An accidental overdose of benzodiazepines as per the psychiatry service. He was discharged home and subsequently developed insomnia, hyperactivity and talkativeness and was referred to the psychiatry ward and additionally found to have a varicella zoster skin rash. Upon resolution of the zoster infection she was started on tocilizumab by subspecialist injection weekly and prednisone was successfully tapered over 4.5 months without recurrence of symptoms.

Case 2: This is a 63 y/o man with ITP on monthly rituximab and chronic prednisone 10 mg daily, hypertension, hyperlipidemia and osteoarthritis who developed worsening shoulder and neck pain for two months with more recent onset of scalp tenderness and left-sided vision changes for two weeks. He was found to have left optic neuropathy, elevated inflammatory markers, and an MRI demonstrating enhancement of the left temporal arterial. Left temporal arterial biopsy was normal. He was given pulse dose intravenous methylprednisolone for suspected giant cell arteritis and transitioned to high dose oral prednisone with improvement in musculoskeletal symptoms, inflammatory markers and stabilisation of his vision. He subsequently developed insomnia, hyperactivity and talkativeness and was diagnosed with steroid-induced mania, which improved with antipsychotics and benzodiazepines as per the psychiatry service. He was discharged home and after three days developed new vision loss of the right eye on prednisone 60 mg daily. On exam, he was found to have progressive visual field loss of the left eye and new inferior visual field loss of the right eye with disc oedema of the right optic nerve. Right temporal artery biopsy was negative. He was again given pulse dose intravenous methylprednisolone followed by oral methylprednisolone and ultimately received tocilizumab intravenously prior to discharge.

Disclosure of Interest: None declared


SP0050 OPPORTUNITIES AND CHALLENGES OF IMAGING IN PRIMARY SJÖGREN’S

S. Jousse-Joulin, Rheumatology, Cavale Blanche Hospital, Brest, France

Sjögren’s syndrome (SS) is a chronic autoimmune inflammatory disorder of exocrine glands. Its diagnosis relies solely on a combination of clinical and laboratory findings. However, recent developments have shown that imaging techniques may have additional value in detecting salivary glands abnormalities in pSS. In general, sialography is considered to be the most reliable of the imaging methods. Salivary gland scintigraphy is very sensitive and especially useful in early stages of the disease. Nevertheless, both imaging techniques are used by only minority of rheumatologists for diagnosis of pSS because of the invasive character of sialography and the low specificity of scintigraphy. MRI has shown a good sensitivity and specificity to detect structural abnormalities in pSS but few centres have access to the specific know-how. A recent development is the increased interest in ultrasonography (US) as a tool to assess major salivary glands. Ultrasonography of the salivary glands (SGUS) appears to be an inexpensive commonly available noninvasive technique that does not cause complications and inconveniences to the patient, although the data are somewhat conflicting. Although, the recent but preliminary American classification criteria for Sjögren syndrome do not include salivary gland such imaging technique this procedure has clearly demonstrated high impact on classification of Sjögren patients and demonstrated good diagnostic properties. A systematic literature review has shown a paucity of data regarding the metric properties of ultrasound, making interpretation and