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/l) 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.

Figure 1. Coronary angiogram showing coronary vasospasm in the left circumflex artery (panel A, yellow arrow), reversible after nitroglycerin infusion (panel B, yellow arrow)

Results: The eosinophilia and the history of asthma rose the suspect of EGPA vasculitis. The patient was treated with intravenous methylprednisolone 250mg 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 10mg/kg was administered every 2 weeks for 2 times, then 12mg/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 artery 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.

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THU0602

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 afebrile 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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THU0603

IGG4-RELATED SINGLE-ORGAN DISEASE: IMMUNOSUPPRESSION NEEDED AFTER COMPLETE RESECTION? A CASE REPORT AND BRIEF LITERATURE REVIEW.

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Background: IgG4-related disease (IgG4-RD) is a polymorphic autoimmune disease leading to tumorous swelling and/or fibrosis of affected organs. Riedel's thyroiditis is – besides chronic periaortitis, Mikulicz Syndrome and many others – an organ manifestation of IgG4-RD that has been thought to be an independent disease for a long time. About 40% of patients have single organ IgG4-RD while the others suffer from multisystemic disease [1].

Objectives: Glucocorticoids, sometimes combined with other immunosuppressives are the standard treatment of IgG4-RD, in some situations (e.g. mechanical complications or suspected malignancy) surgery may be necessary but little is known about the management of fully resected single-organ IgG4-RD [1].

Methods: We report a case of single-organ IgG4-RD (Riedel's thyroiditis) after complete resection and perform a brief review of the literature to guide clinical management in this situation.

Results: A woman (51 y) with pre-existing Hashimoto's thyroiditis (thyroid peroxidase antibody positive) developed a rapidly growing struma with very firm consistency (not allowing fine needle biopsy). Besides slightly increased C-reactive protein (5,3mg/l) there was no laboratory sign suggestive for IgG4-RD (normal serum IgG4, complement, eosinophils and IgE). Within 4 months the patient suffered from hoarseness and progredient dyspnea. Surgical thyroidectomy was performed and histopathology revealed IgG4-related Riedel's thyroiditis with extensive (storiform) fibrosis, a dense lymphoplasmacytic infiltrate, obliterative phlebitis, eosinophilia and 13 IgG4-positive plasma cells per high power field.

After referral to our department a comprehensive work-up showed no signs of other manifestations of IgG4-RD. Treatment with glucocorticoids is clearly recommended for patients with symptomatic IgG4-RD in an international consensus statement, whereas "watchful waiting" may be appropriate in some cases of asymptomatic or mild disease. While some highly fibrotic lesions may not respond well to glucocorticoids and may require surgical intervention, no clear guidance is available for the management of fully resected single organ IgG4-RD [2].

A brief review of the literature revealed that few cases of single-organ IgG4-RD remaining in remission after resection without medical treatment have been reported (e.g. IgG4-related cholecystitis, autoimmune-pancreatitis, tumours of the intestinal tract, lung, thymus, meninges, paravertebral space and others [3–9]). After discussion of the options with the patient no systemic immunosuppression was given under close follow up without signs of relapse in clinical examinations, laboratory or imaging during the first 6 months.

Conclusion: Limited evidence from case reports suggests that a "watchful waiting" strategy without systemic immunosuppressive treatment may be reasonable in some cases of single-organ IgG4-RD after the affected organ was completely resected (e.g. due to mechanical complications or suspected malignoma). However, close follow-up monitoring should be applied due to the risk of relapse or development of new organ manifestations.

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THU0604 UNDIAGNOSED RHEUMATIC DISEASE IN NEWLY PRESENTING MGUS PATIENT

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Background: Monoclonal gammopathy of undetermined significance (MGUS) is considered to be a premalignant condition with on 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 hypergammaglobulinaemia which can be associated with monoclonal gammopathy [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 (HMRN) ethics approval (REC 04/01/1205/69) from Leeds West Research Ethics Committee. The HMRN that comprises a population-based cohort of patients newly diagnosed by a single integrated haemato-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 48 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=8, 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.

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THU0605 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 polyarthritis 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 (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 vertebrae lesion. Lumbar spine MRI showed prevertebral 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 antituberculous-therapy (ATT) for 15 months. The course was marked by the recurrence 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 polyarthritis 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 tubercular spondylodiscitis. It is important to recognize PD in a patient presenting with polyarthritis in order to avoid unnecessary long-term disease-modifying antirheumatic 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.

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THU0606 RHEUMATOID ARTHRITIS INDUCED BY ALPHA-INTERFERON THERAPY: A RARE CASE PRESENTATION

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Background: Interferon-α (IFN-α) is known for its antiviral and antiproliferative effects, used mainly for the treatment of chronic hepatitis C infection [1]. Immunomodulatory effects have been reported in patients treated with IFN-α, including hematological, immunological, rheumatological and dermatological disorders [2]. In fact, IFN-α may lead to the induction or exacerbation of autoimmune diseases such as psoriasis, systemic lupus erythematosus, and rarely rheumatoid arthritis (RA).

Objectives: We report the case of a Caucasian who developed anticyclic citrullinated peptide antibody (anti-CCP)-positive RA following treatment of chronic hepatitis C infection with pegylated IFN-α2a.

Methods: A 57-year-old women was diagnosed of chronic hepatitis C infection after detection of abnormal liver function. She has a genotype 1b with a high viral load: RNA was 100,000 UI/ml. Liver histology showed advanced fibrosis and portal fibrosis (A3 F4 according to metavir score). A history of blood transfusion was found. The patient was placed on a 24-week course of PEGylated -IFN-α2a 180 µg weekly and a 1000 mg daily dose of ribavirin. After