form is associated with an underlying condition such as connective tissue disease, monoclonal gammopathy, cryoglobulinemia, or chronic myelomonocytic leukaemia. It is often associated with other forms of cutaneous lupus, and about 20% of patients develop systemic lupus erythematosus(SLE). The patient usually comes with symptoms of purple plaques or nodules and oedematous skin, mainly around the acral regions of the body. Histologic features are identical to those of discoid lupus erythematosus. The damaged skin gives a Positive fluorescent band test picture. CHLE is defined by the Mayo Clinic criteria, which include two major and four minor. Diagnosing a patient requires two major and at least one minor criterion. Patients with chilblain lupus erythematosus may also display hypergammaglobulinaemia, positive rheumatoid factor, antinuclear antibody, antiphospholipid or anti-Ro antibodies. They are usually negative for anti-double-stranded DNA antibodies. The first-line treatment for mild and localised symptoms is topical corticosteroids. Second-line systemic treatments consist mainly of immunomodulators and immunosuppressants. Studies have shown benefits from the use of topical tacrolimus and pimecrolimus. We want to report a case of a young lady that presented to our centre with CHLE.

Conclusions Chilblain lupus erythematosus is a rare and chronic disease mainly affecting women. Although it is not as severe as Systemic Lupus Erythematosus(SLE), it may be the sentinel sign of a range of underlying auto-immune diseases. Physicians should be vigilant in dealing with CHLE as their symptoms may be subtle and mimic other similar pathologies.

LP-206 ANA-NEGATIVE LUPUS PRESENTING WITH SEGMENTAL HYALINIZING VASCULITIS AND VALVULAR HEART DISEASE – A RARE CASE REPORT

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Description The presence of antinuclear antibody (ANA) is usually considered a hallmark of Systemic Lupus Erythematosus (SLE). However, a small group of SLE patients had the typical clinical manifestation of SLE with negative ANA tests. Segmental hyalinizing vasculitis is an orphan disease associated with various diseases including SLE. We report a case of a 29-year-old female presented with a painful skin ulcer on both her upper and lower extremities for 2 weeks. She also noted joint pain, fever, and shortness of breath. The symptoms were accompanied by multiple redness and pus-filled skin ulcer on both arms, thighs, and legs. The remainder examination revealed hair loss, pale conjunctiva, crackles in chest examination, ascites, and edema in both feet. There were also redness and tenderness on both hand at Distal Interphalangeal(DIP), Proximal Interphalangeal(PIP), and Metacarpophalangeal(MCP). Laboratory studies showed anemia, elevated erythrocyte sedimentation rate, and positive LE cell. The antinuclear antibody immunofluorescence (ANA IF) test was negative. A skin biopsy revealed segmented hyalinizing vasculitis suitable for Lupus. A transthoracic echocardiogram showed mildly abnormal left ventricular systolic function with an ejection fraction 45%, moderate mitral regurgitation, and mild aortic regurgitation. Chest X-ray showed signs of pulmonary edema and right pleural effusion. The conditions fulfilled the clinical criteria of SLE, and the patient was diagnosed with ANA-negative SLE. The patient underwent treatment with hydroxychloroquine 200 mg twice daily, methylprednisolone 16 mg twice daily, and desoximethasone cream. The patient showed significant clinical improvement and her ulcer completely resolved after 6 months of treatment, and there is no recurrent ulcer.

Conclusions Case report of a 29-year-old woman diagnosed with ANA-negative SLE with segmental hyalinizing vasculitis and valvular heart disease as the main manifestation of SLE. Early recognition and aggressive SLE therapy of this rare subset of SLE disease showed clinical improvement and completely resolved skin ulcers.

5. SLE epidemiology and public health

LP-068 THE CHALLENGES IN THE MANAGEMENT OF SYSTEMIC LUPUS ERYTHEMATOSUS DURING THE 3RD WAVE OF COVID19 PANDEMIC IN SRI LANKA: A SINGLE-CENTRE EXPERIENCE

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Background COVID19 pandemic likely has had significant influence on the presentation, management and outcome of Systemic Lupus Erythematosus (SLE). A single-centre experience of managing SLE during the 3rd wave of COVID19 pandemic in Sri Lanka is presented.

Methods New and follow up patients with SLE seen at Peradeniya University Teaching Hospital from the 1st of July to the 31st of August 2021 were audited. Those with moderate to severe disease (assessed by British Isles Lupus Assessment Groups 2004/BILAG score[1]) requiring intensification of immunosuppression, were identified. Possible effects of the pandemic on the clinical presentation, and treatment outcome were assessed.

Results Of 45 patients with SLE seen during this period, eleven had moderate to severe flares (female:male 10:1). Four were new diagnoses during the study period. Of the seven follow-up patients, six had well-controlled disease over the preceding 24 months, while one had intermittent flares.

9 out of 11 patients were BILAG-A in at least one domain and two were BILAG-B. All needed aggressive immunosuppression. Remission was induced in ten patients while one succumbed to severe disease and sepsis.

In 72.7% of patients (n=8), effects of COVID19 were evident. These were possible causal association (n=1), disease flare concomitant with COVID19 infection (n=2), COVID19 complicating immunosuppression (n=1) and delayed presentation leading to requirement of aggressive immunosuppression (n=4).

Conclusions Diagnosing and managing SLE is challenging due to variable clinical presentation, multi-system involvement and complex treatment decisions.[2] The on-going pandemic has increased these challenges several-fold. COVID19 probably has a causative relationship with autoimmune disease.[3] Delayed presentation can cause unfavourable outcomes during the pandemic.