**Methods.**—NOD/LtJ, C57Bl6 (B6), 129S6 mice were immunized with 100 μg of rPR3 or BSA in CFA and boosted 4x with the same dose. Anti-PR3 response was confirmed by ELISA. Mice were sacrificed at day 75.8 ± 105 anti-rPR3 or anti-BSA splenocytes from NOD mice were transferred into NOD/SCID mice. Mice were sacrificed on day 40. Anti-rPR3 was injected into NOD mice. Anti-rPR3 IgG (750 μg/mL) purified from NOD mice was used for in vitro activation of NOD-neutrophils.

**Results.**—After immunization with rPR3, all NOD mice developed high levels of anti-PR3, whereas B6 and 129S6 developed very lower levels of anti-PR3. Anti-PR3 reacted with native PR3 in the cytoplasm of neutrophils. No anti-PR3 was detected in BSA immunized mice. NOD and 129S6 mice injected with rPR3 developed proteinuria, leukocyturia and hematuria, whereas no control mice had urine abnormalities. CGN developed in all rPR3-immunized NOD (average 25.6% crescents) and one out of four 129S6 mice (22.0% crescents). Glomeruli in all mice that developed CGN had granular capillary wall IgG, C3 and PR3. There were no glomerular lesions and no immune deposits in rPR3-immunized B6 and BSA-immunized control mice. NOD/SCID mice that received anti-rPR3 splenocytes developed circulating anti-rPR3 but no glomerulonephritis. Injection of anti-rPR3 IgG at 100 μg/kg body-weight did not induce CGN in NOD mice. Anti-PR3 IgG did not activate murine neutrophils in vitro.

**Conclusion.**—NOD mice immunized with recombinant PR3 develop circulating anti-PR3 and CGN, but the CGN is not pauci-immune.

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**Behçet’s disease**

**P21**

*Infliximab for Behçet disease with aortic involvement*

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**Introduction.**—Behçet disease (BD) is a multisystem inflammatory disorder, there have been only few case reports or small studies showing efficacy of infliximab (IFX) in combination with corticosteroids and/or immunosuppressants. Here, we describe novel cases of BD with aortitis successfully treated by IFX without corticosteroids or immunosuppressants.

**Methods.**—We had three cases of vascular BD, who were successfully treated with infliximab monotherapy. We describe the clinical courses of the patients.

**Results.**—A 43-year-old woman with recurrent oral ulcers, acneiform nodules, transient arthritis of the knees, anterior uveitis and HLA A-26 was diagnosed as BD was made. Computed tomography (CT) angiography revealed diffuse wall thickening of the ascending aorta, aortic arch, and left common carotid artery, with stenosis of the left subclavian artery. The patient, having refused corticosteroids due to the fear of side effects, was administered 5 mg/kg of IFX monotherapy. The patient’s symptoms improved immediately after the first infusion. Laboratory abnormalities normalized within 2 months and remained normal afterward.

The second case is a 31-year-old woman with a 10-year history of BD with aphthous stomatitis, genital ulcers, erythema nodosum, acneiform skin lesions, colitis and posterior uveitis. CT imaging disclosed a diffuse aortic wall thickening from root to bifurcation. Given severe posterior uveitis, 5 mg/kg of IFX was started. Follow-up CT scan showed marked improvement of aortic wall thickening with normalization of CRP and ESR. She continued to receive IFX every 8 weeks and has remained in remission for 12 months without additional therapy.

**Discussion.**—IFX monotherapy rapidly improved clinical symptoms, laboratory abnormalities, and imaging findings in both patients.

**Conclusion.**—This strongly suggests that IFX is beneficial for treating BD with major vessel involvement.

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**P22**

*Infliximab treatment of resistant uveitis in Behçet disease*

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**Introduction.**—Behçet disease is a rare multiorgan vascular condition which has often a severe eye manifestation. The aim was to analyse the effect of infliximab (INF) on uveitis in patients with Behçet disease resistant to conventional treatment.

**Methods.**—Observation of patients with uveitis in Behçet disease resistant to combination of corticosteroids with two systemic immunosuppressive drugs, being azathioprine and cyclosporine A. Treatment included INF (5 mg/kg body weight) was administrated on week 0, 2 and 6. Blood tests and complete ophtalmologic examination was performed at the infusion day and every 6 weeks afterwards. Changes in corticosteroid dosage and adverse events were registered. There was no change in immunosuppressive treatment.

**Results.**—Two female patients (age 23 and 42 years) with Behçet disease, one had had bilateral chronic panuveitis and one had unilateral chronic anterior uveitis. Previously, both patients had received topical treatment, oral corticosteroid equivalent to 1 mg/kg/day of prednisone, cyclosporine A and azathioprine. Both patients improved at 100% from the visual acuity registered before the first INF infusion and reached a normal vision in one of their eyes. Anterior Tyndall became negative at third infusion in both cases, and vitreous Tyndall became also negative. One patient relapsed. She remained asymptomatic for 8 months. The three infusions were repeated with the same response. The other one did not have any flare following 24 months. We could taper corticosteroid dosage below 10 mg/day of prednisone or equivalent in both patients. There has been observed no adverse event.

**Conclusion.**—Infliximab could be a good option in management of Behçet disease associated uveitis resistant to conventional treatment.

**Further readings**


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