prescription and use of concomitant drugs in all patients admitted to the hospital with upper gastrointestinal haemorrhage from October-1999 to November-2000. All patient underwent endoscopy to assess the type of gastroscopic lesion and the presence of *Helicobacter pylori*. Requirements of blood transfusion and surgery were also noted.

Results A total 63 (29%) out of 216 patients admitted with upper gastrointestinal haemorrhage were using NSAIDs (60% aspirin, 16% piroxicam, 13% diclofenac, 6% combined and 5% other) during a median of 7.5 days (range 1- >100 days). Median patients' age was 65 years (range 18-90). NSAIDs were prescribed for pain relieve (75%), platelet anti-aggregation (19%) or both (6%). Indication for prescription was done by rheumatology consultants (0%), general practitioners (25%), other consultants (33%) and self-prescribed (41%). Location of lesions at endoscopy were: esophageal (5%), gastric (35%), duodenal (43%) and, multiple lesions (17%). *Helicobacter pylori* was present in 28 (70%) out of 40 samples. A total of 44 (70%) patients had at least one risk factor for NSAIDs gastropathy of whom only 2 (4%) were receiving prophylaxis with protein pump inhibitors and 1 (2%) with H2-blockers. NSAIDs gastrointestinal haemorrhage accounted for a total of 346 admission days, 40 (63%) patients needed blood transfusion and one (1%) suffered surgery.

Conclusion Self-prescription is a common cause of NSAIDs gastrointestinal haemorrhage. Only a minor proportion of patients with risk factors for NSAIDs gastropathy receive appropriate prophylaxis with protein pump inhibitors.

THU0217 JOINT HYPERMOBILITY SYNDROME: A PROSPECTIVE STUDY OF ARTICULAR AND NON-RHEUMATIC MANIFESTATION IN A VENEZUELAN POPULATION

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Background

Objectives Although Joint Hypermobility Syndrome (JHS) is a common condition, there are clearly a number of articular and non-articular manifestations. Because of this, one study of subjects with JHS was performed in our country.

Methods A prospective, descriptive and analytical of 41 patients attending our Unit from February up to September 1999, and who fulfilled the Beighton Scale for JHS (Beighton P, Grahame R, Bird H (1999) Assessment of hypermobility. In Beighton P (ed) *Hypermobility of Joints*. Spring, London, pp:9-22) was made. The mean age was 32 years, there were 35 females (85.4%) and 6 males (14.6%). All over the group were evaluated through Beighton Scale (BS), being 4 points the lowest and 9 points the highest. All subjects were examined for echocardiogram and a gynaecological exam was performed in all sexually active women.

Results 11 patients (26.8%) had 9 points in the BS and 1 patient (2.4%), being the mean of the group of 6 points. The dorsiflexion of fifth finger was found in all subjects. When comparing passive apposition of the thumb of the flexor aspect of the forearm, with the highest point, there was a good correlation ($p = 0.003$). Patients under 30 years had higher points in the BS ($p = 0.005$). Arthralgia was present in 29 subjects (70.78%), mainly in women ($p = 0.001$). Flat feet was found in 23 patients (56.09%) and Marfanoid habitus in 23 patients. Mitral valve

prolapse (MVP) was found in 24 patients (58.53%), the great majority under 30 years and with higher points in the BS. Uterine prolapse was diagnosed in 12 women of the 24 examined (50.0%), most of them over 30 years, no significance correlation was showed between uterine prolapse and points in the BS.

Conclusion In our study arthralgias particularly of the knees was found, and among extrarticular MVP was the commonest one. We also found a higher incidence of uterine prolapse than expected for women in this age.

THU0218 SUCCESSFUL TREATMENT OF WEBER CHRISTIAN DISEASE (WCD) WITH THALIDOMIDE IN A PATIENT FAILING MULTIPLE OTHER MEDICAL THERAPIES

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Background

Objectives A case of idiopathic nodular panniculitis (WCD) with recurrent febrile episodes resistant to corticosteroids and methotrexate (MTX) in alternating combin. with hydroxychloroquine (HCQ), azathioprine, cyclosporine, colchicine, and doxycycline is described. Thalidomide 50-100 mg/d induced a remission - now since 2y.

Methods CASE REPORT: The patient is a 65y.o. German male who presented first in 3/1998 with a 2-y. hist. of recur. febr. attacks with 1-2 cm, painful, palp., subc., non-draining, eryth. nodules occur. on lower legs, backside of upper thighs, lower back, and upper arms. 3 consec. biop. showed lobular and septal panniculitis. Lab. exam. revealed mild leukopenia (2500/mm³), mild thrombocytopenia, CRP 2.5 mg/dl, sed.-rate 50 mm/h, ferritin 900 ng/ml. Blood cultures, ANA, ANCA, RF, C3, C4, C1q-Inhib., cardiolip.-AB, immunoelpho., borrh. burgd. ser., a1-anti-trypt., serum amyl. and lip., and UA were all normal or neg. Bone marrow biopsy showed unspecific changes. Chest x-ray was normal. Abdominal CT gave no hint for lymphoma or malignancy. Despite 25 mg/d of prednisolone and 20 mg weekly MTX recurrent attacks occurred. Various drugs were tried in combination with MTX in order to lower steroids such as azathioprine 100 mg/d, HCQ 400 mg/d, doxycyc. 200 mg/d, colchicine 1.2 mg/d, and cyclosporine (200 mg/d), all without improvement.

In 3/1999 sympt. worsened and CRP rose intermitt. to 16 mg/dl, further lab. exam. showed persistence of leukopenia 3400/mm³, normal platelet counts, but drop of haemoglobin to 9.5 without clinical evidence of a GI-bleed. A new bone marrow biopsy revealed lymphocytic hyperplasia with no histol. or cytol. support for erythrophagocytosis.

Thalidomide initially 150 mg/d at night, then after 2 weeks at 100 mg/d was started and induced disappearance of febrile attacks and subcutaneous nodules. CPR, sedimentation-rate, and haematological findings normalised. Glucocorticosteroids and MTX were discontinued. After 3 months thalidomide was reduced to 50 mg/d with infrequent mild relapses (with mild subcutaneous nodules only), which disappear within 1-2 day with temporary thalidomide dose increase to 100 mg/d.

Results

Conclusion Rarity of WCD has so far hampered a controlled therapeutic trial with any drug. Only case reports with various drugs exist suggesting mostly corticosteroids, MTX, HCQ, cyclosporine, which all failed in this case. The use of thalidomide in WCD is suggested by clinical similarities to erythema