Conclusion At its simplest this case represents two disease processes occurring by chance in the same patient. However both conditions are uncommon.

A second possibility is that there is a common genetic link. The patient's father had a history of idiopathic thrombocytopenia. Some cases of evolution from ITP to SLE have been reported. It seems possible therefore that there may be a genetic component to his predisposition to lupus. Linkage studies of SLE using microsatellites have revealed a wide range of genome susceptibility loci. Although haemochromatosis is the most commonly inherited single gene disorder, there was no known family history here.

A further possibility was that the two conditions had an additive effect. A high ferritin can reflect lupus activity. It also acts a source of iron causing production of hydroxyl radicals from oxygen and extensive tissue damage.

In conclusion there are several possible theories causing multi-organ failure in this case.

REFERENCE

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AB0074 PULSE METHYLPREDNISOLONE AND CYCLOPHOSPHAMIDE THERAPY IN THREE SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS WITH BRONCHIOLITIS OBLITERANS ORGANISING PNEUMONIA AS THE INITIAL MANIFESTATION

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Background Diverse pleuropulmonary manifestations are common in patients with systemic lupus erythematosus (SLE). Bronchiolitis obliterans organising pneumonia (BOOP) is a pathologic entity characterised by the formation of fibrous tissue plugs within terminal bronchioles and alveolar ducts. Although BOOP has been associated with several connective tissue disorders, there are rare reports of BOOP in patients of SLE as the initial manifestation.

Objectives We described three SLE patients with open lung biopsy-proved BOOP as the initial manifestation which responded well to pulse intravenous methylprednisolone and cyclophosphamide therapy. All three cases presented with fever, cough and dyspnea. Chest radiographs and CT scan of lung revealed bilateral pulmonary infiltrates. BOOP was confirmed by open lung biopsy. Pulmonary vasculitis was also demonstrated in lung histopathology in one case.

Methods

Results The pulmonary lesions and respiratory illnesses responded well to monthly pulse intravenous methylprednisolone and cyclophosphamide therapy.

Abstract AB0074 Table 1

	Case 1	Case 2	Case 3
Sex	Female	Male	Male
Age	43	56	47
ANA	1:160, speckled	1:320, homogeneous	1:320, homogeneous
anti-ENA	SS-A, SS-B	Negative	Negative

anti-dsDNA	Negative	69 IU/ml	>400 IU/ml
Clinical and laboratory data.			

Conclusion

AB0075 AORTITIS SYNDROME (TAKAYASU'S ARTERITIS) ASSOCIATED WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Background Aortitis syndrome (Takayasu's arteritis) associated with various autoimmune diseases have been reported.

Objectives We report the rare association of aortitis syndrome with SLE in two patients.

Methods Case report.

Results Case 1. A 49-year-old woman admitted with Raynaud's phenomenon, right upper extremity claudication, malar rash, and oral ulcerations. Examination showed that her right radial pulse was not palpable. A systolic bruit was heard over her right carotid artery. Laboratory results were as follows: erythrocyte sedimentation rate 89 mm/h, leukopenia, thrombocytopenia, positive ANA, positive anti-ds-DNA. An aortogram demonstrated a complete obstruction of the right subclavian artery near its origin. The patient was diagnosed as having SLE and TA based on ACR criteria for both diseases. She was treated with prednisolone and azathioprine. 6 months later, her right radial pulse was weakly present.

Case 2. A 30-year-old man was diagnosed in 1985 as having SLE based on malar rash, arthritis, positive ANA, positive anti-ds-DNA, hematologic abnormalities. He was treated with prednisolone (P) and azathioprine. He was readmitted in 1992 with progressive difficulty walking and symptoms of lower extremity claudication. Aortogram revealed occlusion of the abdominal aorta below the renal arteries. In 1994, he developed renal and cerebral involvement and superior vena cava syndrome (SVCS). He was again treated with P and cyclophosphamide (C). In 2000, A computed tomogram of the thorax confirmed SVCS due to mediastinal fibrosis. He has been using P and tamoxifen for 1 month.

Conclusion Our experience with these cases suggests that all patients with SLE be followed carefully for the development of occlusive arterial involvement.

AB0076 WARTS IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Background It is widely accepted that patients with systemic lupus erythematosus (SLE) have an increased susceptibility to infections, and infections have also been considered to be important in triggering SLE. An increased frequency of bacterial and mycotic infections have been reported. SLE is also associated with few viral infections.

Objectives During their follow-up many patients with SLE were found to have viral warts. We therefore undertook this study to determine the prevalence of warts in patients with SLE.