Conclusion

REFERENCES

- Otsuka F, Amano T, Hashimoto N, Takahashi M, Hayakawa N, Makino H, Ota Z, Ogura T. Bronchiolitis obliterans organizing pneumonia associated with systemic lupus erythematosus with antiphospholipid antibody. *Intern Med.* 1996;**35**(4):341–4
- Imasaki T, Yoshii A, Tanaka S, Ogura T, Ishikawa A, Takahashi T. Polymyositis and Sjogren's syndrome associated with bronchiolitis obliterans organizing pneumonia. *Intern Med.* 1996;**35**(3):231–5
- Min JK, Hong YS, Park SH, Park JH, Lee SH, Lee YS, Kim HH, Cho CS, Kim HY. Bronchiolitis obliterans organizing pneumonia as an initial manifestation with systemic lupus erythematosus. *J Rheumatol.* 1997;**24**(11):2254–7
- Shinohara T, Hidaka T, Matsuki Y, Ishizuka T, Takamizawa M, Kawakami M, Kikuma H. Rapidly progressive interstitial lung disease associated with dermatomyositis responding to intravenous cyclophosphamide pulse therapy. *Intern Med.* 1997;**36**(7):519–23

AB0079 CYCLOPHOSPHAMIDE EXPOSURE DURING PREGNANCY: TWO CASES

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Background Lupus nephritis is a severe clinical entity that should be treated with cytotoxic drugs. Cyclophosphamide is an effective cytotoxic agent against lupus nephritis. Cyclophosphamide is probably a potent teratogen. Severe birth defects reported in several cases after cyclophosphamide given as little as 200 mg during pregnancy. Some authorities, however, recommend the use of cyclophosphamide in life-threatening lupus during pregnancy.

Objectives In this report, we present two cases that used cyclophosphamide during unpredicted pregnancy.

Methods

Results Case-I: A 20-year-old female was diagnosed as SLE with arthritis, photosensitivity, haemolytic anaemia, leukopenia, proteinuria and positive antinuclear and anti-ds-DNA antibodies. Anti-phospholipid antibodies were negative. The disease remained under control with corticosteroids, hydroxychloroquine and cyclophosphamide. In June 1999, it was noticed that she had been pregnant for 24 weeks and she had received five cycles of intravenous pulse cyclophosphamide (500 mg for each cycle, 2500 mg total dose). Until the end of pregnancy, the treatment was continued with corticosteroids. The baby is now 16 months-old and in good health.

Case-II: A 21-year-old female patient presented with arthritis, carditis, and proteinuria. She had positive antinuclear, anti-ds-DNA, and negative anti-phospholipid antibodies, and the diagnosis of SLE was made. She was treated with oral corticosteroids and intravenous cyclophosphamide. In September 1999, while she was in remission, it was noticed that she had been pregnant for 12 weeks. Since that time, she had been given intravenous 500 mg pulse cyclophosphamide twice (1000 mg totally). During pregnancy, only corticosteroids and salicylic acid were given. In March 2000, she delivered a healthy male baby. The baby is now 9 month old and healthy.

Conclusion Although fertility is decreased in SLE due to lupus nephritis and cyclophosphamide treatment, some pregnancies may occur. The pregnancies of SLE patients with anti-phospholipid syndrome have poorer prognosis. The absence of anticardiolipin antibodies in these two patients might have protected from poor outcome. Some authors believe that cyclophosphamide should not be used due to its teratogenic effect. Reported abnormalities due to cyclophosphamide during pregnancy include

absent thumbs, absence of the great toes or all toes, palatal abnormalities, and a single coronary artery. However there are also reports of normal infants born from cyclophosphamide-treated mothers, and cyclophosphamide was proposed in life-threatening lupus. Experiences of cases like the present two may help the physician to make decisions on cyclophosphamide therapy during pregnancy in life-threatening cases.

AB0080 TREATMENT FAILURE PULMONARY HAEMORRHAGE OF SISTEMIC LUPUS

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Background

Objectives To describe the treatment and outcome of patients with SLE and pulmonary haemorrhage.

Methods Retrospective study (1989–2000). Centre: University Hospital. Area: 700,000 inhabitants. SLE clinic: 154 SLE patients were reviewed. All patients fulfilled the ACR criteria for SLE.

Results All patients received plasmapheresis, 3 bolus of cyclophosphamide 12 mg/kg/day and prednisone 2 mg/kg/day iv. Mechanical ventilation was employed in all patients. Death was secondary to nosocomial infections.

Abstract AB0080 Table 1

Age	Sex	Evolution of SLE (month)	SLEDAI	anti-DNA	Complement C3/C4
43	Female	6	9	1/640	10/2,1
63	Female	120	21	1/2500	46/14
74	Female	40	4	Negative	32/12

Conclusion Pulmonary haemorrhage is a rare and often fatal complication of SLE. There are no uniform recommendations for treatment. Mechanical ventilation and immunosuppressors were a risk factor for a increase mortality.

AB0081 CENTRAL NERVOUS SYSTEM INVOLVEMENT IN CONNECTIVE TISSUE DISEASES – OUR EXPERIENCE

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Background Central nervous system involvements are the most severe clinical manifestations in connective tissue diseases.

Objectives We estimated prevalence of central nervous system (CNS) involvement in our patients.

Methods They were followed up during ten years period.

Results Among 250 patients with systemic lupus erythematosus (SLE), 17 (7%) had alterations of CNS: cerebrovascular insult (5 pts), seizures (4 pts), psychosis (3 pts), transversal myelitis (2 pts), cranial nerve paralysis (2 pts) and psychoorganic syndrome (1 pt). In 3 pts SLE expressed primarily with CNS manifestations. Thirteen patients of 64 (20%) with Behcet disease had impairment of CNS: aseptic meningoencephalitis (2 pts), pyramidal syndrome (2 pts), cerebellar-ataxic syndrome (2 pts), myelopathy (2 pts), cranial nerve paralysis (2 pts), psychosis (1 pt),

cerebrovascular insult (1 pt) and idiopathic intracranial hypertension (1 pt). Only two patients of 50 with primary Sjogren syndrome expressed CNS manifestations as cranial nerve paralysis or disseminated demyelination disease. We also analysed our 20 patients with primary antiphospholipid syndrome, that is not connective tissue disease, but its immunological-mediated pathogenesis may affect functions of CNS. Among them two patients had multiinfarct dementia.

Conclusion We concluded that CNS involvement is not frequent manifestation in our patients with connective tissue diseases.

FRI0092 TWO CASES OF ETANERCEPT-INDUCED SYSTEMIC LUPUS ERYTHEMATOSUS IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background Anti-TNF alpha therapies in human rheumatoid arthritis, appear to be very safe and efficient. Most frequently reported adverse events are infectious complications and local manifestations at site of injection. Auto-antibodies have been reported in some cases.

Objectives We report 2 cases of etanercept-induced SLE in patients with seronegative RA and previous isolated positive ANA.

Methods

Results A 38-year-old Caucasian woman was started on etanercept on February 2000, after a 16-year history of severe seropositive RA unsuccessfully treated with hydroxychloroquine, D-Penicillamine, gold salts, and methotrexate plus prednisone. When aged 32, positive ANA (1/400°) and transient low C4 were noticed with weakly positive Anti-DNA (ELISA, 40 IU/ml, positivity > 40); she had no anti-ENA, anti-keratin, APF or anti-cardiolipin antibodies. RA remained very active [morning stiffness > 3 h, CRP 60, 28 swollen joints]. MTX was stopped and the patient started on etanercept. RA was remarkably controlled within one month, and prednisone tapered. 3 months later, she presented scattered lesions located on the face and the scalp (no sun exposure), fatigue and diffuse pain. Skin analysis demonstrated dermal atrophy with keratinocytes necrosis, perifollicular and perivascular lymphocytic infiltration, with no vasculitis. She had positive ANA, anti-DNA, anticardiolipin Ab and low C4 with negative anti ENA. She also had elevated muscle enzymes, normal blood count, normal liver and renal functions (no proteinuria). Etanercept was stopped; she was started on topical steroids. One month later skin lesions had cleared, very active polyarthritis was again present. At that time ANA remained positive, anti-DNA decreased as well as muscle enzymes and ACL antibodies. Biological abnormalities had returned to normal values in September 2000. The patient has not been rechallenged.

A 50-year-old woman with a familial history of RA, had active arthritis despite steroids and sulphasalazine. Methotrexate and ciclosporin were excluded (chronic alcoholic hepatitis and HTA). Etanercept was introduced in October 1999. RA was remarkably controlled, but she developed after 4 months a diffuse erythematous and purpuric skin eruption with fine scaling (face, dorsa of hands and fingers), erosions and crusts, not involving the injection sites. Histological analysis showed hyperkeratosis, keratinocyte necrosis and perivascular lymphocytic infiltration without vasculitis. She had lymphopenia,

thrombocytopenia, elevated ESR, abnormal liver function test, and normal renal function, positive ANA (1/640), negative anti-double-stranded-DNA and anti-ENA Ab. After etanercept stoppage, skin manifestations spontaneously resolved but synovitis reappeared. The patient has not been rechallenged.

Conclusion Imputability of etanercept the disease is very likely, given the temporal correlation between the onset of signs with the initiation of injections, and their resolution following withdrawal of the drug. Further evaluation is needed to know whether presence of positive ANA or association with other SLE drug inducer are risk factors for development of these TNF inhibitors-induced manifestations.

FRI0093 TWO CASES OF ETANERCEPT-INDUCED SYSTEMIC LUPUS ERYTHEMATOSUS IN PATIENTS WITH RHEUMATOID ARTHRITIS

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10.1136/annrheumdis-2001.128

Background Anti-TNF alpha therapies in RA appear to be very safe and efficient. Most frequently reported adverse events are infections and local manifestations. Auto-antibodies have been reported in some cases.

Objectives We report 2 cases of etanercept-induced SLE in patients with RA and previous isolated ANA.

Methods

Results A 38-year-old Caucasian woman was started on etanercept on February 2000, after a 16-year history of severe seropositive RA unsuccessfully treated with hydroxychloroquine, D-Penicillamine, gold salts, and methotrexate plus prednisone. When aged 32, positive ANA (1/400°) and transient low C4 were noticed with weakly positive Anti-DNA; she had no anti-ENA, anti-keratin, antiperinuclear factor or anti-cardiolipin antibodies. RA was very active [morning stiffness > 3 h, CRP 60, 28 swollen joints]. MTX was stopped and the patient started on etanercept. RA was remarkably controlled, and prednisone tapered. 3 months later, she presented scattered lesions on the face and the scalp (no sun exposure), fatigue and diffuse pain. Skin analysis demonstrated dermal atrophy with keratinocytes necrosis, perifollicular and perivascular lymphocytic infiltration, with no vasculitis. Biological tests revealed positive ANA, anti-DNA, anticardiolipin antibodies, low C4, negative anti ENA. She also had elevated muscle enzymes, normal blood count, liver and renal functions and no proteinuria. Etanercept was stopped; she was started on topical steroids. One month later skin lesions had cleared, very active RA was again present. At that time ANA remained positive, anti-DNA decreased as well as muscle enzymes and ACL antibodies. Biological abnormalities had returned to normal values in September 2000. The patient has not been rechallenged.

A 50-year-old woman had active RA despite low dose steroids and sulphasalazine. MTX and ciclosporin were excluded because of alcoholic hepatitis and hypertension. Etanercept was introduced in October 1999. RA was remarkably controlled; she developed 4 months later a diffuse erythematous and purpuric skin eruption with fine scaling (face, dorsa of hands and fingers) erosions and crusts, not involving the injection sites. Histological analysis demonstrated hyperkeratosis, keratinocyte necrosis and perivascular lymphocytic infiltration without vasculitis. Biological tests showed lymphopenia, thrombocytopenia, elevated ESR, abnormal liver function test, and normal renal function tests,