

that some developed adverse effects which kept them from continuing it. As we believed that hydroxychloroquine should be continued based on the risk-benefit ratio in case of minor adverse events, such as non-severe drug eruption and gastrointestinal intolerance, we decided two systematic approaches for these problems.

For urticaria and erythematous drug rash, we first performed Drug Lymphocyte Stimulation Test (DLST), then offered oral desensitisation if the result is negative. Five patients agreed to undergo oral desensitisation over 5 weeks with crashed hydroxychloroquine tablets in conjunction with once daily levocetirizine 5 mg at night. Desensitisation courses were started on Monday and patients were informed to contact allergologist if skin rash or pruritus emerged. All the five patients successfully went through the graded increment of hydroxychloroquine, and then continued it without the anti-histamine.

For diarrhoea, hangeshashintou was added. Hangeshashinto, i.e. a Pinellia heart-draining decoction; in Chinese: ban xia xie xin tang), is widely administered in Japan to prevent diarrhoea induced by chemotherapy and immunosuppressive agents such as irinotecan and mycophenolate mofetil. The mechanism is reported to the inhibitory effect of glucuronidase-mediated de-conjugation. Two patients who stopped hydroxychloroquine due to diarrhoea became able to resume it with hangechashintou.

In conclusion, desensitisation of hydroxychloroquine and co-administration of hangeshashintou resulted in better tolerance of the anti-malarial in Japanese patients without serious side effects.

## Poster session 10: Difficult cases

### PS10:182 NMDA-POSITIVE NEUROPSYCHIATRIC LUPUS MANIFESTING AS WEIGHT INCREASE AND HYPOSMIA

<sup>1</sup>C Pamfil, <sup>1,2</sup>S Rednic, <sup>3</sup>I Catana, <sup>4</sup>M Deac Badaranza, <sup>4</sup>D Balint Gib, <sup>1</sup>P Vele, <sup>5</sup>L Bene, <sup>2,4</sup>L Damian. <sup>1</sup>Rheumatology, Iuliu Hatieganu University of Medicine and Pharmacy, Cluj, Romania; <sup>2</sup>Center for Connective Tissue and Musculoskeletal Diseases, Cluj, Romania; <sup>3</sup>ENT, Sforait Medical Centre, Cluj, Romania; <sup>4</sup>Rheumatology, Emergency Clinical County Hospital, Cluj, Romania; <sup>5</sup>Laboratory Medicine, Emergency Clinical County Hospital, Cluj, Romania

10.1136/lupus-2018-abstract.224

**Background** Among the clinical manifestation of systemic lupus erythematosus (SLE), neurolupus (NPSLE) is one of the hardest to identify. While active systemic diseases usually evolve with weight loss, the increase is generally associated with glucocorticoid therapy and immobilisation and rarely with hypothalamic inflammation. NMDA encephalitis, increasingly recognised, may be paraneoplastic or autoimmune.

**Material and methods** We present the case of a 20 year female student, with an SLE with juvenile onset, at 16, mainly with renal features and malar rash. She was in a prolonged remission on azathioprine, hydroxychloroquine, low-dose aspirin and 5 mg prednisone/day. However, after the exam session, she came for a significant weight increment (over 12 kg in 2 weeks), despite allegedly normal eating, accompanied by daytime sleepiness and hyposmia. The BMI, initially 22.5, increased to 27.1, with a 29.3% of body fat by screening impedancemetry. The analyses revealed a high ESR (90 mm/h), an increased AAN titer (1/1280), with high anti-DNA (1055), and an anti-NMDA titer of 933 IU/mL. All other tests, including lupus anticoagulant, anti-cardiolipin, and beta-2

glicoprotein IgA, IgG, anti-Ro, anti-La, and ribosomal P anti-TPO, anti-thyroglobulin antibodies, FT4 and TSH, were normal. Cerebral MRI was unremarkable, as well as the organ involvement screening, including genital examination and PAP smear. Olfactory function measurement revealed a threshold score of 6 (normal 7–12) and an identification score of 11 (normal 12–15). She received 3 courses of methylprednisolone and cyclophosphamide courses, with slow weight decrease and normalisation after two months and some correction of hyposmia in more than six months.

**Conclusion** Rapid unexplicable weight gain and decreased olfactory perception in lupus may suggest neurolupus or NMDA encephalitis.

### PS10:184 CONSTRICTIVE PERICARDITIS AS THE FIRST PRESENTATION OF SYSTEMIC LUPUS ERYTHEMATOSUS: A CASE REPORT AND LITERATURE REVIEW

<sup>1</sup>H Jethwa, <sup>1</sup>M Rana, <sup>2</sup>J Kitt, <sup>1</sup>J Democratis, <sup>1</sup>S Menzies, <sup>1</sup>A Steuer, <sup>1</sup>S Gindea. <sup>1</sup>Wexham Park Hospital, Slough, UK; <sup>2</sup>South Buckinghamshire Trust, South Buckinghamshire, UK

10.1136/lupus-2018-abstract.225

**Objective** Although fibrinous and exudative pericarditis is a common feature of Systemic lupus erythematosus (SLE), found in 62% of lupus patients on autopsy, very few cases progress to (effusive) – constrictive pericarditis. We describe the unusual occurrence of constrictive pericarditis (CP) in a patient with Systemic Lupus Erythematosus.

**Methods** This is a chart review-based report of a lupus patient who had constrictive pericarditis as a presenting feature and a systematic literature review of previously published cases. We searched the English medical literature from 1963 to 2016 using PubMed, for terms: ‘systemic lupus erythematosus’ and ‘constrictive pericarditis’.

**Results** A 49 year old African man presented with several weeks of malaise, weight loss, cough, breathlessness, peripheral oedema and hepatomegaly suggestive of right ventricular failure. An echocardiogram demonstrated features of effusive-constrictive pericarditis. The patient was initially treated for suspected tuberculosis; his symptoms progressed in spite of treatment. Further investigations confirmed positive lupus serology (ANA, anti-dsDNA Ab and anti-Sm Ab, low complement levels) and a raised urine protein: creatinine ratio of 177 mg/mmol. A diagnosis of SLE was established and treatment with Hydroxychloroquine and Prednisolone was initiated. However, the CP was refractory to medical management eventually requiring Pericardiectomy.

A literature review identified six other cases of lupus patients with CP. Of these, four patients were male and average age was 38 years. CP was the presenting feature in four cases and TB was part of the differential diagnosis in five cases. The progression from exudative to constrictive pericarditis ranged from one week to six months. Pericardial biopsies performed in four cases showed non-specific chronic inflammation and fibrosis. CP resolved with corticosteroid treatment alone in one case; pericardiectomy was necessary in the other five cases for symptom resolution.

**Conclusions** SLE should be included in differential diagnosis of constrictive pericarditis, especially in ‘idiopathic’ cases and in the context of poor response to tuberculosis treatment. Pericardial biopsy remains a crucial test in excluding an