Objectives: This report describes an atypical initial presentation of peri-orbital inflammation and neurological manifestations associated with this newly recognized syndrome.
Methods: This is a case report.
Results: An 82-year-old male with insulin-treated diabetes mellitus type II, prostate hyperplasia and chronic atrial fibrillation, presented with persistent unilateral peri-orbital swelling and pain for 6 months. An initial evaluation in the ophthalmology department with biopsy showed no evidence of malignancy, myositis, vasculitis or IgG4-related disease. Due to significantly elevated inflammatory markers (CRP 250-300 mg/L, ESR around 100 mm/h), the patient received high-dose glucocorticoids (60mg Prednisolone) with a good clinical response. During the tapering of Prednisolone, the patient developed a maculopapular skin rash in the lower extremities. Skin biopsy showed signs of urticaria-like dermatitis, while immunofluorescence examination was negative. In the following months, he was hospitalized three times due to recurrent fever, generalized weakness, fatigue and general asthenia. Extensive evaluation regarding infectious and neoplastic causes was negative. An extensive autoimmune panel (including ANA and ANCA) was tested and came out negative. CT scan of the thorax and abdomen was unremarkable. During the last hospitalization, he developed expressive aphasia and fascial paresis. MRI of the brain showed signs of leptomeningeal enhancement. Examination of the cerebral fluid showed pleocytosis (leucocyte count 124, with monocytosis), while all cultures were negative. He came to the rheumatology department in November 2022 for further evaluation. He had generalized myalgias and arthralgias but no arthritis. The skin rash had disappeared. The inflammatory markers were still highly elevated and he had a mild anemia, normocytic and normochromic, but no thrombocytopenia or leukopenia. PET-CT scan showed hyperactive bone marrow, while subsequent biopsy showed normal hematopoiesis without signs of dysplasia and no vacuoles. Endoscopic evaluations revealed no pathological findings. Prednisolone was re-introduced after PET-CT with good regress of the symptoms. Repeated MRI of the brain showed regression of the area with enhancement while all neurological symptoms had subsided. A few weeks later, we received the result of the genetic testing showing a mutation of the UBA1 gene, confirming the diagnosis of VEXAS. Our patient had already started methotrexate as a cortisone-sparing agent and started tapering off Prednisolone, so far with reasonable clinical response.
Conclusion: VEXAS syndrome should be suspected in elderly patients (especially males) with systemic inflammation when other common conditions are excluded. Orbital/peri-orbital inflammation and neurological manifestations can occur and should raise the suspicion of VEXAS.
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Acknowledgements: NIL.
Disclosure of Interests: Angeles Shunashy Galindo-Feria: None declared, Katerina Chatzidionysiou Grant/research support from: Galapagos.
DOI: 10.1136/annrheumdis-2023-eular.2138

POS1577 VENOUS INFLAMMATION MIGHT BE ONE OF THE FEATURES OF VEXAS SYNDROME AND ASSOCIATED THROMBOSIS

Keywords: Rare/orphan diseases, Imaging

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Background: VEXAS syndrome is an often fatal, X-linked disease characterized by hematological dysplasia overlapping with severe autoinflammatory manifestations. Thrombosis, predominantly as unprovoked venous thrombosis, has been reported in up to 56% of VEXAS patients. Although chronic inflammation, vasculitis, endothelial dysfunction, disrupted anticoagulant mechanisms, or prothrombotic antibodies are suggested mechanisms, the exact pathogenesis of thrombosis is yet to be elucidated. VEXAS has clinical similarities with Behçet's syndrome (BS), a systemic vasculitis involving arterial and venous vessels of all sizes. Recently, venous wall thickening (VWT) on Doppler ultrasound has been shown to be a highly sensitive and specific (>80%) finding for the diagnosis of BS. Given the clinical and pathogenetic similarities with BS, we thought venulitis might be the underlying cause of thrombosis in VEXAS syndrome.
Objectives: Herein, we report venulitis in two consecutive VEXAS patients with the demonstration of severe thickening of the walls of large veins.
Methods: Bilateral lower extremity common femoral veins (CFV) were examined with Doppler ultrasound in craniocaudal direction for the presence of thrombi, occlusion, venous insufficiency, and arterial occlusive disease. VWT was measured using the methodology described by Alibaz-Oner F et al. **[1].** All measurements were performed thrice, and the arithmetic mean of them was given as the result. We also assessed the internal jugular vein (IJV) in one patient but not in the other due to the jugular venous catheter. VEXAS patients had thickened walls on ultrasound in all examined large veins.
Results: Demographic and clinical features of our VEXAS patients are presented in Table 1. VWT in BS seemed significantly greater than non-inflammatory DVT (0.34±0.1 mm) but not significant with the anti-phospholipid syndrome (APS, 0.49 ±0.1 mm) **[2].** Our VEXAS patients had VWT greater than BS and APS suggesting remarkable vein inflammation. Patients with extensive thrombosis (Case#1) had the most severe VWT of CFV on the affected side, while the latter case (Case#2) had equivalent VWT in both CFVs.
Conclusion: Consequently, our findings suggest that venulitis might be one of the features of VEXAS syndrome and the underlying mechanism for thrombosis. Further studies are needed to clarify the role of inflammation in venous thrombotic diseases.
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Table 1. Demographic, clinical, laboratory and ultrasonographic findings of patients

	Case# 1	Case # 2
Sex	Male	Male
Age (years)	73 y	77 y
Smoking	Former (30 pc/y)	Never
UBA1 variant	M41L	M41V
Duration of symptoms	2 years	1 year
Age at diagnosis	72	77
Co-morbidities	COPD	CAD
Clinical features	Fever, weight loss, arthritis, neutrophilic dermatitis, periorbital edema, pericardial effusion, lung infiltrates, pulmonary embolism, left femoral vein thrombosis, and occlusion of left femoral artery	Fever, weight loss, arthritis, neutrophilic dermatitis, periorbital edema, right lower extremity superficial thrombophlebitis, MDS
Hemoglobin (g/dL)	8.8	6.8
MCV (fL)	>110	99.3
ESR, (mm/h)	117	135
CRP, (mg/L)	88	235
Right CFV thickness*, mm	0.91	1.43
Left CFV thickness, mm	1.21	1.02
Right IJV thickness**, mm	0.57	0.46
Left IJV thickness, mm	0.70	0.65

*Typical CFV thicknesses for healthy adult and child populations are less than 0.5 mm **(2),** and typical IJV thickness is <0.5 mm for adults

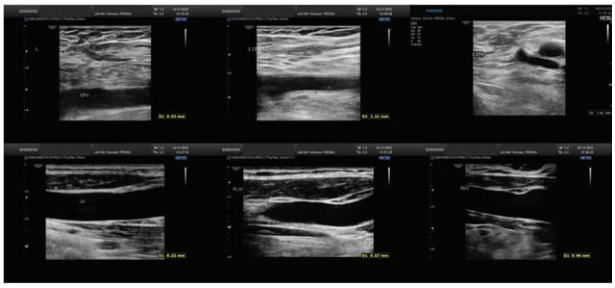


Figure 1. B-mode USG image of the common femoral vein,juguler vein and vena safena magna. **A.** A healthy individual's femoral vein ultrasonography, **B.**Vexas patient's femoral vein (case #1), **C.**Vexas patient's femoral vein (case# 2), **D.** A healthy individual's juguler vein ultrasonography, **E.**Vexas patient's juguler vein (case #1), **F.** Vexas patient's juguler vein (case# 2)

Acknowledgements: NIL.
Disclosure of Interests: None Declared.
DOI: 10.1136/annrheumdis-2023-eular.2824

POS1578 JAK INHIBITORS AND VEXAS SYNDROME: A SUCCESSFULLY CASE TREATED WITH FILGOTINIB

Keywords: Targeted synthetic drugs, Treat to target, Rare/orphan diseases

Ann Rheum Dis: first published as 10.1136/annrheumdis-2023-eular.2824 on 30 May 2023. Downloaded from http://ard.bmj.com/ on September 29, 2024 at Gazi Universitesi. Protected by copyright.