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 fetus 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/menal kg intravenous immune globulin, dexamethasone dose was increased to 4 mg for a week, then decreased to 2 mg. Intratec was given every 2 weeks. Provision 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 therapy.

**References:**


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Background: Gout is an inflammatory arthropathy associated with long-standing hyperuricemia. The first metatarsophalangeal joint is the most commonly involved joint, although gout is often polyarticular. Involvement of tendons has been described, but is rare. We report a case of gout involving the inferior portion of the patellar tendon.

Objectives: A Case report to highlight a rare presentation of gout.

Methods: A 50 year old male presented to the Rheumatology emergency clinic with severe right knee pain, unable to weight bear. He had been recently diagnosed with Sero negative Inflammatory Arthritis and treated with Methotrexate for 4 months. He had presented one week previously to the general medical team on call with similar but less severe pain. He was discharged on steroids, which were of no significant benefit. The pain progressively worsened to the extent that he was not able to bear weight on the right knee. He denied pain or swelling of any other joint.

On examination of his right knee, it was extremely tender, slightly erythematous with increased local temperature. There was no arthritis in any other joint and there were no tophi. Joint aspiration was attempted but there was no fluid.

He was admitted with query Septic arthritis and started on intravenous antibiotics. Uric acid level was 583u/l. US of the knee showed small fluid in the prepatellar bursa. Orthopaedic team was involved and he was taken to the operation theatre. Knee joint was aspirated which was negative for crystals and there was no growth on cultures.

He ultimately had an MRI of his right knee which showed significant soft tissue oedema and abnormality in the patellar tendon.

Results:

USG of the rt knee showing infiltrates in the inferior portion of patellar tendon with increased Doppler flow

He went on to have a patellar tendon biopsy which has shown changes consistent with gout.

He was started on Colchicine 0.5mg bd leaving the hospital and Allopurinol was started two weeks later.

References:


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