References:

- [1] Jennette, J.C., et al., 2012 revised International Chapel Hill Consensus Conference Nomenclature of Vasculitides. *Arthritis Rheum*, 2013. **65**(1): p. 1-11.
- [2] Kastner, D., M. Gaffney, and T. Tak, *Polyarteritis nodosa and myocardial infarction*. *Can J Cardiol*, 2000. **16**(4): p. 515-8.

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THU0593

LIBMAN SACKS ENDOCARDITIS COMPLICATED WITH CEREBRAL EMBOLISM REVEALING SYSTEMIC LUPUS ERYTHEMATOSUS: A CASE REPORT

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Background: Libman Sacks endocarditis (LS) is an uncommon sterile endocarditis mostly associated with malignancies. It can also complicate the evolution of systemic lupus erythematosus (SLE) in 1 out of 10 patients after many years of evolution of the disease.

Objectives: To raise awareness of the possible rare complications of LS in SLE

Methods: We report a case of a complicated Libman Sacks endocarditis revealing the diagnosis of SLE.

Results: A 53 years old female patient with history of hypertension was admitted to the rheumatology department for polyarthritis since 2 months with fatigue and dyspnea. On physical examination, she had no fever nor cutaneous lesions, her pulse rate was accelerated to 112 per minute and there was no heart murmur. Musculoskeletal examination revealed the presence of arthritis of little joints of the hands and bilateral arthritis of the knees. Biological results showed an accelerated sedimentation rate of 49 mm the first hour, elevated c-reactive protein of 79 mg/l, anemia and lymphopenia. Renal and hepatic functions were both normal. Transthoracic cardiac echocardiography showed no valvulopathy but a 5 mm sessile vegetation on the mitral valve. To rule out infectious endocarditis, blood cultures came out negative, serological tests for brucella, parvovirus B19, coxiella brunettii, mononucleosis, were also negative. Culture of knee joint fluid for common bacteria and polymerase chain reaction tests for tuberculosis were also negative. The patient presented rapidly with agitation, cerebellar ataxia, and unilateral paresis. CT-scan showed the presence of ischemic lesions in the lenticular nucleus and the semiovale centers. Lumbar puncture showed no abnormalities. She was prescribed large spectrum antibiotics and anti coagulants but with persistent worsening of her neurological state. She was then transferred to the intensive care unit. Anti-nuclear antibodies, came out by then positive 1:3200 with an homogenous fluorescence and with positive anti nucleosome anti bodies. The diagnosis of LS endocarditis associated with SLE complicated with brain embolisms was confirmed with delay.

Conclusion: LS endocarditis is not common but when it presents it is often associated with high morbidity and mortality. Health care professionals should consider LS diagnosis in patients with underlying SLE and should be aware of the risk of embolisation. Tests to rule out infectious disease may delay initiation of appropriate treatment leading to severe prognosis. The treatment of LS endocarditis is still not well codified.

References:

- [1] Ibrahim AM, Siddique MS. Libman Sacks Endocarditis. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 [cité 27 jan 2020]. Disponible sur: <http://www.ncbi.nlm.nih.gov/books/NBK532864/>
- [2] Gómez-Larrambe N, González-Tabarés L, Millán B, Cobelo C, Armesto V, Pousa M, et al. Libman-Sacks' endocarditis: A frequently unnoticed complication. *Nefrol Engl Ed*. 1 mars 2017;37(2):217-9.

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THU0594

A CASE OF TAKAYASU'S ARTERITIS IN A PATIENT WITH TUBERCULOUS LYMPHADENITIS

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Background: Takayasu's arteritis (TA) is a large vessel vasculitis that principally affects the aorta and its main branches. The incidence has been reported at between 1.2 – 2.3 cases per million per year, more commonly in the Asian population. The age of onset is typically between tenth and fourth decade; between 80 and 90 percent of the cases are female.

The relationship between Mycobacterium Tuberculosis (mTB) and TA has long been considered; both demonstrate chronic inflammatory changes on histological examination and some granuloma formation in arterial walls. There is increasing evidence implicating mTB in the pathogenesis of TA through molecular mimicry between the mycobacterium heat shock protein -65 (mHSP-65) and the human homologue HSP -60 (hHSP-60). However, no definitive link between the two diseases has been explained.

Objectives: Case presentation.

Results: A 23-year-old lady was referred to our outpatient rheumatology clinic with a twelve-month history of persistently enlarged cervical lymph nodes on the left side for which she had received six months of anti-Tuberculosis medication. She had been referred to the respiratory physicians who had diagnosed presumed Tuberculous Lymphadenitis, with caseating granulomas demonstrated on biopsy, positive acid-fast bacilli smear but a negative culture. The patient had been initiated six months of anti-Tuberculosis medication; however, her lymphadenopathy showed no improvement. More recently she described a five-month history of weakness, paraesthesia and claudication symptoms in her left upper limb with episodes of dizziness and blurred vision, episodes occurring 2-3 times per day and lasting between a few minutes to a few hours.

Her examination at this presentation revealed an unrecordable blood pressure in the left upper limb and 104/67 mmHg in the right. There was significant tender lymphadenopathy of the left cervical lymph nodes and diminished pulses in the left upper limb. Right sided pulses were normal. The rest of her examination was normal.

Investigations at presentation revealed elevated inflammatory markers with C-reactive protein (CRP) of 116 mg/dL and erythrocyte sedimentation rate (ESR) of 128 mm/h. Complete blood count (CBC) found her to be anaemic with a haemoglobin of 100 g/L, with a mean cell volume of 71.3 fl, and have elevated platelet count of 649 x 10⁹/L. Recent computerized tomography scan with contrast of the thorax demonstrated features consistent with Takayasu Arteritis. Marked left subclavian stenosis was found on magnetic resonance imaging. High dose prednisolone at 60 mg once daily along with Azathioprine 2 mg/kg/day was started with a follow up appointment in two weeks.

Conclusion: There is increasing evidence implicating mTB in the development of TA and a few cases recognising this link have been reported. We report a case of TA in a patient recently diagnosed and treated for Tuberculous lymphadenitis who then developed symptoms of TA. There should be a low threshold for suspecting a diagnosis of Takayasu's arteritis in patients previously or actively infected with Mycobacterium Tuberculosis. Further research exploring the relationship between mTB and TA is required.

References:

- [1] Espinoza JL, Ali S, Matsumura I. New Insights on the Pathogenesis of Takayasu Arteritis: Revisiting the Microbial Theory. *Pathogens*. 2018;7(3):73.
- [2] Aggarwal A, Chag M, Sinha N, et al. Takayasu's arteritis: role of Mycobacterium tuberculosis and its 65 kDa heat shock protein. *International Journal of Cardiology*. 1996; 55: 49–55.
- [3] Reshkova V, Kalinova D, Rashkov R. Takayasu's Arteritis associated with Tuberculosis Infections. *Journal of Neurology and Neuroscience*. 2016; 3:114.
- [4] Moritz K, Jansson Hilte F, Antje Kangowski, Christian Kneitz, Emil C. Reisinger. Tuberculosis and Takayasu arteritis: case-based review *Rheumatology International* 2019 39:345–351
- [5] D Misra, A Wakhlu, V Agarwal, D Danda. Recent advances in the management of Takayasu arteritis *International Journal of Rheumatic Diseases* 2019; 22: 60–68

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THU0595

SUCCESSFUL COMBINED IMMUNE-MODULATING THERAPY OF IN UTERO MYOCARDITIS AS THE MANIFESTATION OF NEONATAL LUPUS IN A RO/SS-A ANTIBODY EXPOSED NEWBORN

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Background: Congenital heart block (CHB) occurs in 2-5% of pregnancies due to maternal Ro/SSA and/or anti-La/SSB antibodies, and has a recurrence rate of 12-20% in the following pregnancy. The highest risk for CHB of the foetus is in the gestational age between 16- and 28-weeks. Without immunotherapy, this autoantibody mediated disorder comes with substantial mortality with a rate of 15-30%. Ro/SSA and/or anti-La/SSB antibodies attack the atrioventricular node with the subsequent inflammation and fibrosis. In addition, other cardiac manifestations

are known such as endocardial fibroelastosis, dilated cardiomyopathy, and valvular insufficiency. The early clinical diagnosis in utero is essential to be specified due to myocardial tissue damages can be reversible. In the prevention and in the confirmed cardiac involvement the first line therapies are chloroquine, dexamethasone and intravenous immunoglobulins, and also a regular foetal echocardiography is of essential importance.

Objectives: Main objective of this report is description of successful treatment of an anti-SS-A antibody exposed foetus with cardiac manifestation.

Methods: Case report of a 25-year-old pregnant woman and her baby. The mother was diagnosed with Sjogren's syndrome in 2013. In previous case history there were two late foetal deaths at the 23rd and 33rd gestational age in 2016 and 2017, respectively as a consequence of foetal bradycardia. During her 2nd pregnancy the mother received chloroquine and azathioprine. At present she was admitted to our Institute in October 2019 at 23rd weeks of gestation without any compliant and any abnormality of pregnancy. Foetal development was normal. Mother received azathioprine and chloroquine from the beginning of pregnancy and dexamethasone from the 16th weeks of gestation. Foetal echocardiography was performed at the 16th gestational week, and every week thereafter. Reflective areas, reflecting oedema and inflammation, appeared at 24th gestational week, localised to the left atrium.

Results: The case was referred, and the combo therapy was completed with 1 mg/maternal kg intravenous immune globulin, dexamethasone dose was increased to 4 mg for a week, then decreased to 2 mg. Intratect was given every 2nd week. Progression was stopped as according to control foetal echocardiography after the 2nd infusion. After 4th IVIG the involved area of myocarditis decreased significantly, localised to anterior wall of left atrium and the atrial primum septum. However, at 32nd g. week pericardial fluid was visualised in maximum 9 mm width without signs of pericardial tamponade.

At the end of last December, the baby was born at the 35th gestational week with 50 cm and 2570 g and no signs of any congenital anomaly. Pericardial fluid was 4 mm maximum. Her development is normal.

Conclusion: Neonatal lupus with various cardiac manifestations may develop in anti-SS-A antibody exposed babies. Therefore, these pregnancies require stringent gynaecologic and cardiologic controls. Although congenital heart block is the most frequent complication developing between the 18-28th gestational weeks, other manifestations also may occur. High dose intravenous immune globulin therapy can be effective even after failure to combined traditional immune suppressant therapy.

References:

- [1] Congenital heart block: Pace earlier (Childhood) than later (Adulthood). Manolis AA, Manolis TA, Melita H, Manolis AS. Trends Cardiovasc Med. 2019 Jun 20.
- [2] Autoimmune-mediated congenital heart block. Wainwright B, Bhan R, Trad C, Cohen R, Saxena A, Buyon J, Izmirly P. Best Pract Res Clin Obstet Gynaecol. 2019 Oct 8.

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THU0596

ABNORMAL RIGHT VENTRICLE RESERVE ON EXERCISE PREDICTS PULMONARY HYPERTENSION IN MIXED CONNECTIVE TISSUE DISEASE: A CASE REPORT

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Background: Pulmonary hypertension is one of the most common complications in patients with mixed connective tissue disease (MCTD). Patients are usually at the late stage and have irreversible right heart dysfunction when diagnosed as pulmonary hypertension with the rest echocardiography. Early detection of right heart dysfunction before pulmonary hypertension is essential to ensure that patients receive timely and appropriate treatment for this progressive disease. We aimed to use exercise stress echocardiography to detect early right heart dysfunction in patients with CTD and without pulmonary hypertension.

Objectives: To present a clinical case of MCTD with normal right ventricular (RV) function at resting but presenting RV dysfunction on exercise, who developed pulmonary hypertension after one-year follow-up.

Methods: Case report. The patient was subject to the treadmill exercise stress echocardiography. The autoantibodies including anti-nRNP/Sm, anti-Ro-52, and antinuclear antibody (ANA) were detected. The patient was followed-up to one year.

Results: A 31-year-old female patient was admitted to our department in 2018, with a history of MCTD for five years. Autoantibodies testing revealed that the patient was positive for anti-nRNP/Sm (+++), anti-Ro-52 (+++), and ANA (1:3200). Echocardiography revealed no obvious cardiac dysfunction. However, the velocity of tricuspid valve regurgitation was 3.0m/s following treadmill exercise stress. The patient was followed-up to one year. Then, she developed occult pulmonary hypertension with the velocity of tricuspid valve regurgitation of 3.3m/s following treadmill exercise stress. Accordingly, MTX and prednisone were switched to MTX, prednisone, hydroxychloroquine (HCQ) and beraprost.

Conclusion: This study showed that treadmill exercise echocardiography could detect right heart dysfunction early before diagnosed as pulmonary hypertension with rest echocardiography in patients with MCTD in its early stage.

References:

- [1] Aithala R, Alex AG, Danda D. Pulmonary hypertension in connective tissue diseases: an update. Int J Rheum Dis. 2017;20(1):5-24.

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THU0597

CORNEAL MELT - DON'T ALWAYS BLAME RHEUMATOID ARTHRITIS

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Background: Corneal melt is a rare inflammatory disease of the peripheral cornea; it may lead to perforation of the globe and visual failure. Corneal melt can be a manifestation of systemic vasculitis in patients with RA and other conditions, such as cancer. Without early and aggressive treatment it may be associated with a poor visual outcome and a high mortality. It has been reported in patients with stable RA.

Objectives: A case report in a patient with long standing but well controlled Rheumatoid Arthritis (RA) and metastatic disease.

Methods: A 75 year old male with a background of sero positive Rheumatoid Arthritis for more than 10 years presented to the Eye Casualty with a two week history of a painful left red eye. His other medical history was significant for Stage IIB poorly differentiated cancer of the left lower lobe. Left lower lobectomy with a patch of diaphragm resected. Intratumoural lymphovascular invasion noted. He completed Adjuvant Carboplatin/Vinorelbine chemotherapy September, 2017. He had DVT proximal left leg 22nd of September, 2017. Follow up CT in 2018 demonstrated a right renal upper pole lesion for which he was awaiting biopsy with metastatic lung disease vs primary renal carcinoma. His RA was well controlled on Methotrexate 10mg weekly. He had been treated by the ophthalmology team for left marginal Keratitis for the prior 2 months with steroid eye drops without significant improvement. On presentation to ED, he described sharp eye pain, waking him from the sleep, associated with watery discharge and photophobia. Examination showed corneal melt in left eye involving 25% of inferior portion of the cornea and spastic entropion with injecting eye lashes. He had no active joints and there were no other signs of vasculitis. CRP was 4.1. He had a negative ANA and ANCA; viral swabs were negative. He was admitted under the medical team. Intravenous Methyl Prednisolone was started. The patient felt better after 5 days of Methyl Prednisolone. Left temporary tarsorrhaphy was done by Ophthalmology. Cyclophosphamide was initiated after discussion with Oncologist pending the result of the renal biopsy. Patient was discharged after 5 days of admission in the hospital

Results: The renal biopsy was positive for metastatic Squamous cell carcinoma of lung. Cyclophosphamide was withdrawn and he was started on Carboplatin/Gemcitabine. The corneal melt improved with complete resolution of his visual symptoms.

Conclusion: In this case, although the history of RA was felt by the ophthalmology team to be the most likely association with the corneal melt, we would argue the oncological diagnoses were likely the driving force behind the presentation.

References:

- [1] Sule A, Balakrishnan C, Gaitonde S, Mittal G, Pathan E, Gokhale NS, et al. Rheumatoid corneal melt. Rheumatology (Oxford) 2002;41:705-6.
- [2] S. Yano, K. Kondo, M. Yamaguchi et al., "Distribution and function of EGFR in human tissue and the effect of EGFR tyrosine kinase inhibition," Anticancer Research, vol. 23, no. 5, pp. 3639-3650, 2003.

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THU0598

A CASE REPORT ON A RARE PRESENTATION OF GOUT INVOLVING THE PATELLAR TENDON

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