least one risk identified. The most prevalent risks were: overweight or obesity (31.7%), sedentarism (26.4%), anxiety (22.6%), changes in family structure (22.6%), school problems (20.8%), depression (18.9%), 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.

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.3760

AB1052

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

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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-boy presented with large joint arthralgia, fever and respiratory distress for 4 days. On examination he had pallor, oral thrush, and onychomycosis. 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/ μ l). 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 titers were elevated (Anticardiolipin antibody- Ig G: 695 U/L; anti b2 glycoprotein antibody 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 in this child. Pulse methylprednisolone was given, but he soon succumbed to the complications.

Case 2: An 8-year-old girl was admitted with fever for 6 months and cough and respiratory distress for 15 days. On examination she had anasarca, oral ulcers, hyperpigmented macules over face and crepitations in right lung fields. Her HIV ELISA was intermediate reactive. Considering a clinical possibility of secondary immunodeficiency due to HIV infection she was managed with broad spectrum antimicrobials while awaiting confirmatory tests for HIV infection. She went on to develop hypertension and nephritis. ANA was 4+ homogenous, low complements and elevated anti dsDNA. Further tests for confirmation of HIV infection showed CD4 counts - 421 cells/ μ l, negative HIV viral loads, negative HIV DNA PCR and p24 antigen was negative, so it was considered that the intermediate reactivity of HIV serology was false positive. Subsequently she was given immunosuppression (methylprednisolone pulse and cyclophosphamide) to

which she transiently responded however she developed acute intracranial bleed during hospital stay and died.

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.

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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

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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.

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