damage indices at presentation. One rare but life-threatening complication of AAV is diffuse alveolar hemorrhage (DAH). Other clinical features, course and response to therapy in Hispanic American patients with AAV and DAH seen at a large public teaching hospital that serves medically underserved and low income patients with chronic poor health maintenance.

Methods: Among 60 Hispanic American patients with AAV, we retrospectively studied 13 patients with DAH from 2003-2017. Clinical features, laboratory results, diagnostic modalities and treatments given were studied.

Results: A total of 13 patients were identified; 6 men and 7 women, mean age of 51±11 years. Anti-PR3 was found in 5 patients, anti-MPO in 8. Nine patients were diagnosed with microscopic polyangiitis and 4 with granulomatous polyangiitis based on ACR criteria or Chapel Hill Consensus Conference definitions. DAH was a presenting manifestation in 12 patients. Gross hemoptysis with hypoxia, drop in hematocrit and chest X-ray infiltrates were seen in all patients diagnosed with DAH. Bronchoscopy with BAL washings confirming diagnosis was done in 10 patients. All patients had multi-organ involvement including nephritis (n=8), peripheral neuropathy (n=1), palpable purpura (n=2), upper respiratory tract involvement (n=4) and eye involvement (n=2). Serum C3 was normal in 12 patients. Renal biopsy in 9 patients showed pauci-immune crescentic glomerulonephritis. Mean BVAS at time of DAH was 21.2±5.1.

All patients underwent induction-remission therapy with pulse methylprednisolone followed by tapering oral prednisone. Induction therapy included IV cyclophosphamide (n=6), rituximab (n=6) and IV cyclophosphamide/rituximab combination therapy (n=1). Nine patients underwent plasma exchange and 5 received IV gamma globulin. Eleven patients required mechanical ventilation; 6 patients needed hemodialysis, 2 temporarily.

All 13 patients responded to induction therapy; mean post-induction therapy BVAS was 9.3±3.5. Pulmonary fibrosis after DAH was noted in 2 patients. No early deaths (<6 months) were observed, however 1 patient died within 3 years due to infection. Mean follow-up period was 69±4 months. Maintenance therapy used included prednisone (n=13), mycophenolate mofetil (n=2), azathioprine (n=6) and IV rituximab (n=8).

Five patients had clinical relapse, 3 with recurrent DAH. Two patients had minor relapse, defined by their treating physician as requiring increased prednisone dose or worsening proteinuria. Mean BVAS at relapse was 15.2±5.5.

Conclusions: This first in-depth study of DAH in Hispanic American AAV patients shows that in this socioeconomic disadvantaged patient population, the response to induction therapy is not significantly different from other ethnic groups reported in the literature. DAH remains a severe clinical manifestation of AAV and should be recognized without delay. If other ethnic groups reported in the literature. DAH remains a severe clinical manifestation of AAV and should be recognized without delay. If other ethnic groups reported in the literature. DAH remains a severe clinical manifestation of AAV and should be recognized without delay. If other ethnic groups reported in the literature. DAH remains a severe clinical manifestation of AAV and should be recognized without delay. If other ethnic groups reported in the literature. DAH remains a severe clinical manifestation of AAV and should be recognized without delay. If other ethnic groups reported in the literature. DAH remains a severe clinical manifestation of AAV and should be recognized without delay. If other ethnic groups reported in the literature. DAH remains a severe clinical manifestation of AAV and should be recognized without delay.

Methods: A retrospective chart review including records from January 2003 to June 2017 was performed to identify patients with both histologic and clinical features of CPAN. We extracted information regarding patient age, clinical presentation, biopsy results, and response to treatment.

Results: Thirteen patients were identified who had clinical features of CPAN that were supported by histologic findings on biopsy. The majority of patients were female (92.3%). The average age at diagnosis was 44.9 years and mean duration of follow up was 53 months. All patients had involvement of the lower limbs with the most common cutaneous manifestation being subcutaneous nodules (92.3%), followed by papules (46.2%) and livedo reticularis (30.8%). Eight out of fourteen patients (61.5%) received steroids and three did not experience clinical benefit. Another patient did not respond to prednisone and hydroxychloroquine, but had significant improvement of her symptoms on prednisone and methotrexate. Seven out of nine patients (77.8%) that were treated with methotrexate had a favorable response. Three of those patients responded to methotrexate after failing other therapies such as dapsone, azathioprine, and prednisone.

Conclusion: In this case series, we found that most patients had a favorable response to methotrexate and thus the role of methotrexate in treating CPAN merits further investigation. As CPAN often has a chronic relapsing and remitting course, initiating methotrexate at the same time as steroid therapy may lower overall lifetime exposure to steroids.

REFERENCES

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