Objectives We describe a patient with multicentric reticulohistiocytosis whose manifestations have started at a much younger age than mentioned in the literature.

Methods

Results 18-year-old female patient presented with a complaint of arthralgia at her wrists, knees and ankles. Her complaints had started 6 months before admission with arthralgia and painful swellings at the wrists and knees. On admission she had active symmetric arthritis at the shoulders, elbows, wrists and knees. Synovial hypertrophy was prominent at the wrists, knees and MCP joints. Cutaneous examination showed a single 0.5 × 0.5 cm erythematous nodular structure at her 3 MCP joint. There were orange coloured hypertrophic lesions at her nail-folds. Her systemic examination was not remarkable. Her ESR was 29 mm/h, CRP 96 mg/dl, RF(-), Hb: 11.5, WBC: 10.300, platelets 289.000. Liver and kidney functions were normal. x-rays of the hands showed periarticular osteopenia, there were no erosions. Arthrocentesis showed the characteristics of an inflammatory synovial fluid. She was thought to have active rheumatoid arthritis and was started on 7.5 mg prednisolone and sulphasalazine 2 g/day. The dosage of prednisolone was gradually increased to 30 mg/day as there was no improvement in her active arthritis. Methotrexate 7.5 mg/week was added. During her follow-up she developed orange papulonodular lesions on her forehead and pinnae. Biopsy taken from the 3MCP joint revealed reticulohistiocytoma. 10 months after the diagnosis she is still under close surveillance as the disease can be associated with malignancy in 25% of patients. She is currently on methotrexate 12.5 mg/week and prednisolone 20 mg/day. The active arthritis at the shoulders and knees has resolved but she still has active arthritis at the wrists.

Conclusion Although multicentric reticulohistiocytosis affects predominantly middle-aged women the disease should be kept in mind in the differential diagnosis of active arthritis for younger age groups as well.

REFERENCE

- 1 Yee KC, et al. *Clin Exp Rheumatol*. 1993;18: 555-8

AB0216 TRANSFORMATION OF PRIMARY HYPERTROPHIC OSTEOARTHROPATHY INTO SECONDARY CAUSED BY BRONCHOGENIC CARCINOMA

Z Jajic, I Jajic. Department of Rheumatology, University Hospital "Sestre Milosrdnice", Zagreb, Croatia

10.1136/annrheumdis-2001.737

Background

Objectives This paper reports on the two cases of PHO that transformed into SHO under the influence of bronchogenic carcinoma.

Methods

Results The patients had not have any sign of PHO activity until the last 3 and 4 months, when a malignant process of the lungs developed and reactivated all symptoms of the disease (joint swelling, moist palms and soles, unpleasant odour of perspiration, deeper folds on the forehead and deeper nasolabial furrow, enlarged fingers, erythema around the nails). Scintigraphy showed increased radioisotopes accumulation in particular regions of the skeleton.

Conclusion To our knowledge, similar cases have not been described in literature.

AB0217 INTRAVENOUS PULSE CORTICOSTEROID THERAPY IN PATIENT WITH EOSINOPHILIC FASCITIS

W Samborski, R Eaba. Rheumatology, K. Marcinkowski University Medical School, Poznań, Poland

10.1136/annrheumdis-2001.738

Background Eosinophilic fascitis is a disorder characterised by the appearance over weeks or months of tender swelling of the arms and legs with inflammation and sclerosis of the deep fascia and subcutis. Long lasting therapy with prednisone is often unsatisfactory.

Objectives A 40-year-old man suffering from eosinophilic fascitis is reported with skin rash and induration of subcutaneous tissue of the forearm, typical "groove sign" and contractures of the elbow joints (pict.1,2,3). Skin involvement was accompanied by peripheral eosinophilia (0,33) hypergammaglobulinemia (0,24), an elevated erythrocyte sedimentation rate (28/h) increased concentration of acute phase reactants (C-reactive protein 52 mg/l), alpha-1 acid glycoprotein 1489 mg/l) as well as leukocytosis (14,5 G/l).

Methods The typical treatment with dosis of 20 mg prednisone caused only slight improvement. Moreover the patient has suffered from typical poststeroidal skin changes. Therefore we decided to perform an intravenous pulse methylprednisolone therapy as follows: 3 days-every day 500 mg methylprednisolone as solution in 5% NaCl (two courses with 4 weeks pause). As a continuation the patient has got orally dosis 7,5 mg prednisone every second day in the morning.

Results After pulse therapy the remission of the symptoms with regression of skin changes and improvement of the acute phase reactants levels (ESR 14/h, CRP 28 mg/l) as well as the normalisation of leukocytosis (10,8 G/L) and eosinophilia (0,03) were observed. After one year observation the patient was still in remission without signs of active inflammatory process and without eosinophilia in blood wet.

Conclusion We recommend in patients with fascitis eosinophilica the intravenous pulse corticosteroids therapy and reduced dosis of prednisone as an alternative to high-dose oral corticosteroids.

AB0218 AMYOPATHIC DERMATOMYOSITIS ASSOCIATED WITH PNEUMONITIS: IS METHOTREXATE A RISK FACTOR ?

I Tekeoglu, A Akyokus, T Tuncer, B Butun, C Kacar, E Gilgil, G Arslan. Department of Rheumatology, Akdeniz University Faculty of Medicine Hospital, Antalya, Turkey

10.1136/annrheumdis-2001.739

Background We described a case of dermatomyositis which subsequently developed interstitial lung disease. 35 years old woman was admitted to our department complaining of dermal eruptions without weakness of muscles. Characteristic skin changes included Gottron's papules on the dorsal aspect of interphalangeal joints, elbows and patella, heliotrop discoloration of eyelids with associated periorbital oedema, macular erythema of anterior neck and chest (V sign), face and forehead and mechanic's hands. Serum CK levels and EMG was normal and no histological abnormality by muscle biopsy was found.

Since she had not claimed evidence of muscle disease she was diagnosed as having dermatomyositis sine myositis (Amyopathic dermatomyositis) and initially treated with prednisolone (40 mg/day) and methotrexate (10 mg. per week). Since her condition didn't changed high dose intravenous immunoglobulin (IVIG)