least one risk identified. The most prevalent risks were: overweight or obesity (31.7%), sedentaryism (26.4%), anxiety (22.6%), changes in family structure (22.6%), school problems (20.8%), depression (19.9%), suicidal ideation/self-mutilation (18.9%), low self-esteem (15.1%). Risks related to psychiatric diseases were identified in 23 patients (43.4%).

**Conclusion:** This is one of the first studies on transition care in Brazil focused on risks identification in adolescence. Transition care allows improvement survival and quality of life due to advances in preventive medicine and treatment of chronic rheumatological diseases. The identification of inherent risks, especially psychiatric disorders, plays a fundamental role in the long-term follow-up, making it possible to deliver multidisciplinary and rehabilitation of adolescents.

**REFERENCES**


**Disclosure of Interests:** None declared

**DOI:** 10.1136/annrheumdis-2019-eular.3760

---

**SYSTEMIC LUPUS ERYTHEMATOSUS IN CONTEXT OF HUMAN IMMUNODEFICIENCY VIRUS INFECTION: A CLINICAL CONUNDRUM**

Ankita Singh1, Anjani Gummadi1, Laxmi Makam2, Deepthi Suni3, Anju Gupta4, Pandirajaran Vinnes3, Ankur Jindal3, Amrit Rawat1, Surjith Singh2

1Post Graduate Institute of Medical Education and Research, Chandigarh, Advanced Pediatrics Centre, Allergy Immunology Unit, Chandigarh, India; 2Post Graduate Institute of Medical Education and Research, Chandigarh, Advanced Pediatrics Centre, Allergy Immunology Unit, Chandigarh, India

**Background:** Systemic lupus erythematosus (SLE) and Human immunodeficiency virus (HIV) infection can occasionally coexist in a patient (1). Also, in rare scenarios, the clinical symptomatology and laboratory tests of these diseases can masquerade each other (2).

**Objectives:** To describe diagnostic and therapeutic dilemmas of coexistent SLE and HIV

**Methods:** We analyzed case records of 2 patients with childhood SLE who had the clinical conundrum of HIV infection as well

**Results:** Case 1- An 11-year-old boy presented with large joint arthralgia, fever and respiratory distress for 4 days. On examination he had pallor, oral thrush, and onycomycosis. A malar rash was also noted. Systemic examination revealed consolidation in right lung and hepatosplenomegaly. Investigations showed severe anemia and lymphopenia. HIV serology was strongly reactive and CD4 counts were low (49 cells/μl). In view of malar rash he was investigated for SLE and anti-nuclear antibody (ANA) by indirect immunofluorescence (IIF) was 4+ homogenous with rim enhancement. Anti double stranded DNA (dsDNA) antibody titer was 1200 IU/ml, serum complements were low (C3<28 mg/dl; C4<10 mg/dl) and direct Coombs test for IgG was positive. Antiphospholipid antibody titer were elevated (Anticardiolipin antibody Ig G: 695 U/L; anti b2 glycoprotein anti-body Ig G: 3177 U/L). Blood culture grew Streptococcus pneumoniae. He was started on ceftriaxone and amphotericin, however he had an acute neurological worsening (raised intracranial pressure) during hospital stay.

A diagnosis of concomitant HIV infection and neuropsychiatric SLE was considered and she received pulse methyl prednisolone and intravenous immunoglobulin. She also had hematuria and proteinuria (renal biopsy considered and she received pulse methyl prednisolone and intravenous immunoglobulin. She also had hematuria and proteinuria (renal biopsy considered and she received pulse methyl prednisolone and intravenous immunoglobulin. She also had hematuria and proteinuria (renal biopsy considered and she received pulse methyl prednisolone and intravenous immunoglobulin. She also had hematuria and proteinuria (renal biopsy considered and she received pulse methyl prednisolone and intravenous immunoglobulin. She also had hematuria and proteinuria (renal biopsy

Case 2- An 8-year-old girl was admitted with fever for 6 months and cough and respiratory distress for 4 days. On examination she had pallor, oral thrush, and onycomycosis. A malar rash was also noted. Systemic examination revealed consolidation in right lung and hepatosplenomegaly. Investigations showed severe anemia and lymphopenia. HIV serology was strongly reactive and CD4 counts were low (49 cells/μl). In view of malar rash she was investigated for SLE and anti-nuclear antibody (ANA) by indirect immunofluorescence (IIF) was 4+ homogenous with rim enhancement. Anti double stranded DNA (dsDNA) antibody titer was 1200 IU/ml, serum complements were low (C3<28 mg/dl; C4<10 mg/dl) and direct Coombs test for IgG was positive. Antiphospholipid antibody titer were elevated (Anticardiolipin antibody Ig G: 695 U/L; anti b2 glycoprotein anti-body Ig G: 3177 U/L). Blood culture grew Streptococcus pneumoniae. She was started on ceftriaxone and amphotericin, however she had an acute neurological worsening (raised intracranial pressure) during hospital stay.

A diagnosis of concomitant HIV infection and neuropsychiatric SLE was considered and she received pulse methyl prednisolone and intravenous immunoglobulin. She also had hematuria and proteinuria (renal biopsy considered and she received pulse methyl prednisolone and intravenous immunoglobulin. She also had hematuria and proteinuria (renal biopsy considered and she received pulse methyl prednisolone and intravenous immunoglobulin. She also had hematuria and proteinuria (renal biopsy considered and she received pulse methyl prednisolone and intravenous immunoglobulin. She also had hematuria and proteinuria (renal biopsy

**Conclusion:** These cases highlight the fact that serological tests can be difficult to interpret in patients with overlapping manifestations of HIV infection and SLE. However, early diagnosis and prompt therapy is imperative.

**REFERENCES**


**Disclosure of Interests:** None declared

**DOI:** 10.1136/annrheumdis-2019-eular.6739

---

**AB1053**

**MACROPHAGE ACTIVATION SYNDROME AS A PRESENTATION IN PEDIATRIC LUPUS: A RETROSPECTIVE STUDY OF 3 CASES**

Ankita Singh, Anjani Gummadi, Rakesh Kumar, Sandesh Guleria, Johnson Nameirakpm, Pandiarajan Vignesh, Ankur Jindal, Deepthi Suri, Amrit Rawat, Surjiti Singh. Post Graduate Institute of Medical Education and Research, Chandigarh, Advanced Pediatrics Centre, Allergy Immunology Unit, Chandigarh, India

**Background:** Macrophage activation syndrome (MAS) can, at times, be the presentation of pediatric lupus and diagnosis requires high index of suspicion.

**Objectives:** To report children who had MAS as a presenting manifestation in our cohort of childhood lupus

**Methods:** We retrospectively studied 140 pediatric lupus patients from January 1993- November 2018 and collected clinical and laboratory data of patients (3) who had MAS as presenting manifestation

**Results:** Case 1 was 11-year-old girl with fever for 4 months associated with rash and generalized body swelling for 1 month. Examination revealed rash over malar area and ear lobules, anasarca, hepatomegaly, bilateral pleural and pericardial effusion. In view of multisystem involvement a possibility of lupus was considered which was confirmed by investigations (table 1). She had elevated ferritin and fasting triglyceride and low fibrinogen. A clinical possibility of lupus with associated MAS was considered. She received pulses of methylprednisolone, one dose of intravenous immunoglobulin following which she improved. In view of nephrotic range proteinuria she was started on induction regimen with cyclophosphamide and shifted to mycophenolate in maintenance. Her initial SLEDAI-2k was 32- this decreased to 4 at 3 year follow-up. Case 2 was a 9-year-old girl with fever, rash, generalized body swelling for 1 month and altered sensorium for 4 days. Examination revealed pallor, oral ulcers and hepatomegaly. She was in shock at presentation. In view of multisystem involvement a possibility of lupus was considered which was confirmed by investigations (table 1). She had pericardial effusion and low ejection fraction (25%). A possibility of MAS was considered and investigations revealed hyperferritinemia, elevated triglyceride and hypofibrinogenemia. She was given methylprednisolone pulses and continued on oral prednisolone, mycophenolate and hydroxychloroquine. Her initial SLEDAI-2k was 17- this decreased to 0 at 3 year follow-up. Case 3 was an 8-year-old girl who had fever, rash and body swelling for 15 days. On examination she had tachycardia, tachypnea, pallor, anasarca, subconjunctival bleed and frontal alopecia. She had pleural and pericardial effusion. In view of multisystem involvement a possibility of lupus was considered which was confirmed by investigations (table 1). She had high ferritin and triglyceride. So a possibility of MAS was considered and she received pulse methyl prednisolone and intravenous immunoglobulin. She also had hematuria and proteinuria (renal biopsy could not be performed as she was sick and had thrombocytopenia) so was given pulse cyclophosphamide followed by mycophenolate. Her initial SLEDAI-2k was 25- this decreased to 0 at 2 year follow-up.

**Conclusion:** MAS can be the presenting manifestation of pediatric lupus and may contribute to disease severity and requires aggressive management.

**REFERENCES**

[1] Borgia RE, Gerstein M, Levy DM, Silverman ED, Hiraki LT. Features, Treatment, and Outcomes of Macrophage Activation Syndrome in...