due to apparently diffuse alveolar haemorrhage. Both cases had recurrent symptoms after drug use, profound neutropaenia, one had positive ANA, but other serologies were negative. Infections were thoroughly discarded.

Discussion.– Presence of neovascularisation as prominent feature in case 2, without vessel wall inflammation, seldom reported [1], was found. Interestingly also, the patient had internal organ involvement, not previously reported.

Conclusion.– Additional histologic features can be present in levamisole-adulterated cocaine-induced vasculitis, which can also present with severe vital organ involvement.

Figure 1

Reference

http://dx.doi.org/10.1016/j.jlpm.2013.02.268

P198
Cutaneous hypersensitivity vasculitis associated with visceral *Mycobacterium tuberculosis* infection: A report of three cases
M. Areses, C. Perez, J. Ibañez, M. Fanlo, M. Abinzano, M. Cia Complejo hospitalario de Navarra-B, departement of internal medicine, Pamplona, Spain

Introduction.– Erythema induratum of Bazin (EIB) is a chronic recurrent nodular disease of the skin due to a reaction of hypersensitivity to *Mycobacterium tuberculosis* (MT) infections. Histopathologic examination often demonstrates non-specific granulomatous inflammation. We present three patients with EIB and evidence of cutaneous vasculitis associated with visceral tuberculosis.

Methods.– We have retrospectively reviewed the clinical, laboratory, and histological data of these cases.

Results.– The review included three females aged 29, 35, and 80 years, which presented with erythematous painful nodules predominantly involving the skin of the lower limbs. The onset was acute in 2 patients and chronic in one case. A Mantoux test was strongly positive in all patients, and their histological examination of skin lesion specimens showed granulomatous inflammation without caseum in the deep dermis and subcutaneous tissue, with lymphocytic vasculitis. Cultures of the skin lesions specimens were negative for *Mycobacterium avium* species. Cervical tuberculosis lymphadenitis was observed in two patients and thoracic in the other case. All patients received combination anti-tuberculous treatment with complete resolution of the lesions.

Discussion.– The pathogenesis of the erythema induratum with vasculitis is not fully understood, but they are commonly considered to be cutaneous hypersensitivity eruptions to *M. tuberculosis* that occur in patients with a moderate or high levels of immunity against the organism.

Conclusion.– Clinicians should consider in the differential diagnosis of patients with cutaneous granulomatous and lymphocytic vasculitis the possibility of a cutaneous hypersensitivity vasculitis associated with visceral tuberculosis. Resolution of the lesions may be achieved with antitubercular therapy, and no immunosuppressive treatment is needed.

Further reading

http://dx.doi.org/10.1016/j.jlpm.2013.02.269

P199
Severe diffuse alveolar haemorrhage after TAVI with CoreValve in patient with AAV and Horton disease in remission. An immuno-allergic reaction?
G.A. Gregorini1, C. Fiorina2, M.F. Bonetti3
1. Spedali civili di brescia, UO nefrologia e Dialisi, Brescia, Italy
2. Spedali civili di brescia, UO cardiologia, Brescia, Italy
3. Spedali civili di brescia, UO anatomia patologica, Brescia, Italy

Introduction.– Transcatheter aortic valve implantation (TAVI) has recently emerged as alternative treatment for symptomatic aortic stenosis in pts at high surgical risk. Two bioprosthesis valves are commonly implanted nowadays, one is the self-expanded valve – Medtronic CoreValve, a valve in porcine pericardium mounted on a nitinol stent. Usually a transient increase of inflammatory indices and mild fever are observed 24–48 h post-TAVI.

Results.– A 81-year-old male patient (pt) was admitted to cardiology Department in October 2012 for a planned TAVI with CoreValve. At admission he was afebrile, the chest X-ray showed no lesions, CRP and ANCA were negative. He only presented new slight anemia (Hb 10.3 g/dl) (FOB repeatedly positive, pt on OAT). Since January 2007 pt was seen at the vasculitis clinic because of anti-MPO positive MPA. Pt was treated with steroids and ev cyclophosphamide and then with Methotrexate until February 2010. In May 2010 he started to
complain of symptoms that in Nov 2010 were found consistent with Horton arteritis. He resumed steroids and symptoms remitted. At the time of admission, the steroid dosage was 7.5 mg/day. TAVI was uneventful except for a valve in valve procedure due to a “low” valve implantation with a final mild aortic regurgitation. Twelve hours later, pt developed a rash that persisted for 4 days. From day 5, severe increase in CRP with normal procalcitonin values and reduction in plt’s count (nadir on the day 680,000/μL) were demonstrated. On day 6, pt started to complain of shortness of breath and hemoptysis, and from day 8, of fever. Chest X-ray and CT-scan showed diffuse interstitial-alveolar infiltrates. ANCA were confirmed negative as were anti-GBM, anti-DsDNA, anti-phospholipids. Complement fractions were normal. Sputum cultures were repeatedly negative, as was an extensive work up for infectious conditions. Normal valve position and ventricular function were demonstrated by frequent echocardiographic controls. Pt was treated with steroids and supportive care. Pt continued to cough blood until day 19 and 20, when he was treated with nebulized rFVIIa that stopped bleeding. After a transient improvement of clinical and radiological picture, respiratory conditions deteriorated and on day 32 pt died. Autopsy revealed hyperemic lungs at gross examination, with firm gray-brown or pale edematous areas. Histologically pneumonia organizing aspect was prevalent, associated to rare supplicative foci. Only minimal intra-alveolar blood was observed at the periphery of organizing areas. Both septal and interstitial vessels were dilated and congested. Only focal alveolar or interstitial hemosiderin-laden macrophages were present at Pearls stain.

Conclusion.– The clinical spectrum of diffuse alveolar haemorrhage is wider than previously considered. Besides the well-known vasculitic syndromes, immune or hypersensitivity reactions to medications and foreign materials, direct toxic effects to alveolar capillaries, coagulation defects, hemodynamic and vascular conditions, infectious causes should be taken into account. Identification of different causes and treatment based on the different etiologies are challenging tasks.

http://dx.doi.org/10.1016/j.lpm.2013.02.270

P200
Microscopic vasculitis associated to Sjögren’s syndrome. About 4 cases
I. Ben Ghorbel, N. Belfeki, T. Ben Salem, A. Hamzaoui, M. Khanfir, M. Lamloum, M. Miled, H. Houman
La Rabta hospital, department of internal medicine, Tunis, Tunisia

Introduction.– Glomerular involvement during Sjögren’s syndrome is extremely rare and necessitates an etiological investigation. Hereby, we report 4 observations of patients with primary Sjögren’s syndrome associated to proliferative nephritis related to microscopic polyangiitis.

Methods and results.– The report is about 4 patients whose mean age was 68 years. The first presented with arthritis, the second with lower limb edema, the third and the fourth with paresthesias. All patients reported ocular and oral dryness. Biological investigations revealed in all cases an inflammatory syndrome, a hypoalbuminemia, and a 24-hour-proteinuria over 0.5 g/24 hours. Renal biopsy was performed in 3 cases and revealed diffuse extracapillary proliferative glomerulonephritis with crescents in 1 case and focal segmental glomerulonephritis with crescents in 2 cases. The electrolymogram objectified an axonal sensorimotor neuropathy in 3 cases and the nerve biopsy concluded to a necrotizing vasculitis in one case. In all cases, Salivary gland biopsy showed stage 4 chronic lymphocytic sialadenitis according to Chisholm and Mason criteria. The immunological findings revealed positive antinuclear antibodies at a rate higher than 1/400 in all cases, as well as positive anti DNA, anti SSA, anti SSb in 3 cases. P-ANCA antinameloperoxidase antibodies were detected in all cases. The diagnosis of microscopic polyangiitis associated to Sjögren’s syndrome was retained in all cases. All patients underwent a course of corticosteroids associated to 12 monthly pulses of cyclophosphamide relayed by azathioprine. The evolution was favourable in all cases with the mean decline of 40 months.

Conclusion.– Extracapillary proliferative glomerulonephritis with positive p-ANCA in Sjögren’s syndrome is a rare condition and needs to search for an associated systemic vasculitis. In these cases corticosteroids associated to immunosuppressive agents are still the main treatment to ameliorate the renal prognosis.

http://dx.doi.org/10.1016/j.lpm.2013.02.271

Side effects

P201
Quantifying the effect of rituximab on changes in serum immunoglobulin G
D. Roberts, R. Smith, R. Jones, F. Alberici, H. Marco, D. Jayne
Renal Medicine, Addenbrooke’s Hospital, Cambridge, United Kingdom

Introduction.– Rituximab (RTX) decreases production of pathogenic immunoglobulins in autoimmune disease. Hypogammaglobulinaemia (IgG < 7 g/L) is a potential complication and assessment of the rate of change in IgG after RTX may assist in the determination of risk factors.

Methods.– Patients receiving RTX for vasculitis or SLE with sequential IgG levels and no subsequent immunosuppressive treatments known to alter IgG were studied. The rate of change in IgG pre- and post-RTX was determined using linear regression. The regression fit was assessed using the Run’s test and visual inspection.

Results.– Sixty-four patients were identified: median age 47 years, 42 female, and 38 (59%) had previously received cyclophosphamide. The median number of data points and the duration of periods of observation were 8 and 23 months pre- (n = 52) and 10 and 25 months post-RTX (n = 64). Compared to the nadir IgG pre-RTX, the incidence of IgG < 7 g/L was increased post-RTX (P = 0.0395), but not for IgG < 5 g/L (P = 0.1765) or IgG < 3 g/L (P = 0.5864). There was an association between the nadir IgG post-RTX and IgG at the time of RTX (P < 0.001). Marked intra-individual variability was observed pre- and post-RTX so temporal IgG trends were not significant in a number of patients. A decrease in IgG was seen in 23 (35%) (in 3/18 IgG was already decreasing pre-RTX), compared to an increase in 9 (14%). In those with a declining IgG, the median rate was 0.05 g/L/month, range 0.02 to 0.2 g/L/month. However, in 13 (25%) patients whose IgG was decreasing pre-RTX, IgG stopped declining post-RTX in 10, including an upward trend in two. The rate of change in IgG did not correlate with the total RTX dose (up to 20 g, median 6 g), cyclophosphamide (up to 163 g, median 5 g), age or sex.

Discussion.– Linear regression provided an indication of the direction and extent of changes in IgG. RTX was associated with a slow overall