screening was negative, as well as cardiovascular risk factors. Over the next days, the clinical conditions rapidly improved with recovery of normal ventricular function on discharge. However, two weeks later he was readmitted with recurrent mandibular and chest pain. Troponin levels were elevated and fluctuated, suggesting recurrent ischemic events. Repeated ECG during angina crisis showed ischemic alterations in different coronary territories. The coronary angiogram detected coronary vasospasm of the circumflex artery, reversible after nitroglycerin (Figure 1). Nitroglycerin and calcium channel blockers were initiated, but did not resolve the vasospastic angina crisis, occurring daily. Laboratory tests revealed eosinophilia (4390 cells/mcL), increased C reactive protein (9.4 mg/dl) and positive antinuclear antibodies (1:320). The other serological and immunological tests were negative, including MPO-ANCA and PR3-ANCA. An abdomen and chest CT scan was negative.

Results: The eosinophilia and the history of asthma rose the suspect of EGPA vasculitis. The patient was treated with intravenous methylprednisolone 250 mg once daily for 3 days, followed by oral prednisone 1 mg/kg/day, with rapid and complete resolution of the recurrent angina episodes. Intravenous cyclophosphamide 10 mg/kg was administered every 2 weeks for 2 times, then 12 mg/kg every 4 weeks. Oral corticosteroid was tapered, with the persistence of a complete remission of the symptoms, after 2 months of immunosuppressive therapy.

Conclusion: Coronary involvement in EGPA can mimic atherosclerotic coronary disease and can be life threatening, if not promptly recognized. An accurate medical history and complete serological and immunological tests are crucial to detect an atypical onset of EGPA, prompting early immunosuppressive therapy which is pivotal for the patient survival.

References:

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EXTENDED BONE HYDATIDOSIS IN THE HIP AND FEMUR WITH EXTENSION TO THE SOFT PARTS: A CASE REPORT

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Background: Osseous hydatid cyst is an uncommon disease with weak response to treatment. Hydatid disease should be included in the differential diagnosis of cystic lesions of bone in endemic regions. Bone cysts account for only 0.5 to 2.5% of all hydatid cysts in humans.

Objectives: To report a case of osseous hydatid disease extended on hip and femur

Methods: We report a case of osseous hydatid disease

Results: A 49 YEAR OLD BRICKLAYER, with no past-medical history and no animal contact, was admitted to our department for a left hip pain. The patient was apyretic and in a good general health condition. He had a very painful walk, the mobility of the left hip joint was very painful and restricted. The pelvis X-rays showed osteolytic lesions in the ischiopubic branch and in the left femur and proximal extremity of the tibia. The C-Reactive protein value, the protein electrophoresis were normal. tumor markers test was negative.

An ultrasound of the hip showed a low abundance intra-articular effusion. The Pelvic MRI showed multilocular appearance extending over the bone and muscle with breach of the bone cortex of the femur very suggesting of the diagnosis of a bony and muscular echinococcosis.

NO other localization of hydatidosis were detected, body CT scan was normal.

Conclusion: Hydatid disease occurs worldwide and mainly associated with sheep farming. The liver and lungs are the most common locations. Bone cysts are uncommon but severe. Although immunofluorescent assays are useful, the final diagnosis depends on histology. The treatment is almost surgery. Recurrence is common.

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PRESENTING MGUS PATIENT
UNDIAGNOSED RHEUMATIC DISEASE IN NEWLY

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Background: Monoclonal gammapathy of undetermined significance (MGUS) is considered to be a premalignant condition with an average of 1% annual risk of progression to multiple myeloma or other lymphoproliferative disorders [1]. Numerous studies have highlighted a common feature of autoimmune inflammatory diseases is non-specific hypergammaglobulinemia which can be associated with monoclonal gammapathy [2, 3]. We looked at a population of 3.6 million where patients with MGUS was referred to haematology network for evaluation.

Objectives: Our hypothesis was that undiagnosed rheumatic diseases were being referred to haematology rather than rheumatology erroneously.

Methods: The Haematological Malignancy Research Network (HMRR) ethics approved (REC 04/01/122/99) from Leeds West Research Ethics Committee. The HMRR that comprises a population-based cohort of patients newly diagnosed by a single integrated haematology-pathology laboratory in two adjacent UK Cancer Networks (population 3.6 million). The database includes prognostic factors, sequential treatment/response history and socio-demographic details which are recorded to clinical trial standards. 255 patients were screened in this study. We looked at a range of autoimmune/innate immune conditions diagnosed after MGUS.

Results: In the 255 patients cohort group, the average age at the diagnosis of MGUS was 70.23 ± 11.95 years (median 70.2 years), with more subjects being male (n=145, 56.9%). Mean duration of follow up was 2570 days. 10 out of the 255 patients progressed onto multiple myeloma. Diagnosed rheumatic disease was found in 46 patients (18.8%). None of the patient in this group has disease progression to multiple myeloma. In this group, 37 patients (14.5%) presented the rheumatic disease before their MGUS diagnosis and 11 (4.3%) were diagnosed after their MGUS referral. Interestingly, among the 11, more males(n=6, 72.7%) have their rheumatic disease diagnosed after MGUS.

Those 11 cases included crohn's disease (1), polymyalgia rheumatica (2), immune thrombocytopenia (2), autoimmune hepatitis (2), Schnitzler's syndrome (1), giant cell arteritis (1), rheumatoid arthritis (2).

Conclusion: Approaching 1 in 20 cases of MGUS have an underlying inflammatory disease that may often be non-specifically driving antibody production including monoclonal band formation. When diagnosing MGUS, clinicians should be aware of the potential underlying autoimmune rheumatic conditions.

References:

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THU0665
AN ATYPICAL CASE OF PONCET DISEASE

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Background: Poncet disease (PD) is defined as an inflammatory rheumatism associated with visceral tuberculosis without direct bacteriological involvement of the joints [1]. It is classified as a parainfectious rather than a reactive arthritis [2].

Objectives: Here by a first case of PD who presented with sterile arthritis and tuberculous spondylodiscitis.

Methods: We report a case of a 40-year-old women who presented with polyarthritides in 2014. On physical examination, she had synovitis in both wrists, the metacarpophalangeal joints and the fifth proximal interphalangeal joint of the right hand. Her serum was negative for Rheumatoid Factor (RF) and anti-cyclic citrullinated peptide antibody (anti-CCP) antibody. Her C-reactive protein (CRP) was 24.5mg/l. Ultrasound revealed tenosynovitis of the superficial and deep flexor tendons on both hands with Doppler signal. The Magnetic resonance imaging (MRI) of the hands showed active synovitis in the wrists mainly in the distal radioulnar joint, erosions in the ulnar styloid as well as edematous infiltration of the soft tissue of the hands. Since she fulfilled the new ACR/EULAR 2010 criteria for RA, a diagnosis of rheumatoid arthritis (RA) was made and the patient was put on Methotrexate (MTX) 15mg/week/po in January 2015. Eight months later, the patient developed high temperature 38˚c and lumbar stiffness. A chest CT performed as part of the etiologic investigation didn't show pulmonary manifestations but revealed a lytic vertebral lesion. Lumbar spine MRI showed vertebral edema and soft tissue enhancement with abnormal marrow signal in L2 and L3 which was concerning for infectious etiology; MTX was stopped. A CT-guided core needle biopsy concluded to a tuberculous spondylodiscitis. The patient was initiated on an antituberculosis-therapy (ATT) for 15 months. The course was marked by the reoccurrence of low back pain. MRI of the spine was then performed and revealed persistence of spondylodiscitis and multiple abscesses at the levels of L2-L3. The ATT was resumed.

Results: The patient received four drugs for 4 months, followed by isoniazid and rifampicin for 1 year. At follow up, the patient responded well to treatment with complete resolution of symptoms without sequelae. She did not present neither polyarthritides nor synovitis. Moreover, she sustained a negative CRP (2mg/dl). Ultrasound control of the wrists did not show synovitis or tenosynovitis Doppler signal. Similarly, a disappearance of effusion as well as synovitis was noted on the MRI at follow up.

Conclusion: We report a unique case of Poncet disease with tuberculous spondylodiscitis. It is important to recognize PD in a patient presenting with polyarthritides in order to avoid unnecessary long-term disease-modifying anti-rheumatic treatment. Future research is indicated to understand the etiopathogenesis of Poncet’s disease and to educate clinicians as to the importance of maintaining a high index of suspicion about this rare, yet potentially easily treatable disease.

References:

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