Conclusion Giant cell arteritis should be considered in the differential diagnosis of patients with ocular manifestations. Prompt diagnosis and treatment are required if second eye involvement and blindness are to be prevented.

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AB0089 BEHCET'S DISEASE IN AN ARAB COMMUNITY IN ISRAEL

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Background The prevalence of Behcet's disease (BD) varies in different parts of the world.

Objectives To evaluate the prevalence of BD in an Israeli Arab town (Taibe).

Methods Questionnaires about the occurrence and frequency of aphthous ulcers were distributed randomly to the parents of children attending a Paediatric Clinic in Taibe. The parents were asked whether they or any of their children aged over 10 years suffered from recurrent aphthous stomatitis (RAS), and if so, any who had had more than four episodes during the previous year where each episode had lasted for more than 7 days were invited to come for an extensive interview and examination by a rheumatologist or a paediatrician.

Results Overall, six individuals (one male and five females) were diagnosed as suffering from BD. All of these, two of whom were siblings (a brother and a sister) had RAS, genital ulcers and joint manifestations. Five had skin and four had visual involvement, and one out of two had a positive pathergy test. Five of the six carried HLA-B5 antigens. This gave a prevalence in Taibe of 12/10,000.

Conclusion The prevalence of BD found in our survey is high and concurs with that found in other Mediterranean and Asian countries where a high prevalence has also been noted.

AB0090 IS THERE ANY ROLE OF ANTI-ANNEXIN V AUTOANTIBODIES IN THE THROMBOTIC EVENTS OF BEHCET'S SYNDROME

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Background Is there a role for anti-phospholipid-binding protein antibodies in the pathogenesis of thrombosis in Behcet's disease?

Objectives We have proposed that thrombosis in the Behcet's syndrome may be due to the disruption of the annexin-V shield by antiphospholipid antibodies. Measurement of anti-annexin V antibodies may be of value in confirming the diagnosis and in evaluating risk of venous and arterial thrombosis in patients with Behcet's syndrome.

Methods In group one 26 patients with Behcet's with well documented thrombosis, in group two 27 patients with Behcet's without thrombosis and in group three 27 healthy controls are included in the study. Sera were examined for both IgG and IgM anti-annexin V antibodies by ELISA. (American Diagnostica, IMUCLONE® Anti-Annexin V, IgG and 1 gM (#652G and #652M)).

Results Quantitative ELISA test results were used for statistical purpose. Statistical analysis was done with using Oneway Anova tests under the SPSS 9.0 for Windows software package. There were no statistical difference between groups for both IgM and IgG anti-annexin V antibody ELISA test results. Results were as follows:

Abstract AB0090 Table 1

	Numbers	IgM (+)	IgM (Grey Zone)	IgM (-)	IgG (+)	IgG (Grey Zone)	IgG (-)
Group 1	26	3	12	11	8	9	9
Group 2	27	2	10	15	5	12	10
Group 3	27	1	12	14	5	8	14
Total	80	6	34	40	18	29	33

Conclusion These results indicated that these antibodies may not be associated with the pathogenesis of thrombotic events of the patients with Behcet's syndrome.

IgG anti-annexin V antibodies were detected in 5 of 27 healthy subjects (18%).

Compare to previous study results this may indicate the possibility of high prevalence of IgG anti-annexin V antibodies in the healthy Turkish population.

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AB0091 PULMONARY TAKAYASU'S ARTERITIS MIMICKING ACUTE PULMONARY EMBOLISM

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Background Pulmonary Takayasu's arteritis may sometimes be the initial presentation of Takayasu's arteritis. Cases of pulmonary TA mimicking chronic thromboembolism have been reported.^{1–4} However, only two brief reports of Takayasu's arteritis mimicking acute pulmonary embolism have been described in the radiology and pathology literature,^{1,4} but none mentioned the exact duration of symptoms or the detailed presentation. We describe a patient of Takayasu's arteritis who presented with pulmonary symptoms of three days duration, which mimicked acute pulmonary embolism.

Objectives

Methods

Results The patient presented with a three-day history of cough and shortness of breath and had multiple bilateral perfusion

defects on ventilation-perfusion scan, typical of acute pulmonary embolism (Figure 1). She was initially diagnosed with acute pulmonary embolism and treated empirically with heparin. Subsequently a negative venous Doppler, absence of changes of acute or chronic thromboembolic disease on pulmonary angiogram, elevated ESR of 70 mm/hr, and the typical angiographic changes (Figure 2), led us to make the correct diagnosis of Takayasu's arteritis. Her initial arch angiogram was normal (Figure 3A). She responded to treatment with prednisone, with both clinical improvement and a 50% increase in the calibre of both right and left pulmonary arteries on a MR angiogram done six months later. A repeat pulmonary angiogram 11 months later showed a decrease in pulmonary artery pressures from 65/12 mm Hg to 49/10 mm Hg. She was lost to follow-up and returned six years later with symptoms of dizziness and angiographic evidence of carotid artery involvement (Figure 3B), which required arterial bypass grafting. Histopathological examination of the artery specimen showed patchy acute and chronic inflammation of adventitia, media and intima, focal granulomatous foreign body reaction, and intimal proliferation, changes consistent with Takayasu's arteritis.

Conclusion In young women presenting with a clinical picture of acute pulmonary embolism without any risk factors or a previous history of thromboembolism, pulmonary TA must be considered in the differential diagnosis. A careful evaluation of the clinical features, laboratory findings and angiographic appearance, will often lead to the correct recognition of pulmonary Takayasu's arteritis and the initiation of appropriate therapy.

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AB0092 POLYARTERITIS NODOSA PRESENTING WITH BILATERAL PERIRENAL HEMATOMA IN PATIENT WITH FMF

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Background

Objectives

Methods Case Report: A 17-year old Turkish boy was admitted to our clinic with complaints of weight loss, fatigue and abdominal pain. He had been on colchicine therapy for 6 years with the diagnosis of FMF. On January 2000, he was diagnosed as having acute hepatitis A infection in another centre. Two weeks later he was hospitalised due to severe abdominal pain and abrupt decrease in his haemoglobin values. A right renal subcapsular hematoma was demonstrated by computerised tomography (CT). During follow-up haemoglobin values progressively declined and the hematoma showed enlargement in control CT. Therefore right nephrectomy was performed. After the patient was stabilised he was discharged. However he was again hospitalised with similar complaints 4 days later. This time subcapsular hematoma

was demonstrated in the left kidney and he was referred to our hospital in March 2000. In physical examination, blood pressure was 160/125 mmHg. Laboratory evaluation demonstrated anaemia and elevated erythrocyte sedimentation rate and C-reactive protein. Serological tests for anti-hepatitis B surface antigen, anti-hepatitis A IgG and IgM were positive.

Nephrectomy slides were re-evaluated in our pathology department. Patchy and segmental areas of renal infarct were demonstrated. No amyloid deposits could be noted in the histopathology specimens. Renal angiography demonstrated 2 microaneurysms on intertubular arteries. Together with these findings the diagnosis of PAN was made and the patients was treated with intravenous corticosteroids, intravenous cyclophosphamide and oral corticosteroids together with antihypertensive therapy. He is still being followed-up by our clinic in good health.

Results

Conclusion Perirenal hematoma, which is a rare complication of isolated PAN, have been reported in approximately half of the patients with FMF who developed PAN. The exact pathogenetic relationship of FMF and PAN also is not clear. Immune-related mechanisms have been demonstrated in FMF. It has been proposed previously that infection-related antigenic stimuli could trigger the development of vasculitides. In the present case an usual response to hepatitis A infection and/or previous hepatitis B infection might have been among the triggers of vasculitic process. Additional reports demonstrating direct causal relationship between infectious agents and vasculitic syndromes in patients with FMF will help us to clarify the relationship between the two disorders.

AB0093 CALCIPHYLAXIS DUE TO LONG-TERM STEROID USING IN A PATIENT WITH RHEUMATOID ARTHRITIS

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Background Calciphylaxis is a rare and life-threatening condition of progressive cutaneous necrosis secondary to small and medium-sized vessel calcification seen almost exclusively in patients with end-stage renal disease and hyperparathyroidism.

Objectives We report a case with calciphylaxis due to long-term steroid using in a patient with rheumatoid arthritis (RA).

Methods Case report.

Results A 43-year-old man admitted with a history of progressive left leg pain and ulcerations. Several hemoragic bullae were present in these areas as well, and the patient offered that the ulcers began as blisters that then broke down. His past medical history included RA and he had been using steroid in doses of 5-40 mg/day according to his complaints for 20 years when he was admitted to our hospital. His examination revealed destructive and erosive arthritis affecting his bilateral wrists, MCP, and PIP joints, and ischaemic necrosis in the distal parts of the 2nd and 3th. digits of the left hand. Laboratory results were as follows: erythrocyte sedimentation rate 77 mm/h, urea 9 mg/dl, creatinine 0.8 mg/dl, calcium 7 mg/dl, phosphate 3.7 mg/dl, albumin 2 gr/dl, parathyroid hormone 43 pg/ml (n = 12-72), protein S 38% (n = 7-115%). Roentgenogram of the lower aspect of the leg showed calcified larger vessels and subcutaneous vessels. His lesions progressed and required above the left knee and left 2nd., 3th. digits amputations. Pathologic examination showed extensive arterial wall calcification. Now he has