAS2010 indicated satisfactory suppression of disease activity. However the ITAS.A score indicated continued disease activity. In Lucknow, at follow-up, the ITAS.A was higher than 2 in 79% of cases and only one in four had a value less than 1, even at 12 months. The mean score of TADS was 6 indicating marked damage.

Discussion.—The incomplete response to active induction therapy with persistent disease activity despite clinical improvement noted for ITAS.A was seen in two centres using different immuno-suppressive plus steroid regimes. Persistent activity would predict development of damage and indeed significantly elevated TADS scores were seen. Conclusion.—ITAS.A, combining clinical data plus acute phase response, provides new information. The apparent incomplete response to therapy despite clinical improvement has major implications for therapy.

http://dx.doi.org/10.1016/j.lpm.2013.02.185

P115
Chronic asymptomatic aortic dissection (AD) in Takayasu’s arteritis (TA); how to treat?
S.T. Tosounidou, D.C. Carruthers
Sandwell and West Birmingham Hospitals, Birmingham, United Kingdom

Introduction.—AD is extremely rare in TA and only a limited number of reports have been published. Little is known about the management of this rare complication and usually surgery is reserved for Stanford type A AD. We report a case of aortic intramural haematoma (IMH) in 2002 with complete resolution of her symptoms. Histology of the aortic wall specimen obtained during the operation confirmed TA. In our case the diagnosis of chronic intramural haematoma (IMH) was made radiologically using serial MRA in a clinically asymptomatic patient. Despite that we changed patient’s immunosuppressive therapy as we believe IMH was caused by persistent low-grade vaso vasoritis.

Methods.—A young Indian lady was diagnosed with TA based on a history of claudicant legs and left arm with subsequent angiogram revealing complete occlusion of the left subclavian artery and distal abdominal aorta. She underwent aortobifemoral arterial bypass grafting in 2002 with complete resolution of her symptoms. Histology of the aortic wall specimen obtained during the operation confirmed TA.

Results.—She stayed on a low dose of prednisolone and methotrexate (MTX) for nearly a decade. HTN required frequent adjustments of antihypertensive therapy and she has always had a mildly elevated CRP 10–25. Serial MRA from 2008 to 2011 showed slowly increasing thickness of the posterior wall from aortic arch down to descending thoracic aorta. Subsequent CT angiogram confirmed IMH starting from left subclavian artery following spiral dissection to the level of abdominal aorta at L3-L4 just before the graft (pic 1–2).

Discussion.—IMH is a variant of AD caused by ruptured vasa vasorum into the media wall. We hypothesise that fragility of the aortic media in TA is caused by vasa vasoritis [1] leading to infiltration of media by inflammatory cytokines thus causing disruption of elastic fibres and facilitating formation of IMH. No doubt HTN also contributes into fragile media.

Conclusion.—Based on the above we opted for switching this patient’s immunosuppressants from MTX to Mycophenolate Mofetil and to consider further escalation to biologic therapy in case of future radiological progression.

Reference

http://dx.doi.org/10.1016/j.lpm.2013.02.186

P116
Contribution of anti-ferritin antibodies to the diagnosis of giant cell arteritis
A. Regent1,2, K.H. Ly3, A. Blet4, C. Agard5, X. Puech4, N. Tamas4, C. Le-jeunen6, E. Vidal7, L. Guillemin8, L. Mouton1,2
1. Université Paris Descartes, CNRS UMR 8104, Institut Cochin, Inserm U1016, Paris, France
2. Assistance publique–hôpitaux de Paris (AP–HP), hôpital Cochin, Centre de référence pour les vascularités nécrosantes et la sclérodermie systémique, pôle de médecine interne, Paris, France
3. CHU Dupuytren, service de médecine interne A, faculté de médecine, laboratoire d’immunologie, EA3842, Limoges, France
4. Université Paris Descartes, Institut Cochin, Inserm U1016, CNRS UMR 8104, Paris, France
5. Hôpital Hôtel-Dieu, service de médecine interne, Nantes, France
6. AP–HP, hôpital Hôtel-Dieu, service de médecine interne, Paris, France
7. AP–HP, CHU Dupuytren, hôpital Hôtel-Dieu, service de médecine interne A, laboratoire d’immunologie, EA3842, faculté de médecine, Limoges, France
8. Assistance publique–hôpitaux de Paris (AP–HP), hôpital Cochin, pôle de médecine interne, centre de référence pour les vascularités nécrosantes et la sclérodermie systémique, Paris, France

Introduction.—The diagnosis of giant cell arteritis (GCA) can only be ascertained by performing temporal artery biopsy (TAB). Recently, Baerelecken et al. [1] reported on the detection of antibodies directed at the human ferritin heavy chain (FTH1) in 92% of patients with GCA vs 1% of healthy controls. We decided to evaluate the diagnostic value of anti-ferritin antibodies in patients undergoing TAB for a suspicion of GCA.

Methods.—We included 122 consecutive patients suspected of GCA. Blood sampling was performed at the time of TAB. Sera from 40 healthy individuals served as negative controls. We investigated for the presence of IgG directed against 19 individuals served as negative controls. We investigated for the presence of IgG directed against 19.45 FTH1 amino acids by using an ELISA test. Correlations between FTH1 antibodies and clinical manifestations were investigated using non-parametrical tests.

Results.—Anti-FTH1 antibodies were identified in 72.5, 41.3, 9, 31.9 and 2.5% of patients with TAB+ GCA, TAB- GCA, GCA controls and healthy individuals, respectively, with a threshold at the mean of healthy controls + 2 standard deviations (SD). With a threshold at the mean of healthy controls + 3 SD, anti-FTH1 antibodies were identified in 60, 34.5, 21.2 and 0% of the patients with TAB+ GCA, TAB- GCA, GCA controls and healthy individuals, respectively. By grouping TAB+ GCA, TAB- GCA patients with a threshold at 2 SD, the positive and negative predictive value were of 71.9 and 56.9%, respectively. Positive and negative likely ratios were at 1.96 and 0.58, respectively. In addition, in our population, anti-FTH1 antibody titer correlated significantly with CRP and no correlation was found with aortic and/or visual impairment.

Conclusion.—We therefore confirm the presence of anti-FTH1 in 72.5% of patients with histologically proven GCA. However, the detection of anti-FTH1 is not contributory to the diagnosis of GCA in a cohort of patients with suspected ACG. The ability to identify a specific sub-group
Takayasu arteritis in Tunisia: Clinical study of 34 cases

I. Ben Ghorbel, N. Belfeki, S. Souissi, A. Hamzaoui, T. Ben Salem, M. Khanfir, M. Lamloum, M. Miled, H. Houman

Department of Internal Medicine, La Rabta Hospital, Tunis, Tunisia

Introduction. – Takayasu’s arteritis (TA) is a rare inflammatory disease and few data are available in Tunisia. The aim of this study is to assess the demographic, clinical, laboratory, and radiological data, as well as the outcome of patients with TA in Tunisia, through a monocentric series and to compare our data with those in other ethnic groups.

Methods. – We retrospectively studied medical records of patients treated in the internal medicine department of La Rabta's university hospital over the period 1992–2012. The criteria for inclusion were those proposed by the American College of Rheumatology.

Results. – Thirty-four patients were identified. The mean age at presentation was 35.5 years (range 12–65 years) and 83% were female. The mean period from onset of the symptoms to the time of diagnosis was 45.8 months. The diagnosis was made during the pulseless phase in all cases. Constitutional symptoms were present in 67%, intermittent claudication was present in 73%, and hypertension was noted in 52% of cases. Neurological disorders were reported in 22 patients (64%). Ophthalmological manifestations were reported in 13 patients (38%). Three patients presented a bloody mucoid diarrhea related to Crohn’s disease; two more patients had retroperitoneal fibrosis. Twenty-four patients (70%) received corticosteroids with a mean duration of 17.3 months. Fifteen received antiplatelet agents, 7 of them in association with steroids. Six patients received immunosuppressive agents: 5 had cyclophosphamide and one methotrexate. Six patients were submitted to surgical treatment. The clinical outcome in our series revealed an improvement in 41%, stabilization in 23%, and relapse in 23%. Three patients died of a stroke and one patient was lost of sight.

Conclusion. – Our study confirmed the female predominance, the frequency of hypertension, and neuropsychiatric disorders. These results are common to the North African data previously published and confirm the particularity of TA in our region, which is different from the Asian one.

http://dx.doi.org/10.1016/j.lpm.2013.02.189

Radiological features in Takayasu’ arteritis in Tunisia. About 34 cases

N. Belfeki, I. Ben Ghorbel, S. Souissi, A. Hamzaoui, T. Ben Salem, M. Khanfir, M. Lamloum, M. Miled, H. Houman

La Rabta Hospital, Department of Internal Medicine, Tunis, Tunisia

Introduction. – Angiographic assessment is essential to make a diagnosis of Takayasu arteritis (TA). The aim of this study is to describe radiological features of TA in Tunisia and compare it to the literature.

Methods. – Records of patients in the internal medicine department of La Rabta’s university hospital from 1992 to 2012. The criteria for inclusion were those proposed by the American College of Rheumatology. We used the new angiographic classification for TA according to the international conference on Takayasu arteritis in Tokyo in 1994.

Results. – Thirty-four patients were identified. The TA diagnosis was confirmed in all patients by aortography, digital subtraction angiography, or magnetic angiography. Type I (51%) and type V (27%) were the most frequent. Type III, III, and IV were reported in two cases each, and type Ia in one case. Thirty patients had an angiographic study. Stenosis was the most frequent lesion, being present in 21 patients (70%) followed by occlusion in 12 patients (40%), circumferential wall thickening in ten patients (33%), and aneurysm in six patients (20%). The topography and the type of arterial involvement are detailed in table 1 below.

http://dx.doi.org/10.1016/j.lpm.2013.02.188