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ESTABLISHING THE KEY COMPONENTS OF A EULAR PORTFOLIO FOR TRAINING IN RHEUMATOLOGY: A EULAR SCHOOL OF RHEUMATOLOGY INITIATIVE

M. Van Onna¹, S. Ramiro², C. Haines³, M. Holland-Fischer⁴, J. A. P. Da Silva⁵, J. Dudler⁶, C. Edwards⁷, A. Alunno⁸, E. Nikiforou⁹, L. Falzon¹⁰, F. Sivera¹¹ on behalf of Working group on Development of a EULAR Portfolio of Rheumatology. ¹MUMC, Maastricht, Netherlands; ²LUMC, Leiden, Netherlands; ³University of Nottingham, Nottingham, United Kingdom; ⁴Aalborg University Hospital, Aalborg, Denmark; ⁵Faculty of Medicine and University Hospital, Coimbra, Portugal; ⁶Fribourg Hospital Cantonal, Fribourg, Switzerland; ⁷University Hospital Southampton, Southampton, United Kingdom; ⁸University of Perugia, Perugia, Italy; ⁹King's College London, London, United Kingdom; ¹⁰Feinstein Institutes for Medical Research, New York, United States of America; ¹¹Hospital Gral Univ Elda, Elda, Spain

Background: In clinical training, a portfolio is expected to stimulate learning and encourage critical reflection. Some, but not all, European countries use a portfolio in rheumatology training, and their scope varies widely. A EULAR portfolio for Rheumatology trainees could contribute to improve overall training, raise educational standards, foster the setting of common goals and harmonize rheumatology training across countries.

Objectives: Develop key components that should be included in a EULAR portfolio of Rheumatology.

Methods: A working group (WG) composed of 9 rheumatologists and 1 educationalist was established. A systematic literature review (SLR) was conducted in November 2018, according to the PIM structure: Population: trainees; Instrument of interest: portfolio; Measurement of properties of interest: content portfolio. A survey was disseminated among the WG group and WG members of the EMerging Eular Network (EMEUNET), inquiring about the content and structure of existing national portfolios. Portfolio materials of selected countries were reviewed. Last, the WG elected the key components of the portfolio.

Results: 13/2,034 articles were included in the SLR (12 high/1 moderate risk of bias). Information on direct observation of procedural skills (DOPS) (9/13), personal reflections (8/13), learning goals (5/13) and multisource feedback (5/13) were most often included in the portfolio. Twenty-five respondents filled out the survey (response rate ≈ 50%). Reflective writing (n=7), learning goals (n=4) and feedback (n=4) were considered the most useful components of a portfolio. About half indicated that a portfolio was a bureaucratic burden; 4 respondents mentioned lack of feedback by supervisors as a barrier. Portfolio materials of 7 European countries were reviewed. Several portfolios (Germany, Italy, Greece and Spain) were logbooks, i.e. a record of clinical activities. Other portfolios (UK, Denmark, The Netherlands) also included information on workplace-based assessments, learning goals, and personal reflections. The proposed key components of the portfolio are included in Table 1.

Table 1. Key components of the EULAR portfolio of Rheumatology.

Key component	Content
Curriculum vitae	Personal record of achievements, experiences, knowledge and skills
Personal Development Plan	Learning goals and action plan
Clinical work	Information on managing patients (e.g. rheumatoid arthritis) Skills (e.g. joint aspiration) Assessments (summative and formative)
Professional behaviour	Personal reflections Multisource feedback
Education	Personal reflections Continuing professional development, list of formal and non-formal learning activities Assessments (e.g. teaching assessment, evidence based medicine assignment)
Research	Personal reflections List of abstracts, published articles Information on research funding, scholarships, bursaries, academic posts

Conclusion: This initiative resulted in the establishment of a list of key components to be included in a EULAR portfolio of Rheumatology. Assessment forms for each key portfolio component are currently being developed. Portfolio implementation, particularly in countries that do not use it yet, may contribute significantly to promote a higher standard of patient care across Europe.

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Educational cases

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TB OR NOT TB? THIS IS THE QUESTION. CASE REPORT OF AN EXTRAPULMONARY TUBERCULOUS ARTHRITIS.

N. Abaza¹. ¹Faculty of Medicine - Ain Shams University - Cairo - Egypt., Rheumatology and Rehabilitation, Cairo, Egypt

Background: Tuberculous (TB) arthritis consists of 1-3% of all TB cases, whereas TB tenosynovitis & bursitis account for 1%. Primarily it involves large joints but occasionally smaller non-weight-bearing joints. Diagnosis is usually delayed due to lack of awareness, radiographic findings & constitutional or pulmonary involvement.

Objectives: We aim to increase rheumatologists awareness to detect possible TB etiology for arthritis & tenosynovitis.

Methods: Our case is a 32 years old male complaining of polyarthritis of wrists, MCPs, ankle joints 4 months prior to presentation. Patient was referred as diagnosed rheumatoid patient resistant to treatment based on clinical presentation & laboratory investigation. His lab. was as follows; ESR 76 mm/hr, CRP 56.6 mg/L, RF 181.8 IU/ml, Serum creat 0.8 mg/dL, SGOT 20 SGPT 22, FBS 94, Uric acid 5.4, Hepatitis & HIV negative. CBC showing Hb 14.1 g/dL, TLC 7030/ml & platelets 289000/ml. There was no history of genitourinary, gastrointestinal manifestations, oral/genital ulcers, ophthalmological, mucocutaneous, cardiac, pulmonary, hepatic nor renal manifestations. The treatment at time of presentation was Methotrexate 25mg/week IM injection, Leflunamide 20mg/d & low dose steroids, prednisolone 5mg/d. Patient was referred to our department to assess activity, perform musculoskeletal ultrasound to the various involved joints. Hence, expected by referring physician to shift from DMARDs to biologic treatment.

Results: MSUS study following eular guidelines showed active synovitis in both radiocarpal & midcarpal joints bilaterally grade II by doppler signal (figure 1). Other active synovitis in multiple MCPs as well as tenosynovitis of Peroneus longus and brevis bilaterally was detected (figure 1). The swelling around the ankle was alarming though the other swollen joints seemed to be consistent with a case of RA in activity. This swelling revealed a well-defined hypoechoic heterogeneous cystic fluid collection with posterior through-transmission (figure 2) & hyperechoic hyperemic wall on PD imaging opposite medial malleolus of right fibula. The laboratory investigations prior to shifting patient had included TB tests, tuberculin test and PCR following the positive result that we found in the skin test. Aspiration was performed from the cystic swelling and sent for clinical pathology analysis. Thick yellowish fluid aspirate on cytology revealed moderately cellular mainly of PMN cells, neutrophils, nuclear debris in proteinaceous background no atypical or malignant cells were found. As regards bacteriology no pus with no growth (both aerobic & anaerobic). These results warranted us to perform a culture for atypical bacteria and revealed growth of mycobacterium tuberculosis. AntiTB therapy was started for 9 months in the form of 2 months of isoniazid (INH) and rifampicin (RIF), pyrazinamide (PZA) and ethambutol (EMB) followed by 7 months of INH and RIF. Excision of the synovial cyst was done on the spot.

Figure 1.

Figure 2.

Conclusion: Extrapulmonary TB is usually diagnosed late due to a reduced diagnostic suspicion. A variant of 8 - 60% of TB cases are +ve for RF & 7–39% +ve for ACPA. Musculoskeletal manifestations occur in approximately 1-3% of TB cases. Of these, spondylitis and arthritis are the most frequent, whereas bursitis and tenosynovitis are exceptional. Extraarticular cystic masses occur in tuberculous arthritis. Mixture of septic tuberculous arthritis and Poncet's disease is rare but documented.

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TAKAYASU'S ARTERITIS PRESENTING WITH UNILATERAL DIGITAL CLUBBING IN A 23 YEAR-OLD MALE

A. Alnajjar¹, A. Hegazy², N. Al Ghanim². ¹KSMC, Internal Medicine, Riyadh, Saudi Arabia; ²KSMC, Rheumatology, Riyadh, Saudi Arabia

Background: Takayasu Arteritis is a chronic, large vessel arteritis that commonly involves the aorta and its major branches, mostly the ascending/descending aorta, subclavian arteries, and carotids [1]. Herein, we report a case of a 23 year-old medically free Indian male who presented to our hospital in acute distress complaining of cough, hemoptysis and shortness of breath for one week as well as intermittent fever and fatigue for five months. He presented with a BP of 140/100 mmHg as well as both systolic and early diastolic murmurs in the mitral and aortic areas, respectively. He also had a paraumbilical bruit and unilateral clubbing in the left hand with digital ischemia of the left index finger. Doppler ultrasound of the left arm showed monophasic flow pattern with low velocity in left distal radial, distal ulnar, and all digital arteries, except the second digital arteries; low velocity in the median artery; and no flow in the lateral artery of second digit (Figure 1). Computed tomography angiogram (CT Angio) (Figure 2) of the chest, abdomen, and pelvis showed fusiform aneurysm dilatation of the thoracic aorta extending into the right brachiocephalic and subclavian arteries as well as the right common carotid artery.

Figure 1.

Figure 2.

Unilateral clubbing in patients with TA occurs as a result of subclavian artery stenosis that leads to tissue ischemia and hypoxia [2-4]. In turn, the bone marrow release megakaryocytes, which enter the systemic circulation when an A-V shunt exists [5]. Platelet-derived growth factor (PDGF) (release from megakaryocytes) and vascular endothelial growth factor (VEGF) levels are highly expressed in the connective tissues of nail beds, leading to its proliferation and platelets clumps' accumulation [6, 7]. **Objectives:** To report the fourth case worldwide and third case of an adult, respectively, with Takayasu's arteritis who presents with unilateral clubbing.

Methods: Our patient was started on pulse steroid therapy of methylprednisolone 1 gram IV od for 5 days and later switched to prednisolone 20 mg po BID. He also received methotrexate 10 mg PO once weekly and rituximab 750 mg IV stat; another dose of rituximab was given two weeks later.

Results: His clubbing has significantly improved within 2 weeks of starting immunosuppressive therapy. He was discharged with follow up on methotrexate 12.5mg PO once weekly and prednisolone 20mg PO OD (to be tapered). Clubbing improved by a rate of 60% two weeks following discharge in two weeks.

Conclusion: In all four cases of Takayasu arteries presenting with unilateral clubbing, patients' clinical condition including presence of clubbing improved after initiation of immunosuppressive therapy.

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