of CAPS in multiorgan failure form regressed 14 days after the first administration, SLEDAI score decreased to 32 points, GAPPS to 4 points. After 4 weeks complete B-cell depletion was achieved. A month after the course of rituximab she achieved remission, which lasts 4 years already. ANA and antiphospholipid antibodies weren’t detected.

Patient E., 20, with primary APS, cardiolipin positivity, B2-glycoprotein-1 and lupus anticoagulant, thrombocytopenia, livedo reticularis; CAPS-like thrombotic microangiopathy type with damage to cerebral vessels, lung vessels, recurrent pulmonary embolism for six months, deep leg vein thrombosis. GAPPS activity before treatment was 17 points. Pulse therapy wasn’t performed. Therapy rituximab 375 mg/m² 1 time per week, 4 weeks was administered. Multiple organ failure also regressed 10–14 days after 1 administration of rituximab. GAPPS score decreased to 10 points. Incomplete B-cell depletion was achieved.

Conclusion Thus, rituximab demonstrated high effectiveness in CAPS in both cases. Rituximab allowed to reach multiple organ failure regression and a persistent effect was achieved.

P8 REFRACTORY THROMBOCYTOPENIA IN A PATIENT WITH SYSTEMIC LUPUS ERYTHEMATOSUS AND SECONDARY ANTIPHOSPHOLIPID SYNDROME

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Background Thrombocytopenia is a frequent hematological manifestation in patients with systemic lupus erythematosus (SLE), usually treated with glucocorticoids, immunosuppressants (such as azathioprine and cyclophosphamide), intravenous immunoglobulin (IVIG) or splenectomy.

Case report A 44-year-old woman diagnosed with SLE and secondary antiphospholipid antibody syndrome was admitted in our hospital, in July 2018, presenting severe renal and hematological involvement. She underwent treatment with methyprednisolone, followed by prednisolone, and mycophenolate mofetil, with no response. In August 2018, the patient started haemodialysis, human immunoglobulin (transient response) and plasmapheresis due to evidence of secondary thrombotic microangiopathy. The refractory severe thrombocytopenia and lupus nephritis, justify two cycles of rituximab - platelet count rising lasted for five months. Seven months later, the patient presented pancytopenia and due to high hemorrhagic risk, there was a switch from warfarin to LMWH (prophylactic dosing). One month later, anti-coagulation was suspended due to spontaneous intracranial bleeding. In August 2019, the patient had an ischemic stroke of the right occipital lobe, secondary to APS, under prednisolone and hydroxychloroquine, and with platelet count of 24,000/µL. Because of the bleeding risk, no anti-aggregation was instituted, and she started tacrolimus - the initial good response disappeared two weeks later. After consulting a rheumatology board, tacrolimus was kept and rituximab repeated, regardless of the hypogammaglobulinaemia and no lymphocytes CD19+ count.

Conclusion We experienced a severe case of secondary thrombocytopenia, that was refractory to multiple therapeutic agents. A reasonable response was obtained under rituximab. Tacrolimus is kept due to the reported cases of late effect. Ischaemic stroke is a challenging condition in patients thrombocytopenic and further clinical guidance is warranted.