Purpose To review a case report to illustrate this clinical situation

Observation A 53 years old woman, without medical history, who presented with arthromyalgia associated with a skin rash, all of which had been progressively evolving for 3 months. On clinical examination, a typical clinical myogenic syndrome was noted Skin involvement was also noted. erythematous macular lesions poorly limited, partly erosive, periorbital, erythema in shawl and V neckline on the upper limbs and neck with the presence of erosive pulpal lesions on the anterior surfaces of the fingers. There was also diffuse alopecia and butterfly-wing erythema of the face. In addition, a notion of intermittent fever at 38.5 with a progressive deterioration in general condition was reported. Severe signs such as dysphagia and dyspnea on the slightest exertion justified his admission to hospital. The physical examination found a BMI at 25, HR at 88 beats/min, respiratory rate at 20 cycles/min, TA at 110/70 mm Hg and saturation at rest and ambient air at 97%. Apart from the muscle damage, the examination of the various devices (lung, heart, vessels) was unremarkable. The biological explorations revealed leukopenia at 2000 with neutropenia and a lymphopenia at 600. The inflammatory syndrome was attested by an ESR of 59 mm and CRP of 12 mg/l. An elevation of muscle enzymes was noted (X8 N). The ANA and anti-DNA antibodies were positive but without other antigenic specificity. In addition, the blood ionogram, the renal assessment, the assessment of hemostasis were normal. Viral hepatitis (B and C) and covid 19 serologies were negative. The EMNG showed muscle damage. Cardiac evaluation objectified increase in troponins which remained stable over time with no noticeable alteration on the electrical tracing, but nevertheless apical hypokinesia without alteration of systolic function was found on cardiac echography-Doppler. At the end of these explorations, the diagnosis of overlap myositis was retained in front of the signs of dermatomyositis and SLE (the latter accumulated 19 points of the EULAR/ACR 2019 classification criteria). Therapeutically and in view of the severe motor deficit and cardiac involvement, the patient was put on a bolus of corticosteroids and immunoglobulin infusions. The evolution was favorable. The search for cancer (ovaries, lungs, breast, genitals) by the appropriate examinations (thoraco-abdominopelvic CT scan, mammography, cervico-vaginal smear) was negative, as were the anti-TIF1Y antibodies.

Conclusion The association SLE and inflammatory myopathy is rare and all types of myopathy can be found. There is a strong female predominance in so-called overlapping myositis. On the evolutionary level, the presence of another connective tissue does not seem to modify the response of myositis to treatment. The fear of cancer in its forms remains a low probability but nevertheless justifies clinical monitoring.

PO.7.154 JACCOUD'S RHEUMATISM DURING SYSTEMIC LUPUS: A CASE REPORT

A Kella, N Bouziani, A Belabbas, M Derder, D Hakem*. *Internal Medicine, Universitary Hospital Center ~ Mostaganem ~ Algeria*

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Introduction Jaccoud's rheumatism (JR) is a chronic, deforming and non-erosive arthropathy which preferentially affects the hands giving an aspect close to rheumatoid arthritis (RA). It' is distinguished from this connective tissue by the initially reducible character of the deformations and the absence of erosions on standard radiography.

Observation BR, 34 years old, who with inflammatory arthralgia and a dry syndrome. The immunological assessment showed positive AAN 1/320, anti-SSA, anti-SSB and proteinuria for 24 hours at 4 g/24 hours. The accessory salivary gland biopsy showed Chisholm grade 4. The diagnosis of systemic lupus erythematosus (SLE) associated with secondary Sjogren's syndrome (SSj) was retained. The nephropathy had benefited boluses of cyclophosphamide presuming an active and severe lesion. The corticosteroids and immunosuppressants had been continued for 2 years and for the joint damage which appeared 2years ago and a rhulupus had been diagnosed and benefited from treatment with hydroxychloroquine and methotrexate. The physical examination found a deformation of the hands type deviation in ulnar wind. The joint deformity was reducible, painless and the radiographs did not show any erosions allowing the diagnosis of JR be retained. The biological assessment found an accelerated ESR at 94 mm and a CRP at 67 mg/l, and the immunological assessment of AAN 1/320, SSA + and SSB suggesting a lupus inflammatory flare-up. Anti-CCP rheumatoid serology was negative. The patient also presented with autoimmune thyroiditis and heterozygous β-thalassemia.

Discussion The physiopathological mechanism of JR remains imperfectly elucidated. Its diagnostic criteria are not validated and its therapeutic management poorly codified. There are different severity scores for the evaluation of RJ. The most commonly used is the Jaccoud arthropathy (JA) index, used by Spronk and Al, which takes into account the number of fingers affected and the type of deformities visualized (ulnar deviation sup 20°, swan neck deformities, limitation of Metacarpophalangeal extension, buttonhole deformation, Z deformation.). The pathologies most frequently associated with JR are mainly SLE with a prevalence of 10–35%, more rarely SSj 2%. The clinical and serological factors correlated to JR are a longer duration of evolution of SLE, the presence of arthritis of the hands and wrists (rhulupus) and biologically, a higher CRP and the presence of anti-DNA antibodies. native or antiphospholipid antibodies. RJ deformities tend to worsen over time, causing functional disability and impaired quality of life, and no treatment has been proven to be effective. Rehabilitation and the wearing of orthoses remain the usual modest techniques.

Conclusion JR is classically associated with SLE. A JR that has been evolving for several years can lead to degenerative damage and lead to irreducible deformities whose pathophysiology deserves to be better elucidate in order to determine the optimal therapeutic strategy. Therefore, it is important not to ignore this complication, which is the cause of a functional and unsightly disability that alters the quality of life.