Background:
Behçet disease is a rare inflammatory disorder with the unique ability to affect vessels of any size. The disease could be associated to thrombosis in both the venous and arterial compartment, and often aneurysms. In particular, the presence of aneurysms of the pulmonary artery is rare. The presented case is that of a patient with Behçet disease who presented to A&E with fever and acute dyspnea. Blood test revealed raised ESR and CRP and raised neutrophil count. Chest X rays showed bilateral opacities suggesting pneumonia. The patient did not improve over the course of antibiotics. Later on, he presented with an episode of hemoptysis and worsening dyspnea, so he was admitted to the Intensive Care Unit. CT showed bilateral pulmonary thromboembolism and aneurysm of the pulmonary artery. Echocardiogram and cardio-MRI revealed a large, mobile thrombus within the right atrium. Extensive work-up for infections and cancer was unrevealing. ANA, ENA and ANCA antibodies were negative. On the basis of a past medical history of recurrent oral ulcers and papulopustular skin lesions that patient admitted on questioning, a diagnosis of Behçet disease was suspected. In keeping with that, HLA-B51 turned out positive. The patient was promptly started on IV steroid pulses followed by Cyclophosphamide 1 g IV monthly for six months, then on IV anti-TNF alpha Infliximab. He was also commenced on low molecular weight heparin (LMWH) and subsequently direct factor Xa inhibitor Apixaban.

Conclusion:
The patient improved significantly with progressive regression of the pulmonary CT changes. He was discharged and able to get back to his daily life activities. After 2 years and a half of treatment, the aneurysm was stable and the intracardiac thrombus completely cleared.

Disclosure of Interests:
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initiation of intravenous (IV) methylprednisolone followed by cyclophosphamide without significant improvement. Re-evaluation of the long-standing history of joint symptoms unresponsive to immunotherapy, along with recurrent fevers and chronic diarrhea raised the suspicion of unrecognized Whipple’s disease. PCR for Tropheryma Whipplei was positive in stool, urine, blood and CSF, and duodenal mucosal biopsies confirmed the diagnosis. A combination of ceftriaxone, doxycycline, and hydroxychloroquine was initiated. Three days later the patient developed pericardial burning pain and cutaneous vesicles consistent with shingles. Varicella-zoster virus DNA was detected in CSF and IV acyclovir was started. At 3 months follow-up neurologic examination was unremarkable except for a slightly fatuous behavior.

Conclusion: Recognition of rare manifestations of WD is important to avoid diagnostic delay and inappropriate, potentially harmful treatments.

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INSIDIOUS CORONARY ARTERY DISEASE IN A YOUNG PATIENT WITH POLYARTERITIS NODOSA: A CASE REPORT AND REVIEW OF LITERATURE

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Background: Polyarteritis nodosa (PAN) is a systemic necrotizing vasculitis that typically affects medium-sized muscular arteries, with occasional involvement of small muscular arteries[1]. Although overt myocardial infarction is uncommon, myocardial ischemia may result from narrowing or occlusion of the coronary arteries[2].

Objectives: Herein, we report a case with 7-year’s history of PAN and unstable angina pectoris due to coronary occlusions of the three main arteries. We also reviewed the literatures regarding coronary artery involvement in PAN.

Methods: A 22-year-old Chinese man who presented with chest pain lasting for a few minutes and then subsiding spontaneously for 1 month was admitted to our hospital. He was diagnosed as PAN 7 years ago and during 7-years’ follow-up, he has been in stable condition, without any discomfort or abnormal laboratory findings. In December 2019, he suffered from chest distress accompanied by retrosternal pain, with frequency of about 2-3 times a week. His symptoms were gradually aggravating with dyspnea at night.

Results: Coronary computed tomography angiography found diffuse coronary stenosis. (Fig. 1). Further coronary angiography revealed a slight plaque infiltration of the left main coronary artery, and occlusion of all the three major coronary arteries, as well as multiple coronary aneurysms. 95% stenosis of the obtuse margin branch artery was also found and a stent was then implanted (Fig. 2). Prednisone 50mg/day and methotrexate 15mg/week were reintroduced, in combination with anti-anginal medications including aspirin and Stalin.

Conclusion: We report a young PAN patient with insidious stenosis of three main coronary arteries under the circumstance of stable disease activity for years. This reminds us of the necessity of assessing heart, probably other organs as well, in PAN patients even though their acute phase reactants in serum are normal. But how often to do the screening and which screening examination should be done, remain to be further investigated.