Background: Chronic intestinal pseudo-obstruction can be a rare complication of systemic lupus erythematosus. It is often late to be identified in contrast to other commoner organs involvement in systemic lupus erythematosus such as nervous system, joint and kidney.

Objectives: To report a case of uncommon gastrointestinal complication of lupus, with associated hydronephrosis at the ureter, with treatment delay.

Methods: We report a case of chronic intestinal pseudo-obstruction.

Results: A 34 year old, with ten-year history of lupus nephritis, presented with recurrent abdominal pain and diarrhoea past nine months. The patient had just been diagnosed as end-stage renal failure a year ago, on regular haemodialysis. For the past ten years, the patient was not able to tolerate immunosuppressant due to the multiple episodes of infections, including shin carbuncle, herpes zoster, breast abscess and catheter-related candida/bacterial infections. However, the patient did not have any other major organs manifestations of lupus for the past ten years. The patient was afebrile. Multiple stool cultures were negative including *Clostridium difficile*. The abdominal radiography showed dilated small bowel with diffuse thickening of large and small bowels on computed tomography. Bilateral uretero-hydronephrosis was also noted without any evidence of obstructive uropathy on imaging. Ileocolic resection was done for presumed intestinal obstruction and the ileocolic biopsy did not reveal any granuloma, malignancy or vasculitis except for non-specific inflammation of cecum. Cytomegalovirus inclusion body was absent as well. Tuberculosis culture was negative. Oesophagoduodenoscopy and colonoscopy were offered in view of persistent unexplained loose stool and abdominal pain. But unremarkable findings were noted from multiple biopsy specimens of the small and large bowels. Second relook of the initial hemicolectomy specimen with special actin immunostain on the smooth muscle revealed degenerative changes of the muscularis propria. These were evidenced by cytoplasmic vacuolation, atrophy and pyknotic nucleus of the smooth muscle cells with surrounding oedema. Smooth muscle dysmotility could be the underlying pathology of this patient presentation. The patient responded well to intravenous immunoglobulin followed by azathioprine in addition to prednisolone and prokinetic agent.

Conclusion: Prompt recognition is pivotal in this case could have prevented the unnecessary surgical intervention earlier. It is potentially reversible. Long term prognosis of this rare entity is, however, varying.

Disclosure of Interests: None declared

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AB0857

CERTOLIZUMAB PEGOL RELOADING SUCCESSFULLY CONTROLS INFLAMMATORY ARTHRITIS FLARES DURING PREGNANCY – A CASE REPORT

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Background: Approximately 50% of patients with inflammatory arthritis (IA) experience worsening of disease activity during pregnancy.^{1,2} Given the evidence that increased disease activity immediately before or during pregnancy is associated with adverse pregnancy outcomes, it is imperative to maintain tighter disease control during this period.³ Treatment options are limited to steroids or disease-modifying anti-rheumatic drugs (DMARDs) compatible with pregnancy. Certolizumab pegol (CZP) is a humanized TNF- α inhibitor with no to minimal transplacental transfer, making it a suitable option during pregnancy.⁴ In patients who relapse while on treatment with a biologic, consideration can be given to optimizing the dose of the biologic. Studies in Crohn's disease demonstrated that increasing the CZP dose from 400 mg Q4W to Q2W is a viable strategy for recapturing efficacy.⁵ Similar data is not available for the rheumatology population or for pregnancy.

Objectives: To describe the successful control of juvenile inflammatory arthritis (JIA) flares using a reloading strategy with CZP in a pregnant patient with prior failure of multiple conventional systemic (cs)DMARDs and biologics.

Methods: This is a case report of a 31-year old female with JIA who presented with a disease flare in the 1st trimester of her 2nd pregnancy. The patient was treated with multiple csDMARDs and biologics since age 6. She experienced significant gastrointestinal side effects to subcutaneous methotrexate and leflunomide and inadequate response to hydroxychloroquine and sulfasalazine. Subsequently, she initiated and maintained treatment with etanercept for 14 years until she developed secondary loss of efficacy. She had primary non-response to golimumab and abatacept and experienced a severe allergic reaction to infliximab. Since 2017, she has been treated with CZP 200 mg Q2W with good control of disease activity.

Prior to conception, the patient had low disease activity (Table 1). At 11 weeks gestation, the patient noted worsening of disease activity, with pain at 4/10, fatigue at 7/10, morning stiffness for 60 minutes, swollen joint count (SJC)

4/28, and tender joint count (TJC) 19/28. The patient global assessment of disease activity (PtGA) remained at 4/10 while physician global assessment of disease activity (PhGA) and health assessment questionnaire disability index (HAQ-DI) increased to 6/10 and 1.625, respectively (Table 1). She reported that symptoms worsened one week after CZP injection with more joint pain and swelling in hands, wrists, and feet. The patient declined the addition of hydroxychloroquine, sulfasalazine, and steroids due to previous tolerability, lack of efficacy, and concerns about safety during pregnancy. The patient received 3 loading doses of CZP 400 mg Q2W. She then continued treatment with CZP 200 mg Q2W.

Table 1. Disease activity prior to conception and during pregnancy before and after reloading CZP.

Characteristic	Prior to conception	11 weeks gestation	19 weeks gestation after reloading CZP
SJC (28 joints)	2	4	2
TJC (28 joints)	NA	19	NA
PhGA*	4	6	2
PtGA*	4	4	4
HAQ-DI	1.5	1.625	1.5
Pain*	4	4	2
Fatigue*	7	7	5
Morning stiffness (min)	60	60	20-30

*Assessed on a 10-point scale.

Results: On follow-up at 19 weeks gestation the patient reported 80% improvement in joint pain and swelling and reduction in morning stiffness (Table 1). Pain and fatigue were rated as 2/10 and 5/10, respectively. PtGA score was 4/10, PhGA score was 2/10 and HAQ-DI score was 1.5 (Table 1).

Conclusion: Reloading CZP to control increased IA disease activity during pregnancy may be a viable treatment option. To our knowledge, this is the first report of dose optimization in IA and in pregnancy in a patient treated with CZP.

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SUCCESSFUL TERM PREGNANCY IN A PATIENT WITH GRANULOMATOSIS WITH POLYANGIITIS AFTER UNDERGOING RITUXIMAB THERAPY - CASE REPORT

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Background: Granulomatosis with polyangiitis (GWP) is a relatively rare disease with the lack of experience in the management of pregnancy currently. Potentially negative factors of pregnancy prognosis are both disease-related and teratogenic effects of specific vasculitis therapy [1].

Objectives: To describe a clinical case of Successful term pregnancy in a patient with Granulomatosis with polyangiitis after undergoing rituximab therapy.

Methods: 19 years-old woman was admitted to the rheumatology department of Clinical Regional Hospital After Mechnikov in 2013 with the debut of Granulomatosis with polyangiitis. Her disease course included recurrent rhinitis and sinusitis, Granulomatosis of the eye orbits. Positive ANCA titers were present in the disease onset. In the preceding 7 years she had been treated with corticosteroids, cyclophosphan (discontinued in 2017 because of lack of efficiency), than azathioprine. Aseptic necrosis of the both femoral head was estimated on fifth disease year. In 2018 azathioprine therapy had been discontinued owing to the disease progression and biological agents were prescribed – rituximab with positive effect. The disease remission was achieved by rituximab therapy, the patient was warned about the need for contraception. The last dose of rituximab was introduced in February 2020. However, in March 2020, the patient reported pregnancy and therapy was discontinued. At the onset of pregnancy she was