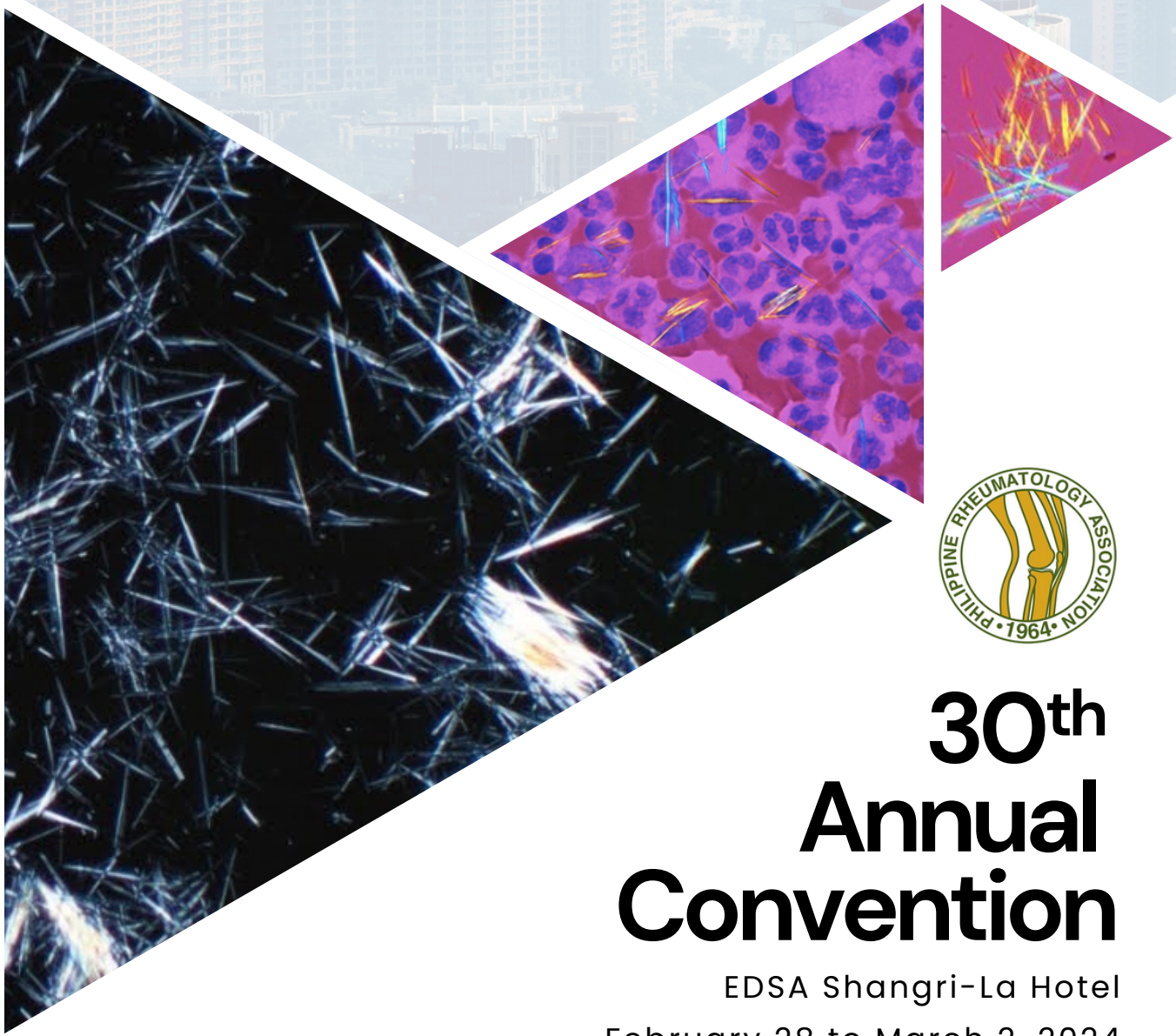
PRO RHEUM 2024

Past, PResent and PrOspects in Rheumatology



30th Annual Convention

EDSA Shangri-La Hotel

February 28 to March 2, 2024

OUR VISION

The recognized leader in the field of rheumatology in the Philippines and a major contributor in the Asia-Pacific region.

OUR MISSION

The PRA is a collegial organization, composed of competent compassionate, socially responsive and ethical rheumatologists and other specialists, that is committed to:

- Recognition and promotion of rheumatology as a specialty
- Provision of high quality patient care
- Exponent of advancement in education and research in the field
- Personal and professional development of its members

OUR CORE VALUES

Compassion

Excellence

Cooperation/collegiality

Social responsiveness

Integrity

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Message from

Malacañan Palace, Manila

Rheumatologists promote our people's overall health and wellness through. the diagnosis and treatment of musculoskeletal disease and autoimmune conditions affecting them. I therefore commend the **Philippine Rheumatology Association** for uniting all rheumatologists and other allied health professionals from the public and private sector to ensure that they remain at the forefront of this critical and ever-evolving field of medicine.

May this **30th Annual Scientific Meeting** encourage all participants to learn from the scientific lectures and best practices highlighted in this gathering so that they may hone their expertise for the benefit of their patients. I trust that you will also make use of this occasion to pursue relevant research and development activities that will open new and innovative horizons in your profession.

With you as our partners, I am confident that we can build a healthier and more productive future for all Filipinos. Together, let us transform our country into the "Bagong Pilipinas" that we can enjoy today and beyond.

I wish you a successful national convention.

FERDINAND R. MARCOS, JR

SAGISAG NG PANGULO NG PILIPINAS

Message from

Department of Health

On behalf of the Department of Health, I extend my warmest greetings and congratulations to the Philippine Rheumatology Association on the occasion of its 30th Annual Scientific Meeting with the theme of *"PRO-Rheum: Past, PResent and PrOspects in Rheumatology".*

As we mark this significant milestone, I commend the Association for its unwavering commitment to becoming a recognized leader in rheumatology within the Philippines and the Asia-Pacific region, and for its dedication to advancing the field.

Rheumatic and musculoskeletal diseases comprise over 200 diseases that oftentimes lead to chronic conditions and multiple morbidities. The emphasis on health promotion regarding arthritis and rheumatologic diseases aligns perfectly with our shared mission to enhance healthcare accessibility and quality for al. Collaboration is pivotal in addressing the multifaceted challenges posed by rheumatic conditions and in advancing the impact of Universal Health Care on service provision.

For the next five years, the health sector is guided by the 8-Point Action Agenda under the banner, **"Sa Bagong Pilipinas, Bawat Buhay Mahalaga"**, which embodies our commitment to improving the overall health landscape of our nation through the lens of every Filipino, every community, and every health worker and institution, making Universal Health Care a felt and tangible reality for every constituent. We encourage your members to align your training, research, and practice to the health sector's vision for a more efficient, inclusive, and robust healthcare system.

Let this conference be productive and enlightening, filled with meaningful discussions and valuable connections. Together, let us continue to propel rheumatology forward and contribute to t h e attainment of our vision of a healthier country.

Sa Bagong Pilipinas.... bawat buhay mahalaga!

TEODORO J. HERBOSA, MD
Secretary of health

REPUBLIC OF THE PHILIPPINES
DEPARTMENT OF HEALTH
FLOREAT SALUBRITAS POPULI

Message from

Philippine Medical Association

"Warmest congratulations to the officers and members of the Philippine Rheumatology Association, as you hold your 30th Annual Scientific Meeting with the theme “PRO-Rheum: Past, PResent and PrOspects in Rheumatology” on February 29-March 2, 2024.

The theme echoes the essence of your collective efforts – a reflection on the rich history that brought you to this point, a deep engagement with the present challenges and triumphs, and an optimistic gaze toward the exciting prospects that lie ahead. May this meeting be a convergence of ideas, a nexus of knowledge, and a testament to your unwavering dedication to advancing rheumatology in the Philippines.

On behalf of the National Officers and Board of Governors, I commend you all for the collective efforts in working hard towards the success of the organization. Indeed, if we dream together, work together, reaching our goals will not be far beyond. Let us always remember that we are ONE PMA for a Healthy Philippines!

Tayo ang “Nagkakaisang PMA: Ang Pamana ng Pilipinong Manggagamot sa Bagong Henerasyon”!

Mabuhay ang PMA at Mabuhay ang Philippine Rheumatology Association!

MARIA MINERVA P. CALIMAG, MD
President

Message from

Philippine College of Physicians

Warmest greetings to the Philippine Rheumatology Association (PRA) members at its 30th Annual Scientific Meeting with a theme of “PRO- Rheum: Past, PResent, and PrOspects in Rheumatology.” As we gather to discuss the latest trends, research, and techniques in rheumatology, it is essential to remember the importance of inspiration.

In pursuing healing and understanding, you stand at the forefront of compassion and innovation. Your dedication to the field of rheumatology is not just a profession; it is a noble endeavor to enhance the quality of life for countless individuals facing the challenges of rheumatic conditions. Every breakthrough, innovative approach, and compassionate interaction with patients contribute to transforming lives. Your work extends beyond the clinic and the lab; it reaches the hearts of individuals and families, offering them the promise of a brighter, healthier future.

As members of the Philippine Rheumatology Association, you are not just practitioners; you are champions of resilience, advocates for understanding, and architects of a more inclusive and compassionate healthcare landscape. Your collective expertise is a testament to the power of collaboration and the impact that dedicated individuals can have on the well-being of others.

Congratulations again on 30 years of exceptional service, innovation, and leadership. Here's to the next 30 years and beyond as you continue leading the charge in transforming challenges into opportunities and paving the way for a future where individuals with rheumatic conditions can live with dignity and vitality.

RONTGENE M. SOLANTE, MD
President

Message from

Asia-Pacific League of Associations for Rheumatology

Greetings! Congratulations to the Philippine Rheumatology Association, its board, organizers and scientific committee on holding its 30th Annual Scientific Meeting on February 28 – March 2, 2024 with its theme “PRO-Rheum: Past, PResent and PrOspects in Rheumatology”.

It’s been 30 years of exchanging our Philippine rheumatology research and clinical experiences. I do remember participating in the 1st PRA convention which was held at the Intercontinental Hotel in Makati City. I was in the first year of my fellowship training. I was very anxious when I presented orally the cardiac findings in Scleroderma with my conclusion that the most common finding was pericardial
effusion. All our mentors were there and thankfully it went well. I share this personal experience as I am interested to see how rheumatology research has progressed in the past 30 years.

A recent search of the PubMed and Herdin publication websites reveals that from 2020-2023 the Philippines has published work on rheumatoid arthritis (11 publications), gout (9 publications) systemic lupus erythematosus (16 publications) and osteoarthritis(4 publications). This is a good output!

My challenge to everyone most especially the younger generation is to continue to advance and inculcate the culture of research in rheumatology. We, together with our mentors, are making steps towards producing quality rheumatology research. The patients and diseases that rheumatologists manage have all been identified in the Philippines. There is a wide range of questions that still need to be answered for all rheumatic diseases. Let’s all contribute to a better understanding of them thru evidence based medicine and research

Finally, the last word in this year’s theme is PROSPECTS. What does the future hold? If I may, let me very briefly mention artificial intelligence (AI). AI and machine learning are here. In the coming years, AI will be churning out diagnostic procedures, robotics, markers of disease, new medications, new approaches to treatment which will have real world and ethical implications. Certainly rheumatology will be involved and part of this coming wave. Let us prepare ourselves and our patients for the future.

Once again, Congratulations to the Philippine Rheumatology Association!

Looking forward to seeing you all!.

JOSE PAOLO LORENZO, MD
President

APLAR

Message from

Philippine Rheumatology Association

Welcome esteemed colleagues, distinguished guests, and fellow members of the Philippine Rheumatology Association to our annual meeting.

As we gather under the theme "Past, Present, and Prospects in Rheumatology," we embark on a journey of reflection, celebration, and anticipation. Reflecting on our past, we honor the tireless efforts and remarkable achievements of those who paved the way for rheumatology in our country. Their dedication and passion have laid the foundation upon which we stand today.

In the present moment, we find ourselves amidst unprecedented challenges and opportunities. The landscape of rheumatology is ever-evolving, with groundbreaking advancements in research, diagnosis, and treatment. It is a testament to our collective commitment to excellence and innovation.

Looking towards the future, we are filled with hope and excitement for what lies ahead. With each passing year, we continue to push the boundaries of knowledge and care, striving to enhance the lives of our patients and communities. Together, we stand at the forefront of progress, poised to shape the future of rheumatology in the Philippines and beyond.

As President of the Philippine Rheumatology Association, I am immensely proud of our organization's achievements and the unwavering dedication of our members. Our annual meeting serves as a testament to the strength of our community and our shared vision for a brighter tomorrow.

I extend my heartfelt gratitude to all who have contributed to the success of this event, from our organizing committee to our sponsors and participants. Your passion and commitment are truly inspiring.

May this gathering be a source of inspiration, collaboration, and camaraderie as we continue to advance the field of rheumatology together.

EMMANUEL PEREZ, MD
President

PHILIPPINE RHEUMATOLOGY ASSOCIATION • 1964 •

Message from

30th PRA Annual Organizing Committee

Welcome to the **30th Annual Convention of the Philippine Rheumatology Association**.

I am honored to serve as the Chair of the Organizing Committee for this event, which has the theme "**PRO** Rheum: **P**ast, P**R**esent, and Pr**O**spects in Rheumatology." As we approach our organization's 60th anniversary, we have curated a comprehensive four-day scientific program covering the past, present, and future of rheumatology. The program will feature talks by distinguished speakers.

This year's Dr. Lourdes Manahan Memorial Lecture will be delivered by the President of the Philippine Medical Association, who will provide insights on the topic of Universal Health Care, entitled **"Five Years Since, What's up with UHC?".**

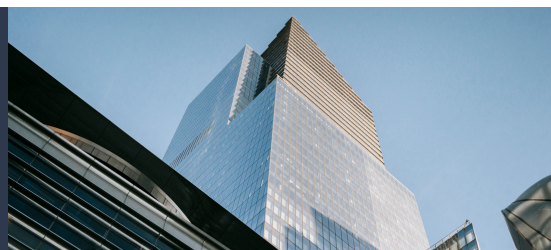
We invite you to visit the exhibition area and explore the wonders of rheumatology through the "Images in Rheumatology" and "Poster Presentations of Rheumatology Research." You can also visit the booths of our supportive pharmaceutical partners.

I want to express my gratitude to all the members of the Organizing Committee for making this convention a resounding success, to our pharmaceutical industry partners for their invaluable
and continuing support of the organization, and to the PRA Board of Trustees for their constant and unwavering support.

We hope all members and physicians who have a particular interest in rheumatology enjoy this four-day convention.

Mabuhay!

AUXENCIO LORENZ A. LUCERO JR., MD
Overall Chair




PHILIPPINE RHEUMATOLOGY ASSOCIATION
• 1964 •

Being PRO typically indicates a supportive or favorable stance towards a particular ideology, group, or activity. Additionally, it may also refer to a person who supports or advocates for a cause, as in being a PROPONENT. Likewise, it is also an abbreviation for PROFESSIONAL – reflecting expertise and a high skill level.

GENERAL INFORMATION

VENUE
EDSA SHANGRI-LA, MANILA
1 Garden Way, Ortigas Centre, Mandaluyong City 1650, Philippines Tel No. +63-2-86311067, esl@shangri-la.com ,www.shangri-la.com

REGISTRATION
The 30th Philippine Rheumatology Association (PRA) Annual Meeting is from **29 February to 02 March 2024**. Pre-convention activities and the opening ceremonies will be held on **28 February 2024**. All participants must register as delegates to the convention. PRA members are automatically pre-registered to the annual meeting following payment of their annual dues. All participants must sign in DAILY for attendance and recording of continuing professional development (CPD) credit units.

The following fees apply to participants of this meeting

PRA members (Annual Dues)	Php 5,000.00
Non-member physicians	Php 3,000.00
Trainees (fellows/residents/medical students)	Free

The physicians' registration fee includes the following

- Admission to the pre-convention course and the scientific sessions
- Opening Ceremonies
- Exhibit hall
- Lunch and snacks offered during breaks
- Convention kit with ID badge

CREDIT UNITS
Physicians will be receiving the following Continuing Professional Development credit units following completion of the convention:

- Professional Regulations Commission **11 CPD units**
- Philippine Medical Association **17 CPD units**
- Philippine College of Physicians **6 CPD Units**
- Philippine Academy of Family Physicians **5 CPD Units Category II**
- Philippine College of Occupational Medicine **20 CME Units**
- Philippine Pediatric Society **2 CPD Units**

Certificates of attendance will be available upon submission of the online conference evaluation. The link will be available on 02 March 2024.

CONVENTION LAYOUT

ANNUAL MEETING OVERVIEW

	Day 0 February 28	Day 1 February 29	Day 2 March 1	Day 3 March 2
Morning	Meeting of Accredited Training Institutions	**PLENARY 1** Revisiting ANA **PLENARY 2** Imaging in the Spondyloarthritides **PLENARY 3** Beyond Gout: Uric Acid in Other Diseases	Breakfast symposium **SYMPOSIUM 3** Philippine Practice Guidelines on Centerstage **PLENARY 4** Inertia in Osteoporosis Care	**SYMPOSIUM 6** Rheumatology Crystal Ball **PLENARY 6** Design Thinking and Health Care
		Lunch symposium	Lunch symposium	Lunch symposium
Afternoon	Annual PRA Research Forum	**SYMPOSIUM 1** Recognizing Uncommon Conditions Even in Rheumatology	**PLENARY 5** Pediatric Rheumatology Year in Review **SYMPOSIUM 4** AI in the Healthcare	Annual Business Meeting Closing Ceremonies
		Snack symposium	Snack symposium	
		SYMPOSIUM 2 Non- Pharmacologic Interventions in the Rheumatic Diseases	**SYMPOSIUM 5** Iatrogenic Rheumatology	
Evening	Opening Ceremonies	Sunset symposium	Sunset symposium	Fellowship Night
	Dinner symposium	Alumni Meetings	Alumni Meetings	

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PRE-CONVENTION | DAY 0
WED, FEBRUARY 28

TIME	ACTIVITY
A.M. 10:00 - 12:00	Meeting of Accredited Training Institutions
P.M. 1:30 – 3:30	Annual PRA Research Forum
5:30 – 9:00	**Opening Ceremonies** Dr Lourdes Manahan Lectures on Rheumatology Memorial Lecture **"5 Years Since, What Now UHC?"** ***Dr. Maria Minerva P. Calimag, PMA President*** *Moderator: Dr. Emmanuel C. Perez*
8:30 - 9:30	*Dinner Symposium (J&J)* **Novel Treatment Strategies for Psoriatic Arthritis |** Dr. Jose Paolo P. Lorenzo

Click the title of the lecture to read the Session Abstracts

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Improving on the Past

DAY 1 | THU, FEBRUARY 29

Click the title of the lecture to read the Session Abstracts

TIME	ACTIVITY
A.M. 9:00 – 9:40	**PLENARY 1** **Revisiting ANA** *Dr. Allan D. Corpuz* Moderator: Dr. Genevieve C. Katigbak
9:40 – 10:30	**PLENARY 2** **Imaging in the Spondyloarthritides** *Dr. Sheila Marie M. Reyes* Moderator: Dr. Juneth Ria Limgenco-Hipe
10:30 – 11:15	Opening of Booths, Exhibits
11:15 – 12:00	**PLENARY 3** **Beyond Gout: Uric Acid in Other Diseases** *Dr. Ma. Hanna Monica Z. Sollano* Moderator: Dr. Sandra Susana Sanidad
P.M. 12:00 – 1:00	Lunch Symposium (Taisho) ***Esflurbiprofen Patch: Clinical data and its position in the Management of Osteoarthritis*** | Dr. Evelyn O. Salido
1:00 – 2:30	**SYMPOSIUM 1** **Recognizing Uncommon Conditions Even in Rheumatology** Moderator: Dr. Francis Martin Cuenco **Understanding CRPS** *Dr. Jonathan Paul Consignado* **More than Skin: Neutrophilic Dermatoses** *Dr. Rogelio A. Balagat*
2:30 – 3:00	Visit Booths
3:00 - 4:00	Snack Symposium (Viatris) ***Revisiting Multi-modal Approach in the Management of Osteoarthritis Post-COVID Pandemic*** | Dr. Ester G. Penserga
4:00 - 5:30	**SYMPOSIUM 2** **Non-Pharmacologic Interventions in the Rheumatic Diseases** Moderator: Dr. Charlie Chan **Revisiting Non-pharmac Interventions in Osteoarthritis** *Dr. Nestor Don N. Santiago* **Introducing Non-Pharma Interventions in RA** *Dr. Angeline Therese D. Magbitang- Santiago*
5:30 - 6:30	Sunset Symposium (Unilab) ***PAIN TRANSFORMERS: The Optimum Approach to Managing Post-Traumatic Osteoarthritis Pain*** | Dr. Sandra A. Tankeh-Torres, Dr. Antonio N. Tanchuling Jr.
7:00 onwards	Alumni Meetings

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Click the title of the lecture to read the Session Abstracts

Living with the Present

DAY 2 | FRI, MARCH 01

TIME	ACTIVITY
8:00 - 9:00	Breakfast Symposium (Inova) ***Real World Effectiveness of Orphenadrine citrate 50 mg + Paracetamol 650 mg (Norgesic® Forte) on Low Back Pain of Filipino Patients*** | Dr. Ramon Jason M. Javier
9:00 – 10:30	**SYMPOSIUM 3** **Philippine Practice Guidelines on Centerstage** Moderator: Dr. Anna Kristina Gutierrez-Rubio **Managing SLE in the Philippines** *Dr. Leonid D. Zamora* **Making it Routine: MSK Screening** *Dr. Evelyn Osio-Salido*
10:30 – 11:00	Visit Booths
11:00 – 11:40	**PLENARY 4** **Inertia in Osteoporosis Care** *Dr. Millicent Tan-Ong Plenary* Moderator: Dr. Bethlehem Mula-Natanauan
11:40 – 12:40	Lunch symposium (Novartis) ***Radiographic and Clinical Evidence of Disease Modification with IL-17 Inhibition*** | Prof. James Wei
12:40 - 1:20	**PLENARY 5** **Pediatric Rheumatology Year in Review** *Dr. Christine B. Bernal Plenary* Moderator: Dr. Ma. Theresa M. Collante
1:20 - 2:50	**SYMPOSIUM 4** **AI in the Healthcare** Moderator: Dr. Sidney Erwin T. Manahan **ChatGPT: Friend or Foe** *Dr. Ronald N. Eullaran* **Understanding the Role of AI Tools in Med Ed** *Dr. Lisa S. Traboco*
3:00 - 4:00	Snack Symposium (GSK) ***Shingles among Rheumatology Patients: Risk, Impact and Prevention*** | Dr. Geraldine T. Zamora-Abrahan
4:00 - 5:30	**SYMPOSIUM 5** **Iatrogenic Rheumatology** Moderator: Dr. Charito Bermudez-Cruz **Drug and Rheumatic Diseases** *Dr. Aileen U. Agbanlog-Dimatulac* **Vaccines and Rheumatic Diseases** *Dr. Geraldine Zamora-Abrahan*
5:30 - 6:30	Sunset Symposium (Pfizer) ***Challenging the Norm: Tofacitinib in Rheumatoid Arthritis*** | Dr. Maria Sheila N. Leynes
7:00 onwards	Alumni Meetings

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What are Rheum Prospects?

DAY 3 | SAT, MARCH 02

Click the title of the lecture to read the Session Abstracts

TIME	ACTIVITY
R.M. 00 - 9:30	**SYMPOSIUM 6** **Rheumatology Crystal Ball** Moderator: Dr. James Barte **CAR T-cells in the Rheumatic Diseases** *Dr. Jemima Felicity L. Albayda* **Hemoperfusion: Beyond COVID-19** *Dr. Marissa Elizabeth Lim*
9:30 - 10:00	Visit Booths
10:00 - 10:40	**PLENARY 6** ***Design Thinking and Health Care*** *Dr. Sandra A. Tankeh-Torres* Moderator: Dr. Melchor Alan Siriban
10:40 - 11:40	Lunch symposium (Boehringer) ***Advancements in Diagnosis, Screening and Management of CTD: Insights from ACR Guidelines*** | Dr. Aileen G. Agbanlog-Dimatulac
11:40 - 1:00	Visit Booths
P.M. :00 - 3:00	**PRA ANNUAL BUSINESS MEETING** Treasurer's Report President's Report Election Results Bidding for 2025 PRA Annual Meeting
3:00 - 5:00	**CLOSING CEREMONIES**
7:30 – 10:00	**FELLOWSHIP NIGHT**

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SCIENTIFIC ABSTRACTS

Dr Lourdes Manahan Lectures on Rheumatology

MEMORIAL LECTURE

5 Years Since, What Now UHC?

Dr. Maria Minerva P. Calimag, PMA President

Dr Calimag is the current President of the Philippine Medical Association and the Regional Anesthesia Society of the Philippines. She is a Past President of the Philippine Society for Experimental and Clinical Pharmacology 2017-2019, Asian and Oceanic Society of Regional Anesthesia and Pain Medicine 2015-2017,Philippine Society of Anesthesiologists 2010-2011, Manila Medical Society 2002-2004, Society for Obstetric Anesthesia of the Philippines 2001-2003, and International College of Surgeons Alliance 2001-2003. She is a Professor at University of Santo Tomas, Faculty of Medicine and Surgery and the Graduate School; and a Consultant Anesthesiologist at USTH and EAMC.

She was awarded 2012 Most Outstanding Professional in Medicine and First Eric NublaAward for Excellence by Professional Regulation Commission, 2014 Quintin J. Gomez Award as Outstanding Filipino Anesthesiologist by Philippine Society of Anesthesiologists, 2017 Dr. Jose Rizal Memorial Award for the Academe by Philippine Medical Association, and 2021 Outstanding Filipino Teacher in Higher Education by Metrobank Foundation.

She completed her Doctor of Medicine at UST Faculty of Medicine and Surgery as bene meritus. She finished her Doctor of Philosophy in Education Major in Educational Management at UST Graduate School and graduated summa cum laude. She obtained her Master of Science in Clinical Epidemiology at the UP College of Medicine as a Philippine Council for Health Research and Development Scholar.

This talk is moderated by Dr Emmanuel C. Perez. *Dr. Perez is the current President of the Philippine Rheumatology Association. He is also a Associate Director for the Center for Clinical Epidemiology and Biostatistics Research Division in De La Salle University (DLSU) – Health Science Institute Dasmariñas, Cavite, and an Associate Professor for the Department of Medicine DLSU Dasmariñas, Cavite. He served as Chair of the Department of Medicine University of Perpetual Help DALTA Medical Center (UPHMC), Las Piñas and of the Philippine Specialty Board of Rheumatology. He is an active consultant at the Section of Rheumatology at UPHMC and DLSUMC.*

He underwent his Internal Medicine residency and Rheumatology fellowship training at USTH. He finished his Masters of Public Health at UP Manila.

ANA Revisited

Dr. Allan D. Corpuz

The choice of methodology depends on several factors

- Clinical context: Is this for initial screening, confirmation, or specific antibody detection?
- Desired level of sensitivity and specificity: How important is it to detect rare antibodies or avoid false positives?
- Available resources and expertise: Does the laboratory have the necessary equipment and trained personnel?
- Cost: What is the budget for the test?
- Specific needs of the patient or research study: Are there unique requirements for the test?

General recommendations

- IF-HEp-2 remains the standard method for initial ANA screening due to its wide availability, broad detection range, and ability to provide valuable pattern information.
- ELISA or LIA may be used for confirmation of positive IF results, specific antibody detection, or high-throughput screening.
- Western blot is reserved for specialized situations requiring high specificity or rare antibody detection.
- Emerging technologies offer promising advancements, but their wider adoption and cost-effectiveness need further development.
- The choice of methodology should be guided by individual patient needs, clinical context, and available resources.

The International Consensus on ANA Patterns (ICAP) plays a crucial role in interpreting ANA results by providing a standardized language and classification system for the various immunofluorescence patterns observed in the indirect immunofluorescence assay (HEp-2 IFA). It offers several benefits such as:

For healthcare professionals

- Improved consistency: ICAP reduces inter-observer variability in pattern interpretation, leading to more consistent and reliable diagnoses.
- Enhanced diagnostic accuracy: By associating specific patterns with particular autoimmune diseases, ICAP helps refine diagnoses and reduce false positives or negatives.
- Streamlined communication: Using standardized terminology facilitates communication between clinicians, pathologists, and researchers, improving patient care and collaboration.
- Guidance for further testing: ICAP recommendations indicate which patterns require further specific antibody testing for better disease characterization.

For patients

- Accurate diagnosis: Standardized interpretation improves diagnostic accuracy, potentially leading to faster and more appropriate treatment.
- Improved prognosis: Early and accurate diagnosis can improve long-term outcomes for patients with autoimmune diseases.
- Reduced uncertainty: Clear interpretations and potential disease associations aid in understanding the diagnosis and its implications.

How the ICAP is used in interpreting ANA results

- Pattern Identification: During HEp-2 IFA, the specific fluorescent staining pattern on the cell is identified.
- ICAP Reference: Healthcare professionals use the ICAP online resource or other references to compare the observed pattern with images and descriptions of various standardized patterns.
- Interpretation: Based on the identified pattern and other clinical information, the healthcare professional interprets the ANA result, considering:
  - Associated diseases: ICAP links specific patterns to certain autoimmune diseases with varying degrees of strength.
  - Additional testing: ICAP may recommend further specific antibody testing based on the pattern for confirmation or further disease characterization.
  - Clinical context: Individual patient history, symptoms, and other laboratory findings are crucial for a comprehensive diagnosis.

Points to consider

- ICAP is not a definitive diagnostic tool. Other clinical findings and specific antibody testing are necessary for accurate diagnosis.
- ICAP is an ongoing initiative, and updates may occur as new knowledge emerges.
- Expertise in pattern recognition and understanding of individual clinical context remain crucial for accurate interpretation.

Dr Corpuz is the Head of the Research Unit at Ilocos Training and Regional Medical Center (ITRMC). *He is an Active Consultant at Lorma Medical Center, ITRMC, Bethany hospital, Inc., and La Union Medical and Diagnostic Center. He was the 2019 Best Mentor in Health Research, Luzon Cluster awarded by the Philippine Council for Health Research and Development - Department of Science and Technology (DOST). He finished his Bachelor of Science in Biology as cum laude and Doctor of Medicine at St. Louis University College of Medicine. He completed his Internal Medicine residency and Rheumatology fellowship training at the UP-PGH.*

This talk is moderated by Dr Genevieve C. Katigbak. *Dr. Katigbak is the current Conference Chair of the Residents' Progress and Promotion Committee Department of Medicine and Assistant Training Officer of the Rheumatology fellowship training at MMC. She is an Active Consultant at SLMC Global City and MMC. She completed her Internal Medicine residency and Rheumatology fellowship training at MMC.*

Imaging in the Spondyloarthritides

Dr. Sheila Marie Reyes Yap Uyseco

Axial spondyloarthritis (axSpA) is a chronic inflammatory disorder primarily affecting the spine and sacroiliac joints. Diagnostic delay poses a significant threat in treatment response as well as the quality of life of patients. Imaging plays a critical role in the diagnosis and management of the spondyloarthritides. However, despite advancements in treatment, early detection remains a challenge.

As rheumatologists, we rely on a combination of clinical, laboratory and radiologic data in the diagnosis; therefore, knowing the appropriate imaging modality increases our confidence and competence in the management of this group of diseases. This also includes being knowledgeable in requesting for the correct views and sequences and interpreting the results. My discussion shall focus on radiography, MRI and CT – including their advantages and limitations - in the diagnosis and management of axSpA (ankylosing spondyloarthritis and non-radiographic axial SpA). I will provide a brief update from the 2019 ACR/SAA/SPARTAN recommendations on the use of imaging in axSpA. In addition, I will discuss some pearls and pitfalls in imaging as well as clinical applications of imaging in diagnosing and monitoring axial spondyloarthritis.

Dr Reyes Yap Uyseco is the Chair of the PRA Committee on Online Engagement and the Treasurer of the PCP Rizal Chapter. *She is an Active Member of the Residency Core Training Committee of World Citi Medical Center. She is a faculty of RheumNow of the American College of Rheumatology Convergence 2020. She is an Active Consultant of SLMC and WCMC. She graduated Doctor of Medicine at UST Faculty of Medicine and Surgery. She completed her Internal Medicine residency and Rheumatology Fellowship training at SLMC.*

This talk is moderated by Dr. Juneth Ria Limgenco-Hipe. *Dr. Hipe is an Active Consultant at the Section of Rheumatology at Surigao Health Specialists Inc., Surigao Doctors Hospital, Surigao Medical Center, and St. Paul Hospital University Surigao. She completed her Doctor of Medicine at the UST Faculty of Medicine and Surgery and graduated cum laude and benemeritus. She was a former Chief Fellow of the Section of Rheumatology at UP PGH. She was awarded as Most Outstanding Resident Physician 2010 at United Doctors Medical Center. She completed her Masters of Science in Public Health major in Hospital Administration at the University of the Visayas in Cebu City.*

Beyond Gout: Uric Acid in Other Diseases

Dr. Ma. Hanna Monica Z. Sollano

Hyperuricemia, although almost always synonymous to gout, is also well known to accompany conditions such as cardiovascular disease, renal disease, diabetes mellitus and obesity. This lecture aims to discuss the role of hyperuricemia in these metabolic abnormalities and dissect the evidence of whether treating asymptomatic hyperuricemia will be beneficial or not.

Dr Sollano is the co-author, project manager, and presenter of the 2021 Asia Pacific League of Associations for Rheumatology Clinical Practice Guidelines for Treatment of Gout. *She is a member of the Asia-Pacific League of Associations for Rheumatology Young Rheumatologists. She is an Active Consultant of the Section of Rheumatology at General Malvar Hospital, De Los Santos Medical Center, Cardinal Santos Medical Center, and MMC. She completed her Rheumatology fellowship training at MMC.*

This talk is moderated by Dr Sandra Susana Sanidad. *Dr Sanidad is the Head of the Section of Rheumatology at Notre Dame De Chartres Hospital (NDCH) and a faculty at the Saint Louis University (SLU) School of Medicine Department of Medicine in Baguio City. She is also a Medical Specialist II at Ilocos Sur Medical Center (ISMC). She completed her Internal Medicine residency training at NDCH, and her Rheumatology fellowship training at UP PGH.*

Understanding Complex Regional Pain Syndromes

Dr. Jonathan Paul Consignado

Complex Regional Pain Syndrome (CRPS) is a rare condition characterized by disproportionate pain, sensory and motor abnormalities, autonomic dysfunction, and trophic changes. Despite efforts to fully understand this enigmatic condition, the exact etiology and pathophysiology still remain unknown thus bringing about challenges in the realm of pain disorders. This presentation explores the current understanding of CRPS, looking into the complex interplay of neuroinflammatory mechanisms leading to a greatly diverse clinical manifestations, diagnostic challenges, and the importance of a multidisciplinary approach in providing evidence-based therapeutic modalities for optimal patient outcomes.

Dr. Consignado is an Adviser of the St. Luke's Medical Center Lay Forum and Psoriasis Philippines - Laguna Chapter. *He is a member of the Asia Pacific League of Associations for Rheumatology Social Commitment & Patient Outreach Special Interest Group, Philippine Specialty Board of Rheumatology, and Advocacy Committee of the Philippine Rheumatology Association. He is a Clinical Associate Professor at St. Luke's College of Medicine - William H. Quasha Memorial. He is an Active Consultant at SLMC and the Perpetual Help Medical Center in Las Piñas City. He finished his Doctor of Medicine at SLMC College of Medicine-William H. Quasha Memorial, and his Rheumatology fellowship training at SLMC.*

This talk is moderated by Dr Francis Martin Cuenco. *Dr Cuenco is an instructor in Rheumatology at Chinese General Hospital Colleges and a member of the Asia-Pacific League of Associations for Rheumatology Young Rheumatologists. He is a Consultant of the Section of Rheumatology at Taytay Doctors Multispecialty Hospital, Dr. Jesus C. Delgado Memorial Hospital, St Camillus Medical Center, Binangonan Lakeview Hospital, and The Medical City Clinics (Cainta, Antipolo, and Sta. Lucia Mall). He underwent his Internal Medicine residency training at Cardinal Santos Medical Center, and Rheumatology fellowship training at USTH. He had his Visiting Fellowship training at Scleroderma and Myositis Center of Excellence, Nippon Medical School Hospital in Tokyo, Japan,*

More Than Skin: Neutrophilic Dermatosis

Dr. Rogelio A. Balagat

Neutrophils are the most abundant leukocyte cell type and a critical component of the innate immune system. Neutrophil activation figure prominently in arthritis-dermatitis syndromes. Neutrophilic dermatoses (NDs) are a group of inflammatory disorders with the common finding of sterile neutrophilic infiltrate on histopathology. The presentation will focus on NDs such as Sweet syndrome, pyoderma gangrenosum, and Behcet disease. It will present data on neutrophil inflammasome and neutrophil extracellular trap (NET). It will also show overlap with autoinflammatory syndromes such as generalized pustular psoriasis, bowel-associated-arthritis-dermatosis syndrome (BADAS), pyogenic arthritis-pyoderma gangrenosum-and-acne (PAPA), and vacuoles-E1 enzyme-X-linked-autoinflammatory-somatic syndrome (VEXAS).

Dr Balagat is a Fellow of the Philippine Rheumatology Association and Philippine Dermatological Society. *He was the Head of Department of Medicine at Victor R. PotencianoMedical Center from 2017-2018 and at Rizal Medical Center from 2020-2023. He is the current Chief of the Section of Rheumatology at RMC, and a faculty of Ateneo de Manila School of Medicine and Public Health and Mapua University. He is an Active Consultant at VRPMC and RMC. He completed his Internal Medicine residency and Rheumatology fellowship training at UP PGH.*

This talk is moderated by Dr Francis Martin Cuenco. *Dr Cuenco is an instructor in Rheumatology at Chinese General Hospital Colleges and a member of the Asia-Pacific League of Associations for Rheumatology Young Rheumatologists. He is a Consultant of the Section of Rheumatology at Taytay Doctors Multispecialty Hospital, Dr. Jesus C. Delgado Memorial Hospital, St Camillus Medical Center, Binangonan Lakeview Hospital, and The Medical City Clinics (Cainta, Antipolo, and Sta. Lucia Mall). He underwent his Internal Medicine residency training at Cardinal Santos Medical Center, and Rheumatology fellowship training at USTH. He had his Visiting Fellowship training at Scleroderma and Myositis Center of Excellence, Nippon Medical School Hospital in Tokyo, Japan,*

Revisiting non-pharma interventions in osteoarthritis

Dr. Nestor Don N. Santiago

Osteoarthritis is the most common type of joint disease and is the leading cause of chronic disability in older adults worldwide. Its management has been extensively reviewed and is periodically updated. The European league against Rheumatism (EULAR) has come up with an update in 2023 on the non-pharmacologic interventions for the hip and knee. Key points of the update regarding exercise and assistive devices will be discussed along with other relevant rehabilitation medicine management

Dr. Santiago is the Unit head for the Lifestyle Medicine Program – Physical wellness at NKTI, and the Clinic Head of the Sports Physical Therapy at UP Diliman*. He is an Assistant Faculty at the College of Rehabilitation Sciences in De LaSalle Health Sciences Institute. He was a Courtside Physician of the Philippine Basketball Association in 2015, and a Varsity Team Physician of the UP Diliman, College of Human Kinetics from 2008-2009. He is a Medical Specialist at Mandaluyong City Medical Center – Department of Rehabilitation Medicine. He completed his Rehabilitation Medicine residency training at UP PGH.*

This talk is moderated by Dr Charlie Chan. *Dr Chan is an Active Consultant of the Section of Rheumatology at Meycauayan Doctors Hospital, De Los Santos Medical Center, Capitol Medical Center, and Our Lady of Mercy General Hospital. He completed his Internal Medicine residency and Rheumatology fellowship training at MMC.*

Introducing Non-pharmacologic Interventions in Rheumatoid Arthritis

Dr. Angeline Therese D. Magbitang-Santiago

The optimal management of rheumatoid arthritis involves pharmacologic and nonpharmcologic interventions. The 2022 American College of Rheumatology Guideline for Exercise, Rehabilitation, Diet, and Additional Integrative Interventions represents a pioneering effort, providing clinicians and patients with a robust framework for integrating nonpharmacologic strategies into the management of rheumatoid arthritis. A key emphasis of the guidelines lies in recognizing the complementary effect of pharmacologic and nonpharmacologic approaches, emphasizing the need for a collaborative, interdisciplinary healthcare teams and an individualized approach to management. Reviewing the evidence for exercise, rehabilitation, diet, and other integrative interventions, it also aim to be a catalyst for future much-needed research, elevating awareness, facilitating shared decision-making, and promoting accessibility to these interventions.

Dr. Magbitang-Santiago is the Training Officer of the Rheumatology Fellowship Training at UP PGH. *She is a Science Research Specialist of the SLE Genetics Study at UP PGH and NIH, and a member of the Research Committee of Internal Medicine at San Juan De Dios Educational Foundation, Inc. She is a Clinical Associate Professor of the UP PGH, and an Active Consultant of the Section of Rheumatology at San Juan De Dios Educational Foundation, Medical Center Manila and Ospital ng Maynila Medical Center. She completed her Rheumatology fellowship training and finished her Masters of Science in Health Informatics at UP PGH. She is the 2013-2014 recipient of the Department of Medicine Ramon Abarquez Most Outstanding Fellow Award.*

This talk is moderated by Dr Charlie Chan. *Dr Chan is an Active Consultant of the Section of Rheumatology at Meycauayan Doctors Hospital, De Los Santos Medical Center, Capitol Medical Center, and Our Lady of Mercy General Hospital. He completed his Internal Medicine residency and Rheumatology fellowship training at MMC.*

Managing SLE in the Philippines: The PRA CPG

Dr. Leonid D. Zamora

Systemic Lupus Erythematosus (SLE) is a chronic, complex, multisystem autoimmune disease that primarily affects women of child-bearing age but can also occur in children, men, and the elderly. It is more common and severe among Asians, Hispanics, and African-Americans. Diagnosis is based on clinical features and characteristic serologic abnormalities. The management of SLE is highly individualized, taking into account factors such as organ involvement, disease severity, comorbidities, and shared decision-making between physicians and patients. Early diagnosis and timely referral to a lupus specialist significantly improve outcomes for this disease. The overall treatment goals in SLE focus on long-term patient survival, prevention or reduction of organ damage, and optimization of health-related quality of life and productivity.

To aid healthcare providers in managing SLE patients, the Clinical Practice Guideline (CPG) for SLE was developed. It's important to note that this CPG is not intended to replace clinical judgment or timely referral to a lupus specialist. The guideline development process for SLE involved four phases: preparation and prioritization, CPG generation, CPG appraisal, and implementation. The technical working group reviewed existing CPGs, appraised evidence, and drafted initial recommendations. The scope of the guidelines includes the diagnosis of SLE, management of SLE (including general measures, non-renal involvement, and lupus nephritis), as well as the management and prevention of infectious complications.

Dr. Zamora is the Assistant Research Head of the UST-FMS Department of Medicine at UST Hospital. *He is the Assistant Training Officer of the Section of Rheumatology, USTH. He is a member of Asia Pacific League of Associations for Rheumatology Young Rheumatologists, APLAR SLE Special Interest Group, and Asia-Pacific Lupus Collaboration. He is a Climate Advocate of the Climate Reality Project's Leadership Corps, Manila, and an Active Consultant of the Section of Rheumatology at USTH and JRMMC. He completed his Internal Medicine residency training at MMC and Rheumatology fellowship training at USTH. He was a Rheumatology Research Fellow at University of Texas Health Science Center. He finished his Master of Science in Molecular Medicine at SLMC College of Medicine.*

This talk is moderated by Dr Anna Kristina Gutierrez-Rubio. *Dr. Gutierrez-Rubio is the Medical Director of the Centre Medicale Internationale. She is an Active Consultant of the Section of Rheumatology, at the The Medical City, Victor R. Potenciano Medical Center, and Makati Medical Center. She completed her Internal Medicine residency and Rheumatology fellowship training at UP PGH.*

Making it Routine: MSK Screening in the PHEX

Dr. Evelyn Osio-Salido,
on behalf of the Philippine Periodic Health Examination Task Force on Musculoskeletal Disorders

Musculoskeletal diseases (MSDs) are acutely or chronically painful conditions that cause limitations in mobility and participation in society leading to a large burden in terms of years lived with disability worldwide. Their burden is higher in countries with a lower sociodemographic index, like the Philippines. The goal of this clinical practice guideline is to provide recommendations to primary care providers on screening for MSDs among asymptomatic, apparently healthy children and adults.

The CPG focused on screening for nine musculoskeletal conditions and risk factors. Evidence on net benefit or harm of screening was obtained through systematic literature searches from August 2022 up to March 2023. Additional information on cost-effectiveness, patient values and preferences, acceptability, feasibility of screening and its impact equity were also obtained.

The Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach was used to determine the certainty of the evidence. The final recommendations were composed through consensus by a panel of representatives from multiple stakeholder groups.

There were 15 recommendations formulated. Strong recommendations were given to screen for physical inactivity among adults, fall risks and sarcopenia for adults aged ≥60 years old, and osteoporosis among women aged ≥65 years old. However, strong recommendations were made against screening for low vitamin D among infants, children, and adults, and against screening for osteoporosis among men and among women aged <65 years old.

Through a comprehensive evaluation of the best available evidence using the GRADE approach, the Task Force developed 15 recommendations on screening and risk factor assessment for nine MSDs. These recommendations will serve as guidance on screening for MSDs at the level of primary care.

Dr. Osio-Salido is a Past Preident of the Philippine Rheumatology Association. *She is the Chief of the Section of Rheumatology-Department of Medicine at UP PGH, a Professor V at UP Manila College of Medicine, and a Professor II at De La Salle College of Medicine-Division of Clinical Epidemiology. She is a research committee member, independent consultant, and technical reviewer of research protocols of affiliated institutions. She is an Active Consultant of the Section of Rheumatology at UP PGH, DLSU Medical Center, and Asian Hospital and Medical Center. She completed her Internal Medicine residency and Rheumatology fellowship training at UP PGH. She finished her Master of Science in Clinical Epidemiology at UP Manila.*

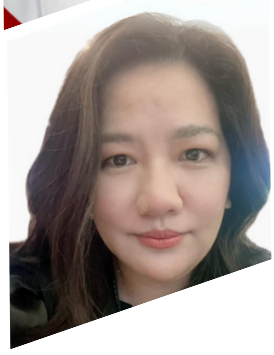
This talk is moderated by Dr Anna Kristina Gutierrez-Rubio. *Dr. Gutierrez-Rubio is the Medical Director of the Centre Medicale Internationale. She is an Active Consultant of the Section of Rheumatology, at the The Medical City, Victor R. Potenciano Medical Center, and Makati Medical Center. She completed her Internal Medicine residency and Rheumatology fellowship training at UP PGH.*

Inertia in Osteoporosis Care

Dr. Millicent Tan-Ong

Osteoporosis and its complications remain as an under-recognized public health challenge in the Philippines. This lecture aims to discuss the concept of inertia in osteoporosis care and its impact, cite the provider-related, patient-related factors and healthcare system challenges, and propose strategies to overcome inertia in osteoporosis care including patient education, healthcare provider initiatives and policy-level interventions. Ultimately, this lecture seeks to empower healthcare professionals and stakeholders with knowledge and tools to address inertia in osteoporosis care, advocating for proactive management and improved outcomes for individuals at risk of osteoporotic fractures.

Dr. Ong is the President of the Philippine Society of Ultrasound in Clinical Medicine and the Head of USTFMS Ultrasound Skills Unit-CME Division. *She is the Secretary of the Philippine Society for Digital Health, and the Assistant Fellowship Training Officer of the Section of Rheumatology, Clinical Immunology and Osteoporosis at University of Santo Tomas Faculty of Medicine and Surgery. She completed her Internal Medicine residency and Rheumatology fellowship training at USTH.*



This talk is moderated by Dr Bethlehem Mule-Natanauan. *Dr. Mula-Natanauan is an Associate Professor V at the College of Medicine of Cavite State University, and a faculty at the College of Medicine of Batangas State University. She received an award for Most Outstanding Resident of the Department of Internal Medicine at Ilocos Training and Regional Medical Center (ITRMC) in La Union, and Leadership Award at Lyceum Northwestern University-Francisco Q Duque Medical Foundation in Dagupan City.She completed her Internal Medicine residency training at ITRMC and Rheumatology fellowship training at USTH.*

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Pediatric Rheumatology Year in Review

Dr. Christine B. Bernal

There were thousands of journal articles published in the field of Pediatric Rheumatology in the year 2023. This talk will highlight on the studies that can provide practical information on the management including novel information that can affect and improve patient outcomes. Focus will be on the updated recommendations for vaccinations of pediatric patients with autoimmune inflammatory rheumatic diseases, use of new biologics in JIA, utility of musculoskeletal ultrasound in JIA, pediatric lupus in the covid 19 era and mental health issues in JIA.

Dr. Bernal is the Chief of Section of Pediatric Rheumatology at UST Hospital and Cardinal Santos Medical Center. *She is an Associate Professor V of the Department of Pediatrics and Medicine at UST Faculty of Medicine & Surgery. She is the Vice Chair of the Philippine Pediatric Society, and Chairof the PRA Pediatric Rheumatology Special Interest Group.She is an Active Consultant at the Section of Rheumatology in USTH and Cardinal Santos Medical Center. She completed her Pediatrics residency training at UST Hospital, and her Pediatric Rheumatology fellowship training at Baylor College of Medicine in Houston, Texas.*

This talk is moderated by Dr Ma. Therese M. Collante. *Dr. Collante is the Training Officer of the Section of Pediatric Rheumatology and the Chair of the Research Committee for the Department of Pediatrics at USTH. She is the Head of the Section of Pediatric Rheumatology at the National Children's Hospital and an Active Consultant atWestlake Medical Center. She completed her Pediatric residency and Rheumatology fellowship training at UST Hospital. She was a part of the Visitor Scholars Program in Rheumatology at Baylor College of Medicine-Texas Children's Hospital. She obtained a Post-graduate Certificate in Public Health (International) from University of Leeds in United Kingdom, and a Master of Science in Epidemiology at UP-Manila. She underwent Global Clinical Research Training Program at Harvard Medical School.*

ChatGPT: Friend or Foe

Dr. Ronald N. Eullaran

In the rapidly evolving landscape of medical practice, ChatGPT emerges as a groundbreaking tool, offering both significant advantages and notable disadvantages. Its strengths lie in its ability to process vast amounts of medical literature swiftly, aiding in diagnostics, patient education, and staying abreast of the latest research. However, its limitations are equally important to consider. ChatGPT may lack the nuanced understanding of complex clinical scenarios and the ability to capture the subtleties of human emotions and cultural contexts, crucial in patient interactions. Furthermore, its dependence on the quality and scope of its training data can lead to biases or gaps in knowledge. This presentation aims to delve into these aspects, offering insights into the balanced integration of ChatGPT in enhancing medical practice while acknowledging its constraints."

Dr. Eullaran is a Consultant of the Section of Rheumatology-Department of Medicine at Chong Hua Hospital in Cebu City. *He is a faculty of the Cebu Doctor's Hospital and Gullas College of Medicine. He completed his Internal Medicine residency training at Chong Hua Hospital, and Rheumatology fellowship training at UP-PGH.*

This talk is moderated by Dr Sidney Erwin T. Manahan. *Dr. Manahan is the current Secretary of the Philippine Rheumatology Association Board of Trustees. He is the Training Officer of the Section of Rheumatology and a Medical Specialist III at East Avenue Medical Center. He is an Active Consultant at Rayuma Atbp Klinik. He completed his Internal Medicine residency and Rheumatology fellowship training at UP PGH*

AI Resources for Physicians

Dr. Lisa S. Traboco

Am "AI" a rheumatologist? Understanding the hype means sorting through the misconceptions and demystifying the doomsday predictions. Recently, I attended a meeting of doctors who seem to have a very creative imagination that, by this time next week, AI "doctors" will be doing rounds in the hospital, "diagnosing" ancillaries and kicking out radiologists, cardiologists and other specialties. Humans fear what they don't understand. As researchers, we need to understand in order to make informed decisions and not jump into conclusions on the basis of "that's too technical for me". It is absolutely possible for doctors to understand where we are going in AI without the need for code.

This lecture will discuss three types of AI models: Large Language Models, Text to Image Models and Multimodal AI formats. We will be focusing on their current and potential use in medical education. We will talk about the concept of "prompt" engineering in physician-friendly terms. We will focus on two more common LLMs such as ChatGPT and BARD. For Text to Image AI; DALL-e will give several examples of its use in medical education. Ethics and AI's privileged use will be from WHO and ACR's recent white paper statements. Visual diagrams and use case scenarios are available for clearer explanations.

Slides will be available upon request and will be uploaded in sites.google.com/view/rheumarhyme.

Dr. Traboco is a Temasek Scholar at the World One Health Congress Delegate in Singapore. *She was a 2023 ILAR Project Grant Awardee Applied Rheumatology on the Cerego, a 2023 Japan College of Rheumatology and Korean College of Rheumatology Research Travel Grant Awardee. She was an APLAR JCR Midterm Symposium Speaker on Digital Health last year. She is an Active Consultant at St. Luke's Medical Center Global City, Paranaque Doctors Hospital, and USTH. She completed her Internal Medicine residency and Rheumatology fellowship training at SLMC.*

This talk is moderated by Dr Sidney Erwin T. Manahan. *Dr. Manahan is the current Secretary of the Philippine Rheumatology Association Board of Trustees. He is the Training Officer of the Section of Rheumatology and a Medical Specialist III at East Avenue Medical Center. He is an Active Consultant at Rayuma Atbp Klinik. He completed his Internal Medicine residency and Rheumatology fellowship training at UP PGH*

Vaccines and rheumatologic conditions

Dr. Geraldine Zamora-Abrahan

Well controlled autoimmune mechanisms contribute to the defense against infections in humans. Vaccines have been helping humans by eradicating or controlling many infectious diseases, saving millions of lives.

Theoretically, vaccines could trigger autoimmunity by means of cytokine production, anti-idiotypic network, expression of human histocompatibility leukocyte antigens, modification of surface antigens and induction of novel antigens, molecular mimicry, bystander activation, epitope spreading, and polyclonal activation of B cells.

This talk will discuss the evidence (or the lack thereof) on vaccine-related autoimmune rheumatologic diseases, with special focus on COVID vaccines, and management principles.

Dr. Zamora-Abrahan is the Treasurer of the APLAR Young Rheumatologists, and the Vice President of Hope for Lupus Foundation, Inc. *She is the Chair of the PRA Vasculitis Special Interest Group and a member of the US Vasculitis Foundation. She is a Clinical Associate Professor at UP-PGH. She is a recipient of the 2019 The Outstanding Women in the Nation's Service for Medicine and the 2016 Outstanding Book: IM Platinum 2nd edition. She is an Active Consultant at SLMC and Manila Doctors Hospital. She completed her Internal Medicine residency and Rheumatology fellowship training at UP-PGH.*

This talk is moderated by Dr Charito Cruz-Bermudez. *Dr. Cruz-Bermudez is the Head of the Section of Rheumatology at Marikina Medical Center and at Diliman Doctors Medical Center. She is an Assistant Professor IV at St. Luke's College of Medicine, and an Active Consultant at SLMC and NKTI. She finished her Rheumatology fellowship training at USTH.*

Drugs and rheumatologic conditions

Dr Aileen U. Agbanlog- Dimatulac

Several drugs are implicated in the development of different rheumatologic conditions which can range from simple arthralgias, myalgias to frank arthritis, myositis and autoimmune diseases such as lupus and vasculitis. Diagnosis is often challenging and sometimes a neglected differential in clinical discussion. Detailed history taking, temporal profile of clinical manifestations and high index of suspicion are valuable tools to identify drug induced rheumatic syndromes. This lecture will help us recognize different clinical patterns, assess causality and guide us in formulating a clinical plan in the management of these conditions.

Dr. Agbanlog-Dimatulac is the Chair of the PRA Scleroderma Special Interest Group, and the Training Officer of the Section of Rheumatology at St. Luke's Medical Center. *She is an Active Consultant of the Section of Rheumatology at St. Luke's Medical Center QC and Global City. She completed her Internal Medicine residency and Rheumatology fellowship training at SLMC.*

This talk is moderated by Dr Charito Cruz-Bermudez. *Dr. Cruz-Bermudez is the Head of the Section of Rheumatology at Marikina Medical Center and at Diliman Doctors Medical Center. She is an Assistant Professor IV at St. Luke's College of Medicine, and an Active Consultant at St. Luke's Medical Center and NKTI. She finished her Rheumatology fellowship training at USTH.*

CAR T-cells in the Rheumatic Diseases

Dr. Jemima Felicity L. Albayda

Autoimmune diseases are associated with autoreactive B and T cell clones which trigger disease and autoantibody formation. Although many of the current medications target inflammation or downregulate cytokine production, these agents often do not sufficiently stop the inflammatory process and continuous treatment is needed. We have moved from the era of glucocorticoids, disease modifying anti-rheumatic drugs, and biologics, to the new era of cellular therapy. The advent of autologous chimeric antigen receptor (CAR) T cells directed against the CD19 antigen has made an impact in the treatment of B cell malignancies. In the last few years, this same technology has been applied in a novel fashion for the treatment of severe cases of SLE, myositis, antiphospholipid antibody syndrome, and scleroderma leading to prolonged remission. These cases will be reviewed to understand the therapeutic principles and the related toxicities which can occur as a result of CAR T cell therapy. Patient selection and future directions of cellular therapy will also be discussed.

Dr. Albayda is the Director of the Rheumatology Fellowship at Johns Hopkins and of the Musculoskeletal Ultrasound and Injection Clinic at Johns Hopkins Bayview Medical Center. *She is a Mentor at the Ultrasound School of North American Rheumatologists (USSONAR), and an Associate Professor of the Department of Medicine-Division of Rheumatology at Johns Hopkins University School of Medicine in Baltimore, Maryland. She was the Chair of Musculoskeletal Ultrasound Education Subcommittee of American College of Rheumatology from 2020-2023. She is an Active Consultant at Johns Hopkins Hospital; Johns Hopkins Bayview Hospital. She finished her Doctor of Medicine at UST Faculty of Medicine and Surgery. She completed her Internal Medicine residency training at New York Downtown Hospital-Weill Cornell in New York, and her Rheumatology fellowship training at Johns Hopkins Hospital.*

This talk is moderated by Dr James Barte. *Dr. Barte completed his Internal Medicine residency training at University of the East Ramon Magsaysay Memorial Medical Center and his Rheumatology Fellowship training at UP-PGH.*

Hemoperfusion: Beyond COVID-19

Dr. Marissa Elizabeth Lim

Hemoperfusion is a therapeutic modality designed initially for toxin removal. It has potential utility in managing systemic lupus erythematosus (SLE) and other connective tissue diseases (CTDs). This lecture explores the application of hemoperfusion in these autoimmune conditions.

SLE and CTDs represent a spectrum of disorders characterized by dysregulated immune responses, leading to multi-organ involvement and systemic inflammation. Despite advances in conventional treatments, some patients remain refractory to standard therapies or experience intolerable side effects, necessitating alternative approaches.

Hemoperfusion, which involves the extracorporeal removal of circulating inflammatory mediators and immune complexes, offers a promising adjunctive or salvage therapy in SLE and CTDs. It aims to mitigate systemic inflammation, alleviate disease activity, and improve clinical outcomes by targeting cytokines, autoantibodies, and other pathogenic factors.

Studies have explored the efficacy and safety of hemoperfusion in SLE and CTDs, demonstrating variable results. While some trials report significant reductions in disease activity scores, improvements in organ function, and corticosteroid-sparing effects, others suggest more modest benefits or emphasize the importance of patient selection and treatment timing.

The mechanisms underlying hemoperfusion's therapeutic effects in SLE and CTDs remain incompletely understood. However, its ability to rapidly remove circulating immune complexes, cytokines, and other inflammatory mediators likely contributes to symptom relief and disease stabilization.

Despite its potential, hemoperfusion faces several challenges and limitations, including the need for specialized equipment, cost considerations, and the risk of adverse events such as hemodynamic instability and blood loss. Furthermore, hemoperfusion sessions' optimal timing, frequency, and duration require further elucidation through well-designed prospective studies and randomized controlled trials.

In conclusion, hemoperfusion holds promise as a valuable therapeutic adjunct in the management of SLE and CTDs, offering a targeted approach to mitigate systemic inflammation and improve patient outcomes. Continued research efforts are warranted to refine treatment protocols, identify ideal candidates, and establish their long-term efficacy and safety profile in these complex autoimmune disorders.

She is the Training Officer of the Section of Nephrology at the East Avenue Medical Center. *She is an Assistant Professor VII at the Department of Physiology-College of Medicine in UP Manila, and a Clinical Associate Professor of the Division of Nephrology at Philippine General Hospital. She is a 2018 Presidential Awardee of the Philippine Society of Nephrology. She is an Active Consultant of the Section of Nephrology at East Avenue Medical Center, Diliman Doctors Hospital, and Pacific Global Center. She completed her Internal Medicine residency and Nephrology fellowship training at UP-PGH. She finished her Master of Science in Physiology at UP Manila.*

This talk is moderated by Dr James Barte. *Dr. Barte completed his Internal Medicine residency training at University of the East Ramon Magsaysay Memorial Medical Center and his Rheumatology Fellowship training at UP-PGH.*

Design Thinking and Health Care

Dr. Sandra A. Tankeh-Torres

The Interaction Design Foundation defines and describes Design Thinking (DT)as a "methodology that provides a solution-based approach to solving problems by understanding the human needs involved, by re-framing the problem in human-centric ways, by creating many ideas in brainstorming sessions, and by adopting a hands-on approach in prototyping and testing. The goal of DT is to help design better products, services, processes, strategies, spaces, architecture, and experiences. Design work processes help us systematically extract, teach, learn and apply human-centered techniques to solve problems in a creative and innovative way—in our designs, businesses, countries and lives. Design Thinking is not exclusive to designers."

Dr Bon Ku, the pioneer of the HDT process, set up the Health Design Lab of the Thomas Jefferson University in Philadelphia. He stresses that "design thinking is an open mindset rather than a rigid methodology where participants are encouraged to take risks and rewrite the rules of business-as-usual. The principles of human-centered design can be applied to real-world health challenges such as reducing medical errors, reimagining hospital waiting areas, and creating innovative products that improve comfort and efficiency."

For this session, we will provide an introduction to the practice of Design Thinking which may inspire our PRA colleagues to think like human-centric designers for their future programs and projects. Examples of healthcare programs where DT has been applied will be presented.

Dr. Tankeh-Torres is a recipient of the Presidential Recognition Award by the Philippine College of Physicians in 2009, 2010, 2020, and 2022. *She is the current Chief of the Section of Rheumatology at Cardinal Santos Medical Center. She is an Active Consultant at Ospital ng Makati. She completed her Rheumatology fellowship training at UP PGH and Master of Science in Clinical Epidemiology in UP Manila. She is currently taking Masters in Human Movement Science in UP-College od Human Kinetics in UP Diliman.*

This talk is moderated by Dr Melchor Alan L. Siriban. *Dr Siriban is the Mindanao Representative of the Philippine Rheumatology Association Board of Trustees, and a member of the Philippine Rheumatology Association Board of Accreditation. He is a Past President of the PCP Western Mindanao Chapter. He is currently a faculty at the Ateneo De Zamboanga University School of Medicine and an Active Consultatnt at the Zamboanga Doctors' Hospital. He completed his Internal Medicine residency and Rheumatology fellowship training at UP PGH.*

INDUSTRY SPEAKERS

CALENDAR CONTENTS

Johnson & Johnson

Novel Treatment Strategies for Psoriatic Arthritis

| Dr. Jose Paolo P. Lorenzo

Dr. Lorenzo is the President Elect of the Asian Pacific League of Associations for Rheumatology (APLAR). He is the current Chairman of the Department of Internal Medicine at Makati Medical Center. He is an Active Consultant at Makati Medical Center, Asian Hospital and Medical Center, UP-PGH and Medical Center. He is a Principal Investigator for several ongoing clinical trials that focuses on pharmacotherapies of gout, SLE and RA. He was a Clinical Research Fellow at Medical College of Wisconsin Affiliated Hospitals in the US. He completed his Internal Medicine residency and Rheumatology fellowship training at the UP-Philippine General Hospital

Feb 28, Wed 8:30 - 9:30 PM Dinner symposium

TAISHO

Esflurbiprofen Patch: Clinical data and its position in the Management of Osteoarthritis

| Dr. Evelyn O. Salido

Dr. Osio-Salido is a Past President of the Philippine Rheumatology Association. She is the Chief of the Section of Rheumatology-Department of Medicine at UP Philippine General Hospital (UP-PGH), a Professor V at UP Manila College of Medicine, and a Professor II at De La Salle College of Medicine-Division of Clinical Epidemiology. She is a research committee member, independent consultant, and technical reviewer of research protocols of affiliated institutions. She is an Active Consultant of the Section of Rheumatology at UP PGH, DLSU Medical Center, and Asian Hospital and Medical Center. She completed her Internal Medicine residency and Rheumatology fellowship training at UP PGH. She finished her Master of Science in Clinical Epidemiology at UP Manila.

Feb 29, Thu 12:00 - 1:00 PM Lunch symposium

VIATRIS™

Revisiting Multi-modal Approach in the Management of Osteoarthritis Post-COVID Pandemic

| Dr. Ester G. Penserga

Dr. Penserga is a Past President of the Philippines Rheumatology Association. She served as Vice-president and Secretary General for the Rheumatology Association of the ASEAN. She is the editor of the *Atlas of Rheumatic Diseases in the Philippines* (published 2022), and a member of the editorial board of the first *Philippine College of Physicians Textbook of Internal Medicine* (published 2024). She is a Commissioner of the *Lancet* Commission on Osteoarthritis. She is a clinical professor and retired professor at the College of Medicine of the University of the Philippines. She is a five-time awardee of the Best Teacher in the UP College of Medicine by the UPMASA. She completed her Rheumatology fellowship training at UP-Philippine General Hospital and an observership in Rheumatology at George Washington University in St. Louis, Missouri, USA.

Feb 29, Thu 3:00 - 4:00 PM Snack symposium

CALENDAR CONTENTS

UNILAB

PAIN TRANSFORMERS: The Optimum Approach to Managing Post-Traumatic Osteoarthritis Pain

| Dr. Sandra A. Tankeh-Torres
| Dr. Antonio N. Tanchuling Jr.

Dr. Tankeh-Torres is a recipient of the Presidential Recognition Award by the Philippine College of Physicians in 2009, 2010, 2020, and 2022. She is the current Chief of the Section of Rheumatology at Cardinal Santos Medical Center. She is an Active Consultant at Ospital ng Makati. She completed her Rheumatology fellowship training at UP PGH and Master of Science in Clinical Epidemiology in UP Manila. She is currently taking Masters in Human Movement Science in UP-College od Human Kinetics in UP Diliman.

Dr. Tanchuling is an Orthopedic Surgeon at St. Luke's Medical Center and Global City. His fields of interestincludes joint replacement, geriatric orthopedics, and osteoporosis.

Feb 29, Thu 5:30 - 6:30 PM Sunset symposium

inova pharmaceuticals

Real World Effectiveness of Orphenadrine citrate 50 mg + Paracetamol 650 mg (Norgesic® Forte) on Low Back Pain of Filipino Patients

| Dr. Ramon Jason M. Javier

Dr. Javier is the Chairman of the Department of Family and Community Medicine at UERM Memorial Hospital. He is a Family and Community-Tropical Medicine Specialist at The Medical City Clinic, Proser Health Services. He is a Professor at the Department of Preventive and Community Medicine, College of Medicine, University of the Ramon Magsaysay Memorial Medical Center.

Mar 01, Fri 8:00-9:00 AM Dinner symposium

NOVARTIS

Radiographic and Clinical Evidence of Disease Modification with IL-17 Inhibition

| Prof. James Wei

Mar 01, Fri 11:40-12:40 NN Lunch symposium

CALENDAR CONTENTS

GSK

Shingles among Rheumatology Patients: Risk, Impact and Prevention

| Dr. Geraldine T. Zamora-Abrahan

Dr. Zamora-Abrahan is the Treasurer of the APLAR Young Rheumatologists, and the Vice President of Hope for Lupus Foundation, Inc. She is the Chair of the PRA Vasculitis Special Interest Group and a member of the US Vasculitis Foundation. She is a Clinical Associate Professor at UP-PGH. She is a recipient of the 2019 The Outstanding Women in the Nation's Service for Medicine and the 2016 Outstanding Book: IM Platinum 2nd edition. She is an Active Consultant at SLMC and Manila Doctors Hospital. She completed her Internal Medicine residency and Rheumatology fellowship training at UP-PGH.

Mar 01, Fri 3:00-4:00 NN Snack symposium

Pfizer Inflammation & Immunology

Challenging the Norm: Tofacitinib in Rheumatoid Arthritis

| Dr. Maria Sheila N. Leynes

She is an Active Consultant at Mary Mediatrix Medical Center. She completed her Rheumatology training at University of Santo Tomas Hospital.

Mar 01, Fri 5:30-6:30 NN Sunset symposium

Boehringer Ingelheim

Advancements in Diagnosis, Screening and Management of CTD: Insights from ACR Guidelines

| Dr. Aileen G. Agbanlog-Dimatulac

Dr. Agbanlog-Dimatulac is the Chair of the PRA Scleroderma Special Interest Group, and the Training Officer of the Section of Rheumatology at St. Luke's Medical Center. She is an Active Consultant of the Section of Rheumatology at St. Luke's Medical Center QC and Global City. She completed her Internal Medicine residency and Rheumatology fellowship training at SLMC.

Mar 02, Sat 10:40-11:40 AM Lunch symposium

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ORIGINAL RESEARCH

01.

REPEAT KIDNEY BIOPSIES IN 6 PATIENTS ON IMMUNOSUPPRESSIVE TREATMENT FOR LUPUS NEPHRITIS: A SINGLE-CENTER STUDY

Jan Erico Pabustan, MD; Peter Paolo T. Daleon, MD; Sandra Teresa V. Navarra, MD | University of Santo Tomas Hospital

OBJECTIVES Lupus nephritis (LN) requires early recognition and immunosuppressives to prevent end organ damage. A kidney biopsy (KB) is helpful to guide management, but the value of repeat KB is unclear and not routinely performed in clinical practice. This study analyzed 6 patients who underwent repeat KB within 3 years and received at least 2 years of immunosuppressive (IS) therapy for active LN.

METHODS We reviewed the records of 6 LN patients seen at the University of Santo Tomas Hospital who underwent repeat KB within 3 years of monitored IS therapy. We obtained data on demographics, disease characteristics, LN medications and used descriptive statistics to analyze renal parameters and histopathology reports of each patient.

RESULTS The average age at initial KB was 21.17±0.98 years, with mean 33.17 (29-41) months duration between biopsies. Average urine protein-creatinine ratio was 3.05 and 4.95g/g, with serum creatinine 0.69 and 0.98 mg/dL at the initial and repeat KB, respectively. Medications in the interval between biopsies included prednisone (n=5), mycophenolate mofetil (n=5), tacrolimus (n=2), azathioprine (n=1), and ACE inhibitors (n=5). Three patients had the same ISN-RPS class on repeat KB. One patient each showed ISN-RPS Class change from III+V to IV+V, IV to V, and II to IV. Three patients showed decrease in both activity (AI) and chronicity index (CI) scores. One patient each had increase in both AI and CI, decreased AI with increased CI, and showed same AI with increase in CI.

CONCLUSION A repeat biopsy showed no change in ISN-RPS class in 3 patients; whereas one patient progressed from focal to diffuse proliferative, another from mesangial to diffuse proliferative, one patient switched from pure Class IV to pure membranous LN. The results show limited additional information obtained from a repeat KB within 3 years. It supports the recommendation of maintaining IS for a minimum 3 years of maintenance therapy to achieve and sustain renal remission. We underscore the importance of close monitoring and medication adherence in LN management.

02.

EFFECT OF TUBERCULOSIS INFECTION AND TREATMENT ON LUPUS DISEASE ACTIVITY AND GLUCOCORTICOID DOSE

Marivic Bolando, MD; Marjorie Faye Nierra, MD; Sandra Teresa V. Navarra, MD | University of Santo Tomas Hospital

BACKGROUND Systemic lupus erythematosus (SLE) or lupus, is an autoimmune disorder with heterogeneous clinical manifestations, multiorgan involvement and inherent association with infection due to immunological abnormalities that contribute to morbidity. Accordingly, this study aimed to determine the effect of tuberculosis (TB) infection and treatment on SLE disease activity and prednisone dose among lupus patients who completed TB treatment. It elucidated data on the change in the lupus disease activity and the prednisone dosage before, during and after therapy.

METHODS A retrospective patient record review was performed for all patients who had SLE and TB infection at a tertiary hospital (University of Santo Tomas Hospital) for the recent three-year period (2021-2023). In addition to the collected demographics, data on the lupus disease activity and prednisone dosage were determined on different periods in the course of TB management. Then, the changes were deduced.

RESULTS The findings revealed a dynamic change in the lupus disease activity before, during and after completion of tuberculosis treatment. Prior to anti-TB treatment, 60 % of the cases had lupus low disease activity state with prednisone dosage mode of 5 mg. Then, 3 months after anti-tuberculosis medication initiation, there were negative impacts on the prednisone dosages and lupus disease activities. There was an increase of 20 % in the lupus disease activity and prednisone dosage mode of 20 mg. On the other hand, there were positive changes in the prednisone dosages and lupus disease activities within 1 month of completion of anti-TB treatment that showed improvement of the overall patients' clinical status and tapered prednisone dosages.

CONCLUSION Tuberculosis and medications induce an increase in the disease activity of lupus and the prednisone requirement during the diagnosis of infection with higher values recorded 3 months after anti-TB medication initiation. On the other hand, completion of treatment results to better SLE disease scores and lower prednisone requirements.

03.

PROGNOSTIC SIGNIFICANCE OF HYPERURICEMIA IN ADULT STROKE: A SINGLE CENTER, PROSPECTIVE COHORT STUDY

Jean Kerstin S. Pasardoza, MD; Richard John B. Pelo, MD | Bicol Medical Center

OBJECTIVE To investigate the association of hyperuricemia with the severity and outcomes of acute stroke among adult patients admitted at Bicol Medical Center.

METHODS Prospective cohort design.
SETTING Bicol Medical Center, a tertiary Department of Health-retained hospital in Naga City, Camarines Sur.
PARTICIPANTS Acute stroke patients admitted at Bicol Medical Center from August 2023 to September 2023 with three-month follow-up from the date of discharge.
MAIN OUTCOME MEASURES: To determine the demographics and clinical profile of the stroke patients, and determine the association of hyperuricemia with stroke severity, in-hospital mortality, 3-month mortality, and Modified Rankin Scale (MRS) 3-months from the date of discharge.
ANALYSIS Stata MP version 17 software was used for data processing and analysis.
ETHICAL CONSIDERATIONS The study adheres to the principles highlighted in the Declaration of Helsinki and was submitted to the Bicol Medical Center Review Board for ethics approval.

RESULT A total of 209 acute stroke patients were included in the study. Among the studied population, 55% had hyperuricemia with a median uric acid of 7.1 mg/dl. The differences in the demographic and clinical profile of the studied population showed no significant differences between patients with and without hyperuricemia except for patients with Chronic Kidney Disease (CKD). Wherein, a higher proportion of patients with CKD have hyperuricemia. Of the studied population, the mortality rate among patients with hyperuricemia was significantly higher during hospitalization (16%) and during the first three months of follow-up (23%). The median MRS at 3-months post-discharge was three and most patients with hyperuricemia had unfavorable MRS 3-months post-discharge.

CONCLUSION The findings of our study showed that hyperuricemia is a poor prognostic marker among stroke. There is significant evidence indicating that hyperuricemia was associated with unfavorable stroke severity, in-hospital mortality, and discharge outcome.

04.

THE USE OF INTRA-ARTICULAR CORTICOSTEROIDS, HYALURONIC ACID, OR PLATELET-RICH PLASMA BY RHEUMATOLOGISTS IN MANAGING KNEE OSTEOARTHRITIS IN A TERTIARY CARE CENTER

Eloisa Trina C. Generoso, MD; Anna Kristina Gutierrez-Rubio, MD | Makati Medical Center

OBJECTIVE Osteoarthritis is a degenerative joint disease that causes knee pain, stiffness, and swelling. Guidelines recommend intra-articular corticosteroids for pain, while recent sources have been comparing hyaluronic acid (HA) and platelet-rich plasma (PRP). This study aims to analyze the use of corticosteroids, HA, and PRP in patients with knee osteoarthritis in routine Rheumatology clinical practice.

METHOD
DESIGN/SETTING/PARTICIPANTS: Conducted at the outpatient Rheumatology clinics of a tertiary hospital over two months, this single-center, prospective, observational study included 14 patients (22 knees) with Kellgren- Lawrence grade 2-4 osteoarthritis.
INTERVENTIONS They were approached after receiving a therapeutic agent (corticosteroids, HA, or PRP) administered by the attending rheumatologist.
MAIN OUTCOME MEASURES Main outcomes, which included rating of pain, stiffness, and physical function, were assessed using the Visual Analogue Scale (VAS) and the Western Ontario and McMaster Universities (WOMAC) scores at baseline, after 2 weeks, and 4 weeks.
ANALYSIS Differences among the groups was analyzed using repeated measures ANOVA, and Tukey post- hoc test was used to check for differences between groups.
ETHICAL CONSIDERATIONS The study adhered to the Declaration of Helsinki and received institutional review board approval.

RESULTS Patients had a mean age of 67□14.1 years, were predominantly female (85.71%), and had a mean BMI of 28, suggesting that most were overweight or obese by Asian standards. Type 2 diabetes mellitus is the usual comorbidity, and most subjects were categorized with KL grade 3 radiologically (57.14%). While all interventions improved pain, stiffness, and function over the study period, PRP and HA recipients generally exhibited lower pain levels and stiffness scores than corticosteroid recipients, as seen in the statistics portraying the VAS and the WOMAC scores.

CONCLUSION Injections of PRP, HA, and corticosteroids are effective in the alleviation of pain, stiffness, and function of patients with knee osteoarthritis, though patients receiving PRP and HA at baseline may exhibit lower initial scores. While this study provides valuable insights into knee osteoarthritis treatment, its small sample size may limit generalizability. Future research should use larger samples to enhance external validity and to account for potential dropouts.

05.

OUTCOMES OF PATIENTS WITH RHEUMATIC DISEASE AND COVID-19 HOSPITALIZED IN A COVID REFERRAL CENTER FROM 2020-2023

Blessie Marie Perez, MD; Rohanifah Sarosong, MD; Evelyn O. Salido, MD; Geraldine T. Zamora, MD | University of the Philippines-Philippine General Hospital

OBJECTIVE To describe the profile and outcomes of patients with rheumatic diseases hospitalized in a tertiary center

METHODS
Design Retrospective, descriptive cross-sectional study
Setting Tertiary COVID referral center
Participants Adult patients with rheumatic disease and confirmed COVID-19 infection hospitalized from March 2020 to February 2023
MAIN OUTCOME MEASURES Clinical characteristics and COVID outcomes of patients with rheumatic disease
ANALYSIS Descriptive statistics were used to summarize the data collected.
ETHICAL CONSIDERATIONS The institution's Technical and Ethical Review Board has approved this study.

RESULTS
A total of 87 patients with rheumatic diseases (RD) were admitted from March 2020 to February 2023. Most were females (50.9%) with a mean age of 44 years (range 19-86). The most common comorbid condition is hypertension (43.7%), followed by chronic kidney disease (29.9%). The most common RD is systemic lupus erythematosus (SLE) (46%), followed by gout (33.3%) and infectious arthritis (5.7%). Most patients were on conventional disease-modifying antirheumatic drugs (DMARDs) and/or corticosteroids. Among the 40 SLE patients that were admitted, most had moderate disease activity (37.5%) on admission and 14 patients received either methylprednisolone or dexamethasone pulse therapy due to the development of severe activity (nephritis in 8 patients, thrombocytopenia in 4 patients). Among the 29 gout patients that were admitted, most had arthritis flare during admission (93.1%). Among the 5 patients with infectious arthritis, 4 were diagnosed with tuberculosis. Most patients were infected with COVID-19 in the community, except for 5 that were hospital-acquired. Most had moderate severity of COVID (60.9%), and received disease severity- specific interventions which included corticosteroids (34.5%), remdesivir (21.8%) and molnupiravir (6.9%). Most patients were discharged. Nine patients with autoimmune rheumatic disease and 8 who had non-autoimmune rheumatic disease died.

CONCLUSION: The mortality rate of patients with rheumatic disease in our institution was slightly higher than in the reported literature. This is complicated by comorbid conditions and concurrent significant flares of the underlying rheumatic disease.

06.

CLINICAL PROFILE OF PATIENTS WITH CONNECTIVE TISSUE DISEASE-RELATED INTERSTITIAL LUNG DISEASE AT ST. LUKE'S MEDICAL CENTER: A RETROSPECTIVE STUDY

Charysse B. Vergel De Dios, MD; Juan Javier Lichauco, MD | St. Luke's Medical Center

BACKGROUND: Interstitial lung disease (ILD) is a common pulmonary manifestation in patients with connective tissue disease (CTD) but remains to be a challenging clinical entity and a significant cause of morbidity and mortality. Several studies in Asia, although limited, have been done to provide a detailed understanding of patients with CTD-ILD. The ability to identify the clinical features and risk factors for CTD-ILD can help in its early diagnosis and treatment, and translate to better patient outcomes.

METHOD: The study was a 10-year retrospective cross-sectional descriptive study which involved review of medical records of patients with CTD-ILD at St. Luke's Medical Center, Philippines. Clinical profile of included participants was reviewed based on symptoms and clinical manifestations, autoantibody profile, HRCT, PFT and 2D echocardiography findings, comorbid conditions and medications used.

RESULTS: A total of 86 patients were included. The age ranged from 24 to 84 years, and majority were female patients (n=79, 91.9%), with female to male ratio of 11:1. Systemic lupus erythematosus (n=26, 30.2%) was the most common CTD followed by rheumatoid arthritis (n=15, 17.4%). The most common rheumatologic features observed were arthritis (n=54, 62.8%), rashes (n= 48, 55.8%), morning stiffness (n=30, 34.9%) and Raynaud's phenomenon (n=29, 33.7%). ANA was present in 81.4% of patients, with anti-RNP positive in 25.6% of cases. Majority of pulmonary complaints were cough (n=52, 60.5%) and dyspnea (n=37, 43%); fine crackles were present in 64% of cases. Interval between onset of pulmonary symptoms to the diagnosis of ILD was estimated at ~1 year. NSIP was the most common ILD pattern on HRCT and was observed in 80.2% of cases. Restrictive pulmonary defect was noted in 55.8% of cases, and 74.4% had reduced DLCO on spirometry. Pulmonary artery hypertension was present in 12.8% of cases. Majority were on glucocorticoid therapy (79.1%) and mycophenolate mofetil was the most used immunosuppressive agent (59.3%). Eleven (12.8%) patients received antifibrotic agents.

CONCLUSION: Among Filipinos, CTD-ILD were mostly observed in middle aged females with systemic lupus erythematosus. ILD should be suspected in all CTD patients who develop cough, dyspnea, and fine crackles. NSIP pattern on HRCT, restrictive pulmonary defect and reduced DLCO was seen in majority of cases which is consistent with global data.

07.

CROSS-CULTURAL ADAPTATION AND VALIDATION OF THE CEBUANO TRANSLATION OF THE KNEE INJURY AND OSTEOARTHRITIS SCORE (KOOS) IN FILIPINOS WITH KNEE OSTEOARTHRITIS

Anchie Veh B Mariano, MD; John Elmer C. Quilisadio, MD | Davao Regional Medical Center

INTRODUCTION Osteoarthritis, a prevalent chronic joint disease and a leading global cause of disability, is frequently assessed using standardized tools. Despite the widespread use of the Knee Injury and Osteoarthritis Outcome Score (KOOS) questionnaire, there is no currently validated Cebuano version translation.

OBJECTIVE This study aims to translate the KOOS English questionnaire into a Cebuano version and validate the Cebuano translation among patients with knee osteoarthritis.

METHODOLOGY This is a quantitative, prospective, observational, cross-sectional, analytical, translation, and validation study design, various domains such as Pain, Symptom, ADL (Activities of Daily Living), Sports and Recreation, and Knee-Related Quality of Life (QOL) were assessed among Cebuano-speaking adults with knee osteoarthritis.

RESULTS 30 adult participants with knee osteoarthritis met the inclusion criteria (average age 66.13 ± 9.9 years, 96.7% females, 63.3% married, mostly with college degrees (70%), and predominantly homemakers (56.7%), overweight (50%), with hypertension (43.3%), and an average osteoarthritis duration of 6.2 ± 8.5 years). Cronbach's α values showed >0.7 for all domains, with the ADL domain demonstrating the highest consistency (0.948) and the symptom domain the lowest (0.740), indicative of good consistency. Correlation coefficients varied across domains, with most showing no significant relationship between the overall WHOQOL and the following domain of KOOS-Cebuano: pain (p=.890), symptoms (p=.637), ADL (p=.425), sports and recreation (p=.094) and knee-related injury (p=.378)

CONCLUSION The KOOS-Cebuano translation demonstrated acceptable psychometric properties among Filipino patients with knee osteoarthritis. This underscores the utility of the Cebuano version in capturing various aspects of functional disability that impact the quality of life for patients with knee osteoarthritis. The study highlights the consistent reliability of the KOOS- Cebuano as a psychometric tool for assessing functional disability in patients with knee OA.

08.

EFFECTIVENESS OF A VIDEO-BASED EDUCATIONAL TOOL IN BRIDGING KNOWLEDGE GAPS AMONG ADOLESCENTS WITH RHEUMATOLOGIC CONDITIONS

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OBJECTIVE To assess the effectiveness of a video-based educational tool on the awareness and knowledge of adolescents with rheumatologic conditions towards puberty and their chronic diseases using a generated structured questionnaire at baseline and post-intervention

METHODS
DESIGN This study comprised of two phases. The first phase was a validation study of the questionnaire. The validated questionnaire was then used in the second phase of this study which is a pretest/post-test experimental design.
SETTING The study was conducted at the Pediatric Rheumatology outpatient department of a tertiary hospital in Metro Manila.
PARTICIPANTS For the first phase, a sample of 30 participants aged between 10 and 18 years were randomly selected. In the second phase, a sample of 55 participants who met the following inclusion criteria were included: (1) adolescents 10 to 18 years old, (2) able to read and understand English, and (3) diagnosed with a chronic rheumatologic condition.
INTERVENTIONS The questionnaire was administered as a pre-test to all participants. The participants were then instructed to watch two videos developed by the Philippine Rheumatology Association. After watching, a post-test questionnaire was given.
ETHICAL CONSIDERATIONS Written informed consent were obtained. The study was approved by the Research Ethics Committee of the hospital.

RESULTS After validation, a total of 55 patients participated in the study, 46 (83.64%) of which are females and 9 (16.36%) are males. The mean age of the respondents is 14.73. Overall, the average pre-test and post-test scores are 8.96 and 9.36, respectively which are statistically significant. For the overall rating on the educational videos, the mean responses for the first, second, third, fourth, and fifth questions are 4.45, 4.27, 4.31, 4.24, and 4.73, respectively. These results imply that the video-based educational tools were effective and helpful to the participants.

CONCLUSION Patient education is an essential element in transition care programs. The use of video educational materials can contribute to a better understanding of adolescent rheumatology patients on their chronic medical condition.

09.

PREVALENCE OF PSORIATIC ARTHRITIS AMONG PSORIASIS PATIENTS IN A TERTIARY INSTITUTION

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OBJECTIVES Determine the prevalence of psoriatic arthritis (PsA) among psoriasis patients in a tertiary institution.

METHODS
DESIGN Cross-sectional prospective study
SETTING Tertiary Institution PATIENTS/PARTICIPANTS:
A total of 150 psoriasis patients in Dermatology Clinic.
MAIN OUTCOME MEASURES
Presence of PsA defined as score of > 3 on Psoriatic Arthritis Screening Tool (PEST) and confirmed with (Classification of Psoriatic Arthritis) CASPAR Criteria
ANALYSIS Descriptive statistics was used to describe the demographic and clinical characteristics. The prevalence was calculated as the percentage of the population who scored > 3 on the CASPAR criteria
ETHICAL CONSIDERATIONS Ethical approval was given by the Technical and Ethics Review Boards. Informed consent was sought from all the participants.

RESULTS Out of the 150 psoriasis patients, a total of 50 scored > 3 on PEST. Of these, 47 patients (31.3%) qualified the diagnosis of PsA using the CASPAR criteria. Thirty-seven of them (79%) are known PsA patients while the remaining 10 patients (21%) were newly diagnosed PsA. A total of 32 patients (68%) were female, with a mean age of 33 and 39 years at the onset of psoriasis and PsA respectively. Family history of psoriasis was present in 22 patients (47%). The most common pattern of arthritis was polyarticular (51%). Morning stiffness was present in 83% of the patients. Dactylitis was recorded in 16 patients (34%) while 19 patients (51%) had enthesopathy. Onycholysis was the most common nail abnormality seen in 20 patients (43%). Only 13 patients had rheumatoid factor at baseline and all were negative. Most of the patients did not have imaging studies at baseline.

CONCLUSION The prevalence of PsA among psoriasis patients in this study is 31.3%. This is higher compared to the previous studies in Asia. Routine monitoring using screening tools such as PEST to recognize PsA early is suggested.

10.

PSYCHOMETRIC EVALUATION OF THE TAGALOG (PHILIPPINE) VERSION OF PSORIATIC ARTHRITIS QUALITY OF LIFE QUESTIONNAIRE

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OBJECTIVE Evaluate the psychometric properties of the Tagalog version of the Psoriatic Arthritis Quality of Life (PsAQoL) to complete its validation.

METHODS
DESIGN Prospective validation study
SETTING Tertiary Institution PARTICIPANTS:
A total of 47 PsA patients seen in Rheumatology Clinic
MAIN OUTCOME MEASURES Psychometric properties of PsAQoL questionnaire such as internal consistency, test- retest reliability, convergent validity and known group validity
ANALYSIS Descriptive statistics were used to describe the demographic and clinical characteristics. The psychometric properties tested were internal consistency using Cronbach's alpha coefficients, test-retest reliability and convergent validity using Spearman's rank correlation and known group validity using Mann-Whitney U Test or Kruskal-Wallis One-Way Analysis of Variance.
ETHICAL CONSIDERATIONS Ethical approval was given by the Technical and Ethical Review Board. Informed consent was sought from all the participants.

RESULTS The PsAQoL on both week 0 and week 2 had Cronbach's alpha coefficients of 0.926 indicating high internal consistency. Test-retest reliability was 0.93, which demonstrates low level of random measurement error and excellent reliability. For the test of convergent validity, the PsAQoL highly correlated with the Disability Index (correlation coefficient=0.75) but did not show significant correlation with the Pain Scale (correlation coefficient=0.23). There was no significant difference in PsAQoL scores for demographic factors but there was a significant difference in scores for self-reported general health (p- value of 0.015).

CONCLUSION The PsAQoL Tagalog version demonstrates excellent psychometric properties and can be recommended for clinical monitoring of Tagalog-speaking patients with psoriatic arthritis.

11.

TREATMENT RESPONSE OF PEDIATRIC LUPUS NEPHRITIS PATIENTS TO CYCLOPHOSPHAMIDE IN A TERTIARY HOSPITAL

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OBJECTIVE To determine the treatment response to cyclophosphamide (CYC) of pediatric lupus nephritis (LN) patients.

METHODS
DESIGN This is a single center retrospective cohort study.
SETTING & PATIENTS/PARTICIPANTS All at University of Santos Tomas Hospital (USTH) Pediatric Rheumatology out-patient clinic files from 2006-2022 were reviewed. LN patients' age at diagnosis, sex, disease duration, steroid dose, pre-treatment proteinuria level, extrarenal manifestations, associated factors that may affect treatment response were determined.
MAIN OUTCOME MEASURE To determine the average random urine protein-creatinine ratio (UPCR) of pediatric LN patients at 3, 6, 12 months after CYC initiation.
ANALYSIS Descriptive statistics (mean and standard deviation) were used to describe continuous variables and frequency and percentage for categorical data.

RESULTS Included in the study were 92 pediatric LN patients. The mean age at LN diagnosis and mean current age of patients were 12±3.3 years and 20+4.5 years, respectively. Majority of LN patients were female (83%). The most common presenting manifestations were fever (64.1%), malar rash (62%) and proteinuria (58.7%). A steady decline in the median random UPCR of 2.75 to 1.50, 0.60 and 0.31 were observed after 3, 6 and 12 months of treatment, respectively. As to improvement in random UPCR after CYC treatment, 70 patients (78.7%) developed partial remission and 55 (63.2%) achieved complete remission. Partial remission had a significant association with proteinuria and patients with a higher baseline random UPCR were more likely to achieve partial remission (OR=1.29, 95% CI 0.99 to 1.68). However, the random UPCR was not a significant factor for complete remission (p=0.0635).

CONCLUSION Majority of pediatric LN patients at USTH achieved partial remission by the 6th month and complete remission by the 12th month of CYC treatment. Partial remission may likely be observed with a higher baseline random UPCR. A longer recovery time was required in patients with higher baseline random UPCR to achieve complete remission. Also, it was shown that duration of illness is significantly proportional to achieving complete remission.

12.

PERCENTILE DETERMINATION OF HAND GRIP STRENGTH MEASURED USING JAMAR DYNAMOMETER AND MODIFIED SPHYGMOMANOMETER AMONG HEALTHY ADULTS

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BACKGROUND An accurate, quantifiable assessment of hand grip strength (HGS) can predict overall strength and health with a good predictor for identifying populations at higher risk for any medical conditions that helps clinicians establish realistic treatment goals and provides treatment outcome data. Normative values for adults in different age groups using dynamometers and sphygmomanometers were not established.

OBJECTIVES Determine the percentile scores of HGS of healthy adult individuals of various age groups using Jamar dynamometer (JD) and modified sphygmomanometer (MS).

METHODS
DESIGN AND SETTING Descriptive study of HGS using MS and JD obtained in a tertiary hospital ambulatory care clinic.
PARTICIPANTS One hundred twenty randomly selected participants 20 years old and above without any hand orthopedic problem or disability, with or without age-related conditions with no influence on predicted 5-year mortality. All enrolled patients completed the assessments and no withdrawal of consent.
INTERVENTIONS Use of JD and MS for HGS measurements. HGS was measured three times with 5-minute interval for each participant and recorded.
OUTCOME MEASURE Percentile scores of HGS as measured by JD (kg) and MS (mmHg).
ANALYSIS Comparative analyses of the 2 apparatuses were conducted using One-Way ANOVA. The reference intervals at different percentiles were calculated using the Clinical and Laboratory Standard Institute (CLSI) guidelines.
ETHICAL CONSIDERATIONS Vulnerable group-elderly. Approved by the Hospital Research Ethics Committee.

RESULTS HGS using JD and MS among younger (20-29 years old) participants, the 50th percentile (Q2) JD score was 28.29 kg with an equivalent MS score of 161.38 mmHg, were significantly higher compared to those across older age groups especially among the ≥70 years old with a JD Q2 score of 16.74 kg and MS Q2 score of 101.33 mmHg. These findings suggest that HGS decreases with increasing age.

CONCLUSION Scores obtained from this study can serve as preliminary baseline values or guides for interpreting HGS measurements in adults of several age groups.

13.

CLINICAL AND IMMUNOLOGICAL CHARACTERISTICS OF ANTIPHOSPHOLIPID SYNDROME IN FILIPINO PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS: A RETROSPECTIVE STUDY

James Harold A. Barte, MD; Angeline Therese Magbitang-Santiago, MD | University of the Philippines - Philippine General Hospital

OBJECTIVE Antiphospholipid syndrome (APS) is characterized by the presence of antiphospholipid antibodies in the setting of vascular (venous and/or arterial) thrombosis and/or pregnancy morbidity. Prevalence of APS varies in different parts of the world. This study was conducted to describe the clinical and immunologic features of APS in Filipino patients with systemic lupus erythematosus (SLE).

METHODS In this retrospective study at the University of the Philippines – Philippine General Hospital (UP- PGH) inpatient and outpatient services from March 2020 to March 2022, we performed a review of 408 patients with SLE for the prevalence of APS and its different characteristics. The diagnosis of SLE was made according to the 1997 American College of Rheumatology (ACR) or the 2019 European League Against Rheumatism (EULAR)/ACR classification criteria, and diagnosis of APS was made according to 2006 consensus criteria for APS.

RESULTS The current study included 408 SLE patients (394 females, 96.6%) with a mean age of 34.9 ± 11.4 years and disease duration of 8.0 ± 6.6 years. Fifty-nine (14.5%) were positive for any aPL. Ninety (22.0%) had a thrombotic event and/or pregnancy morbidity, with 55.6% of these had an aPL antibody panel testing done. Prevalence of APS in SLE was 8.3%. The most common APS manifestations in SLE-APS patients were obstetric complications (55.9%), followed by ischemic stroke (29.4%) and deep vein thrombosis (26.5%). Among the SLE-APS patients, LAC antibodies were present in 13 (38.2%) patients; aCL in 11 (32.4%) patients; and anti-β2GP1 in 5 (14.7%) patients.

CONCLUSION The incidence of APS in SLE varies in different geographical regions and it was 8.3% in our study. Pregnancy morbidity was the most common complication of APS. LAC was the most common antibody in APS patients. The low utilization of aPL antibody testing in our cohort showed that APS may be underdiagnosed in Filipino SLE patients. This emphasized the importance of screening for the presence of aPL antibodies in SLE patients who present with thrombotic events or obstetric complications.

14.

DIFFERENTIATING INFECTION FROM DISEASE FLARE: DIAGNOSTIC UTILITY OF ERYTHROCYTE SEDIMENTATION RATE AND C-REACTIVE PROTEIN RATIO AMONG FILIPINO SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS WITH FEVER A RETROSPECTIVE COHORT STUDY

Joseph Peter T. Lim, MD; Augusto O. Villarubin, MD | Makati Medical Center

OBJECTIVES This study aimed to investigate the utility of the ESR:CRP ratio in distinguishing disease activity from infection in febrile systemic lupus erythematosus (SLE) patients.

METHODS A single-center, retrospective, analytical cohort study conducted over six years.
SETTING Tertiary private hospital.
PATIENTS/PARTICIPANTS Adult Systemic Lupus Erythematosus patients admitted for fever.
ANALYSIS Demographic and clinical characteristics of patients were recorded and summarized using descriptive statistics. Numerical data were summarized as mean and standard deviation or median and interquartile range. Categorical data were presented as frequencies and percentages. Association between socio-demographics, baseline characteristics and specific markers of inflammation of patients with their respective outcomes assessed using Chi-square, F-test (One-way ANOVA), Fisher-exact test and Kruskal Wallis test. Results were considered significant when p was <0.05.
ETHICAL CONSIDERATIONS The study adhered to ethical guidelines, ensuring confidentiality and privacy.

RESULTS Among 465 SLE admissions, 46 met the inclusion criteria, predominantly female (93.5%). Admission reasons were infection (37%), flare (22%), and concurrent infection and flare (41%). Clinical manifestations varied, with infectious manifestations predominantly bacterial. ESR:CRP ratio ≤2 was common across infection (64.7%), flare (80%), and concurrent infection and flare (57.9%) groups. Notably, 35.3% in the infection group and 31.6% in the concurrent group had ratios between 3-14. A ratio of ≥15 was observed in 20% of flares and 10.5% in concurrent infection. Sensitivity and specificity for diagnosing flares and infections using the ESR:CRP ratio were 20%/100% and 100%/20%, respectively.

CONCLUSION The ESR:CRP ratio, while sensitive to infection, lacks specificity for lupus flares. Careful interpretation is crucial, with consideration to the complex interplay of inflammatory markers and clinical manifestations. The study contributes insights into the diagnostic landscape, emphasizing the need for caution in applying the ESR:CRP ratio in clinical practice.

15.

ASSESSMENT OF NUTRITIONAL STATUS AMONG SYSTEMIC LUPUS ERYTHEMATOSUS IN A TERTIARY HOSPITAL (EAST AVENUE MEDICAL CENTER)

Kristopher Paul C. Quitiquit, MD; Sidney Erwin T. Manahan, MD | East Avenue Medical Center

OBJECTIVE This cross-sectional study aims to correlate the nutritional status among the Systemic Lupus Erythematosus (SLE) Filipino patients of East Avenue Medical Center with their disease activity.

METHODS
DESIGN This is a cross-sectional study
SETTING The study was conducted at a tertiary hospital at Quezon City, Philippines (East Avenue Medical Center)
PARTICIPANTS All patients diagnosed with SLE at least 18 years-old seeking consultation at the East Avenue Medical Center was included in this study. Pregnant, those with anatomical or functional abnormalities that would impair food intake, those with other chronic and/or autoimmune systemic conditions not related to the main disease were excluded. This included 48 patients which consented freely to participate.
MAIN OUTCOME MEASURES Nutritional status and risk level was assessed using the modified Subjective Global Assessment (SGA) tool. SGA grading, anthropometric measurement and nutritional risk level were assessed using the collected history and physical examination. ANALYSIS: Association of nutritional status, disease activity and demographic characteristics were assessed using Chi-square, Fisher-exact test or Kruskal-Wallis test.
ETHICAL CONSIDERATIONS The study was approved by the Technical Board and Institutional Review Board prior to the start of the study. Informed consent was secured for each participant and case numbers were assigned to protect their identities.

RESULTS Most included patients are well nourished (97.9%) using the SGA assessment tool. Patients were classified through BMI which showed 8.3% were underweight, 25% normal, 25% overweight and 41.7% obese. There were no noted statistically significant association between BMI and the demographic and clinical profiles and as well as the nutritional status and nutritional risk level among the SLE patients. 52% of SLE patients had moderate risk of developing malnutrition and as many as 22% were at high risk for malnutrition warranting consultation with a clinical nutrition physician.

CONCLUSION In this cohort of SLE Filipina patients with low disease activity, most are well nourished with an increased prevalence of underweight and obesity. In any setting, all SLE patients should undergo nutritional status assessment.

CASE REPORTS

01.

A PECULIAR PAIR: A CASE REPORT ON INFLAMMATORY MYOPATHY AS AN INITIAL PRESENTATION OF A HEPATITIS B INDUCED HEPATOCELLULAR CARCINOMA

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BACKGROUND Hepatocellular carcinoma is one of the most common primary liver malignancies and cause of cancer related death worldwide with Hepatitis B infection as one of the most common attributable risk factors in more than half of cases among developing countries. Paraneoplastic polymyositis is a relatively uncommon autoimmune disorder that affects the muscle which presents as proximal myopathy.

CASE SUMMARY We present a case of a 62 year old Filipina presenting with 3-month history of progressive bilateral myalgia and myopathy as an initial presentation of eventual diagnosis of hepatocellular carcinoma prior to the development of clinical signs and symptoms of liver disease. Diagnostics were done, all of which pointed to a presence of hepatocellular carcinoma with concomitant chronic Hepatitis B infection. Electromyography results and elevated creatinine kinase were consistent with polymyositis. High doses of corticosteroids were started with noted significant improvement of symptoms.

CONCLUSION Although its mechanism is unknown, there are different proposals to define and explain how this causes such symptoms which includes autoimmunity. This case is being reported due to the rare presentation and coalesce of hepatocellular carcinoma to a myopathic disease. The association between inflammatory myopathies and cancer has already been observed and this case highlights the importance of an exhaustive work-up for malignancy and other secondary causes in light of the occurrence of inflammatory myopathies. To the best of our knowledge, there are only a limited number of case reports (8) worldwide documenting the occurrence of inflammatory myopathy with that of hepatocellular carcinoma.

02.

A TOUGH PILL TO SWALLOW": A CASE SERIES OF DYSPHAGIA AS AN EARLY PRESENTATION OF DERMATOMYOSITIS

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BACKGROUN Dermatomyositis (DM) is one of the inflammatory muscle diseases characterized by chronic muscle weakness, muscle fatigue, and varying organ involvement. Dysphagia is frequent in DM, with a prevalence of 32.2%.

CASE SUMMARIES Case one is a 59-year-old male was admitted due to difficulties swallowing liquids and solids. He had been having hyperpigmented, scaly skin lesions for a month and was noted to have gottron's signs and papules, shawl signs, a heliotrope rash, and mechanical hands with symmetrical weakness in the upper and lower extremities. He had elevated CKMM, liver function tests (LFTs), and ESR. He underwent esophagogastroduodenoscopy (EGD) findings of bile reflux gastritis and erosive esophagitis, LA Gr. A. He was managed as a case of DM and started on methotrexate (MTX) 7.5 mg subcutaneously once a week, folic acid, prednisone at 1 mkd, and calcium and vitamin D.

Case two is a 59-year-old female with progressive dysphagia to solid food with associated findings of proximal muscle weakness on both upper and lower extremities, weak neck flexors, heliotrope rash, gottron's papules, polyarticular joint pains, and difficulty breathing with a noted elevated CKMM, liver function test, and positive anti-Mi2 results. She was a newly diagnosed DM and was managed as having aspiration pneumonia. MTX was put on hold due to elevated LFTs and started on antibiotics; however, the patient subsequently expired.

DISCUSSION Dysphagia rarely manifests as the initial symptom in DM, that it typically occurs in severe cases of DM and frequently manifests late in the course of the illness. Complications from dysphagia include low quality of life, aspiration pneumonia, extended hospital admissions, and a higher risk of pneumonia-related death.

CONCLUSION We have reported two cases of dysphagia as the main symptom in patients with underlying dermatomyositis. Glucocorticoids remain the main initial treatment. Since dysphagia in DM is multifaceted, it is advised to utilize both clinical bedside and instrumental examinations to detect problems related to swallowing in this population to avoid complications.

03.

RHUPUS SYNDROME IN A MOTHER AND DAUGHTER: A RARE CASE OF SHARED AUTOIMMUNITY

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BACKGROUND Rhupus syndrome is an uncommon condition characterized by the rare coexistence of systemic lupus erythematosus (SLE) and rheumatoid arthritis (RA). Shared autoimmunity presents variably, including: [1] the presence of autoimmune rheumatic disease in several members of the same family, [2] the presence of manifestations of different autoimmune rheumatic diseases in the same patient, and [3] patients who fully develop two or more diseases simultaneously or sequentially are classified as overlapping syndromes, such as Rhupus. Prevalence of Rhupus is between 0.01% and 2% of patients, more common in women. The main feature of is RA-like arthritis with a typical RA-like distribution with higher erosive burden. Treatment should be individualized and may include corticosteroids, disease-modifying antirheumatic drugs (DMARDs), immunosuppressants, and biologic agents.

CASE SUMMARY We present two cases of Rhupus syndrome in a mother and daughter. The first case involves a 60-year-old mother presented with intermittent bilateral proximal interphalangeal joint pain and swelling accompanied by morning stiffness of 6 months duration. She developed fatigue, malar rash, oral ulcers, alopecia, and pallor. The second case involves a 28-year-old daughter who presented with debilitating bilateral proximal interphalangeal and metacarpophalangeal joint pain and swelling accompanied by morning stiffness of 3 years duration. She also reported a history of oral ulcers, alopecia, and fatigue. She now exhibits swan neck deformities and ulnar deviation in both hands. Both patients were diagnosed with rheumatoid arthritis overlap systemic lupus erythematosus (Rhupus syndrome) after testing positive for ANA, rheumatoid factor, and anti-dsDNA, with low C3 levels. Both patients achieved clinical remission with hydroxychloroquine, methotrexate, and tapering doses of prednisone.

CONCLUSION Rhupus syndrome is a rare clinical entity, and its diagnosis relies on clinical findings supported by the standard classification criteria for the two overlapping diseases. The occurrence of Rhupus, in both a mother and child, represents a unique demonstration of shared autoimmunity. Treatment with medications indicated for both conditions has been successful in achieving clinical remission.

04.

EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS PRESENTING AS RECURRENT NASOMAXILLARY MASS IN A FILIPINO FEMALE SUCCESSFULLY TREATED WITH RITUXIMAB: A CASE REPORT

Nizaah Glaire A. Aggabao, MD; Marinette Jambaro, MD | Cagayan Valley Medical Center

BACKGROUND Eosinophilic granulomatosis with polyangiitis (EGPA, Churg-Strauss syndrome) is characterized by asthma, eosinophilia and small vessel vasculitis affecting the lungs, nasal sinuses, peripheral nerves, and heart. Up to date, there is no systematically developed, evidence-based guidelines specifically dedicated to the diagnosis and treatment of EGPA. Our objective was to add a case of EGPA to the existing literature in order to learn other manifestations and other treatment options like Rituximab for this autoimmune disease.

CASE SUMMARY We report a 26-year-old Filipino female, who presented with recurrent intranasal mass, and a background history of chronic sinusitis for three years. She underwent multiple biopsies and complete excision of mass which reappeared four months post- operatively with disfiguring facial features despite compliance to treatment. She tested negative for antineutrophil cytoplasmic antibody (ANCA). Tissue biopsies were consistent of chronic granulomatous inflammation with eosinophilic predominance, with immunohistochemistry (IHC) result strong for CD20. She was able to fulfill the American College of Rheumatology (ACR)- EULAR endorsed weighted criteria for EGPA including obstructive airway disease, nasal polyps and extravascular eosinophilic predominant inflammation. The patient was treated with glucocorticoid of 1mg/kg/day tapered every 2 weeks to the minimal effective dose and Rituximab 500mg/IV weekly for 4 weeks.
Improvement of clinical symptoms was documented as early as one month after induction. The paranasal sinus CT scan showed partial response of the left nasomaxillary mass. Patient is planned to receive Rituximab 500mg/IV every 6 months for the next 24 months.

CONCLUSION EGPA is a rare small-vessel vasculitis characterized by eosinophilic-rich and necrotizing granulomatous inflammation associated with asthma and eosinophilia. ANCA are detectable in 40% of cases and associated with features of vasculitis, whereas the eosinophilic features are more frequent in ANCA-negative patients. Two trials involving patients with granulomatosis with polyangiitis and microscopic polyangiitis showed rituximab to be safe and effective inducing remission.

05.

PIERRE-MARIE BAMBERGER SYNDROME IN EARLY STAGE NON-SMALL CELL LUNG CANCER

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BACKGROUND Hypertrophic osteoarthropathy (HOA) clinically presents as clubbing of fingers, periostosis of the long tubular bones, and arthritis. Due to its rarity as an initial presentation, the clinicopathologic characteristics of primary lung cancer with HOA have not been completely elucidated.

CASE SUMMARY A 32-year-old woman presented to the clinic complaining of progressive polyarthralgia for 8 months. She denied a history of fever, weight loss, or cough. She is a 40 pack year smoker with a significant family history of lung cancer. She had swelling of the ankle and wrist joints and acyanotic clubbing. Active movement of the joints was restricted due to pain. Other examination was unremarkable. Skeletal survey showed cortical thickening of the left proximal ulna suggestive of periostitis. Anti-nuclear antibody and rheumatoid factor were normal. A suspicious right pulmonary mass was seen on chest radiography. Computed tomography (CT) of the chest revealed a spiculated mass over the right lower lobe measuring 3.1 cm x 4.5 cm with no hilar and mediastinal lymphadenopathy. CT-guided biopsy confirmed non-small cell lung cancer. Subsequent posterolateral thoracotomy, right lower lobectomy, and mediastinal lymph node biopsy were performed. Postoperative pathological examination showed invasive adenocarcinoma, R0 resection, stage IIB (T3N0). Biomarker analysis revealed more than 50% programmed cell death 1 ligand (PD-L1) tumor proportion score, and negative for epidermal growth factor receptor and anaplastic lymphoma kinase mutations. Adjuvant systemic therapy is planned.

DISCUSSION AND CONCLUSION Hypertrophic osteoarthropathy, often referred to as Pierre Marie-Bamberger syndrome, occurs in 1 – 5 % of lung cancer as a rare paraneoplastic syndrome. It exists in two forms: primary, which is the rarest form, and secondary, which is frequently associated with lung diseases, most commonly non-small cell lung cancer. Since the symptoms of paraneoplastic syndromes may occur before the local symptoms of the primary tumor, it might be helpful in the early diagnosis of malignancy. Curative resection heralds eradication of most symptoms, if not all.

06.

CHRONIC TOPHACEOUS GOUT IN A YOUNG ADULT FEMALE WITH GENETIC VARIANTS OF UNCERTAIN SIGNIFICANCE: A CASE REPORT

Rose Elaine Gumafelix, MD; Melissa Aquino-Villamin, MD | De Los Santos Medical Center

BACKGROUND Gout is a chronic and easily treatable condition in which chronic hyperuricemia causes accumulation of monosodium urate crystals into articular and extra-articular areas. Management available in the Philippines for hyperuricemia are Allopurinol and Febuxostat.

CASE SUMMARY Here we report a case of a 31-year-old young adult Filipino female diagnosed with chronic tophaceous gout at the age of 20 but has hypersensitivity reactions to both Allopurinol and Febuxostat. Serial monitoring of serum uric acid since eleven years ago ranges from 9 to 11 mg/dL, with normal creatinine, liver function and thyroid function tests. At present physical examination showed multiple tophi on multiple areas with limitation of range motion. Determination for the cause of early-onset chronic hyperuricemia showed fractional excretion of uric acid was 3.78% with random uric acid and creatinine ratio of 0.42, compatible with underexcretion of uric acid. Ultrasound of kidney, ureter and bladder were unremarkable. Consideration then was a possible Familial juvenile gouty nephropathy probably from a rare autosomal dominant genetic condition. Patient then underwent expanded renal disease panel which evaluated 401 genes for variants that are associated with genetic disorders. The four genes of interest - UMOD, REN, HFN1B and SEC61A1 - were normal. However, variants of uncertain significance were identified. The c.3017A>T (p.Gln1006Leu), c.4220T>C (p.Val1407Ala), c.4226A>G (p.His1409Arg) and c.4592G>A (p.Arg1531Gln) were identified in ITGB4. The c.260A>G (p.Tyr87Cys) was identified in STX16. The c.2396_2401dup (p.Pro799_Pro800dup) was identified in SYNPO. The c.4742C>T (p.Thr1581Ile) was identified in WNK1. At present, the presence of these variants of uncertain significance still need to be explored.

DISCUSSION This case is rare and unusual in several ways. The onset of gout occurred early in a young adult female. Genetic work up for primary hyperuricemia secondary to underexcretion is also unknown and rarely done in the Philippines. This case revealed the presence of genetic variants of uncertain significance which later need to be explored.

CONCLUSION Treatment is challenging due to hypersensitivity to both Allopurinol and Febuxostat which are the only urate-lowering agents in the Philippines. Desensitization to Allopurinol or Febuxostat and genetic counselling are highly recommended.

07.

LUPUS NEPHRITIS COEXISTING WITH PSEUDOMEIGS' SYNDROME

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BACKGROUND Systemic lupus erythematosus (SLE) is a systemic autoimmune disease that affects several organ systems and is associated with increasing morbidity and mortality worldwide. The diagnosis is challenging especially for those with atypical presentations. Here, we present a 23-year old woman with pelvic tumor, ascites, bipedal edema and pleural effusion, with elevated CA-125 level, assessed as pseudo-meigs' syndrome, who later presented with hypocomplementemia, hemolytic anemia, nephritis and (+) ANA.

CASE SUMMARY Patient is a 23 year old woman who complained with 2 weeks history of bipedal edema, progressive orthopnea, non-productive cough and exertional dyspnea. On work up, she has left ovarian mass measuring 3.2 x 2.4 x 4.6 cm and 5 x 5 x 5 cm, ascites and bilateral pleural effusion. However, urinalysis showed proteinuria with urine protein/creatinine ratio of 17.61 with dysmorphic RBCs compatible with nephritis. On further review, she has recurrent oral ulcers since 12 years ago, anemia, and arthralgia. Work up for possible systemic lupus Erythematosus showed +ANA 1: 1280 with Nuclear Homogenous (AC-1) pattern, low c3 at 489 mg/dl and + direct Coombs test, satisfying 7 points in the 2019 SLICC criteria and 16 points SLEDAI for SLE. Management for SLE with possible lupus nephritis was initiated with pulse Methylprednisolone therapy, Mycophenolate mofetil and hydroxychloroquine, with noted gradual improvement in serositis and peripheral edema. Patient is still for renal biopsy and biopsy of the ovarian tumor.

DISCUSSION Lupus nephritis coexisting with pseudomeigs disease is rare and not well understood. A possible hypothesis could be an underlying excessive inflammatory process that results in immune complex deposition, vasculitis, and lymph aggregation of plasma cells. For this reason, a combination of immunosuppressive and immunomodulating therapy produces gradual recovery of the patient.

CONCLUSION Pseudo Meigs' syndrome can coexist in systemic lupus erythematous creating a diagnostic dilemma. Careful history and physical examination and multidisciplinary approach, including renal and ovarian tumor biopsy are essential for diagnosis, prognostication and guided management for both conditions.

08.

PEMPHIGUS VULGARIS IN A 72 YEAR OLD FILIPINO FEMALE PRESENTING AS A BECHET'S DISEASE MIMIC

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BACKGROUND Bechet's disease is an auto-inflammatory systemic vasculitis of unknown etiology. It is characterized by recurrent mucocutaneous manifestations, including recurrent oral and genital ulcerations. Pemphigus Vulgaris is a rare debilitating autoimmune disease especially if left untreated. The oral mucosa is frequently affected in almost 80% of cases presenting as multiple ulcerations accompanied by flaccid skin blisters. These manifestations may be similar with other autoimmune disorders which can lead to a misdiagnosis

CASE SUMMARY This is a case of a 72 year old female who complained of painful ulcerations which started on the vagina and mouth with difficulty swallowing for 3 months. There was also appearance of flaccid blisters on the skin but with predominance in the mucosal areas. Initially managed as disseminated Herpes with no improvement in Valacyclovir and Fluconazole. Patient met the International Criteria for Bechet's Disease with presence of Oral and Genital Ulceration with presence of skin lesions.

Skin biopsy was done where histopathology revealed findings compatible with pemphigus Vulgaris. Skin and Oral Direct immunofluorescence revealed intercellular IgG and C3 distribution. Serum ELISA revealed presence of Desmoglein 1. Patient was started on Hydrocortisone 100mg IV Once a day and showed gradual improvement in oral ulcerations and swallowing.

CONCLUSION Prompt recognition and diagnosis led to prompt treatment and alleviation of the patient's suffering and progression of complications. Although several autoimmune disease may present alike, reports on Bechet's disease mimicking PV is rare. Careful history and physical examination followed by skin biopsy with histopathology are emphasised to confirm the diagnosis.

09.

A CASE OF JUVENILE-ONSET SYSTEMIC SCLEROSIS WITH INTERSTITIAL LUNG DISEASE IN A 33-YEAR OLD FILIPINO FEMALE

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Scleroderma, or systemic sclerosis (SSc), is a rare disease with an unknown cause. It is characterized by a variety of clinical symptoms and unpredictable progression. The key characteristics of SSc include autoimmunity and inflammation, structural and functional changes in small blood vessels, as well as widespread fibrosis that affects the skin and other organs.

We hereby present a case of a 33-year old Filipino female, who was admitted due to increased severity of difficulty breathing during her 33rd week pregnancy. At age 15, started to notice bluish discoloration of her fingers whenever exposed to cold, with development of digital ulcerations a few months thereafter. Two years later, she developed exertional dyspnea associated with intermittent cough. Patient sought consult and was managed as a case of Bronchial Asthma. In her 20s, skin thickening and tightness of the face, neck, and hands developed. She sought consult with a dermatologist and was diagnosed with Dermatitis. Treatment provided no improvement. There were no associated fever, blurring of vision, rashes, alopecia, eye and mouth dryness, mouth ulcers, and join pain. Persistence of cough and dyspnea prompted another consult, and she was treated with Anti-Kochs.

Salient physical features include telangiectasia on the face and upper back, and fine "velcro-like" inspiratory crackles on bilateral mid to basal lung fields. There was also a note of digital shortening of the 2nd distal interphalangeal joints of both hands. Diagnostic work-up revealed a positive Anti-sCL70 test. Chest HRCT revealed diffuse parenchymal interstitial lung disease (ILD). Patient was started on Cyclophosphamide and calcium channel blocker.

Scleroderma can lead to significant morbidity and mortality, especially when it affects the major organs. Pulmonary involvement in juvenile SSc ranges from 30% to 55%. The clinical presentation of ILD with slowly progressive dyspnea on exertion is similar between adults and children with SSc. Holistic physical examination and a complete history are crucial components in assessing patients. By doing so, problems and clinical features may be correlated one to another, which may possibly lead to the diagnosis of a single disease entity and avoid misdiagnosis.

10.

CONFRONTING THE DUAL CHALLENGE: BILATERAL KNEE BACTERIAL ARTHRITIS AND CHRONIC TOPHACEOUS GOUT IN A 68-YEAR OLD FILIPINO MALE

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Cases of bacterial arthritis caused by Burkholderia cepacia have rarely been documented, with only a few reported cases. These aerobic, gram-negative bacteria are often resistant to common antibiotics. Burkholderia cepacia infections are most often associated with extreme ages, being immunocompromised, and chronic lung disease. The available literature on Burkholderia cepacia causing bacterial arthritis is limited and occurrence of septic arthritis in an oligoarticular or polyarticular form is only noted in approximately twenty percent of septic arthritis. The coexistence of bacterial and crystal-induced arthritis also poses a diagnostic challenge in resource-limited areas.

We present the case of a 68-year old Filipino male admitted for a two-month history of non-healing sacral wounds and polyarticular joint pain. Past medical history is pertinent for chronic tophaceous gout and chronic kidney disease secondary to gouty nephropathy. He was previously maintained on colchicine and febuxostat, to which he was non-compliant. Patient was initially managed as gout in a polyarticular flare. Diagnostic and therapeutic arthrocentesis were done, where synovial fluid analysis revealed moderate growth of Burkholderia cepacia on bilateral knees.

This case report of bilateral knee bacterial arthritis with B. Cepacia, who initially presented as a gout flare, emphasizes the value of diagnostic aspiration and microscopy in order to arrive at a specific joint disease etiology. Infectious processes in the background of a gout flare should always be considered. This opportunistic pathogen is difficult to treat due to its microbiological resistance, which poses a high mortality rate.

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11.

DERMATOMYOSITIS AND SYSTEMIC LUPUS ERYTHEMATOSUS OVERLAP SYNDROME IN A 48-YEAR OLD FILIPINO FEMALE: A CASE REPORT

Shiaianne T. Genolos, MD; Therese Eileen L. Natividad, MD | East Avenue Medical Center

The overlap between systemic lupus erythematosus(SLE) and dermatomyositis rare (<15%).In such cases females are predominantly affected and presents with myriad symptoms. The diagnosis is based history, clinical manifestations and serologic and imaging findings . The presence of another connective tissue does not seem to modify the response of myositis to treatment. Treatment with systemic glucocorticoids and immunosuppressives is individualized. Prognosis depends on the specific organ involvement and poorer outcomes are expected for those with major organ involvement.

A 48-year old female presented with a six-month history of symmetric polyarthritis, fever, bipedal edema, malar rash, alopecia, and irregularly-shaped, erythematous plaques and patches on the popliteal area, progressing to both extremities, trunk and back. Proximal muscle weakness and consequent difficulty ambulating were also noted. Pertinent physical examination cutaneous findings included discoid and hyperpigmented rashes on the face, ears and back, heliotrope rash,and mechanic's hands. Manual muscle testing revealed,½ strength on bilateral upper and lower extremities. During admission, she also developed psychosis and delusions. Work-up revealed a positive direct Coomb's test, elevated CK-MM, UPCR: 0.7 g/g, hypocomplementemia, negative ANA, pulmonary tuberculosis on imaging and interface dermatitis on skin biopsy. Work- up for malignancy was unremarkable. She was managed as a case of Dermatomyositis (EULAR/ACR: 8.9) and SLE (ACR7 SLICC9) with clinical class III lupus nephritis and neuropsychiatric, musculoskeletal and mucocutaneus activities. She received methylprednisolone pulse therapy and Cyclophosphamide infusion with notable improvement prior to discharge.

The diagnosis of SLE and is still based on the history, clinical manifestations with the utility of serologic and imaging findings . The presence of another connective tissue does not seem to modify the response of myositis to treatment. The treatment is also individualized, usually composed of systemic steroids and immunosuppressives. Prognosis also depends on the organ involvement and portends poorer outcomes in patients with major organ involvement.

12.

DIFFUSE ALVEOLAR HEMORRHAGE IN A 20-YEAR OLD PATIENT WITH SYSTEMIC LUPUS ERYTHEMATOSUS: A CASE REPORT

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Diffuse alveolar hemorrhage(DAH) is a rare complication of systemic lupus erythematosus(SLE) with an incidence rate of 0.5-5.7%. It has the highest mortality rate(80%) among pulmonary complications in SLE . Patients present with severe respiratory compromise, with a sudden drop in hemoglobin being the most prominent clinical manifestation. Dyspnea,hemoptysis,diffuse infiltrates identified by chest imaging, thrombocytopenia and C3 hypocomplementemia are other commonly reported signs of diffuse alveolar hemorrhage.

We present a case of a 20-year old female who was admitted for a 2-month history of malar rash,arthritis,alopecia and bipedal edema. No prior consults nor medications were taken.Physical examination revealed pallor, malar and discoid rashes, grade 2 bipedal edema, and symmetric polyarthritis of the hands and feet. Work-up revealed a positive ANA(1:40 dilution),low C3(4 mg/L),Urine Protein-to-Creatinine Ratio of 5.1g/g, an elevated ESR(116 mm/hr),bicytopenia(hemoglobin at 66g/L,platelet count of 122g/L). Her baseline chest radiography was unremarkable.

The patient was managed as a case of SLE(ACR 7 SLICC 8) with nephritis clinical class III/V, hematologic activity(autoimmune hemolytic anemia), mucocutaneous and musculoskeletal activities. She underwent methylprednisolone pulse therapy (MPPT) 1 g for 3 days followed by prednisone(1mkd). Other medications included were Hydroxychloroquine, Calcium with Vitamin D, Aspirin, Losartan, and was set for initiation of cyclophosphamide infusion. However, the patient had sudden-onset progressive hemoptysis, with associated desaturation, fever, and coarse crackles on all lung fields. Repeat chest radiograph showed diffuse bilateral patchy infiltrates.On work- up, there was note of sudden drop of hemoglobin from 85 to 76 to 51g/L over a span of 4 days. Procalcitonin was elevated at 33 ng/ml. Patient was intubated, due to progression of given MPPT 1g, antibiotics were started and she was transferred to the ICU. The patient eventually expired on the third ICU day.

DAH is a rare, but life-threatening, complication of SLE, with a poor survival rate(~20%). Suspicion of DAH requires a prompt investigation and management, and exclusion of other causes with a similar presentation.

13.

A TALE OF COEXISTENT CHALLENGES: FIBROMYALGIA IN A RHUPUS PATIENT

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Rhupus syndrome is a rare overlap condition in which a patient has both systemic lupus erythematosus (SLE) and Rheumatoid arthritis (RA). Fibromyalgia (FM) is a chronic disorder characterized by widespread musculoskeletal pain, tenderness, fatigue, insomnia, and mood disturbances that can occur in individuals with RA and SLE, with variable prevalence rates. Data is scarce on comorbid FM in overlap syndrome. Distinguishing the active components of these coexisting diseases is crucial for distinct and appropriate management approaches.

We present a case of a 34-year old female who is known case of SLE for the past three years, initially presenting with a photosensitive rash and symmetric inflammatory polyarthritis of the hands, wrist and knees. On further investigation, she tested positive for anti-cyclic citrullinated peptide determination of 45.7 U/mL. She was maintained on hydroxychloroquine 200 mg tablet OD and Prednisone 5 mg tablet OD. The patient followed up at OPD due to recurrence of bilateral joint pains involving the hands, wrist, elbows, knees and ankles for the past 5 months with pain scale 10/10. There was no erythema, swelling, and was associated with generalized myalgia, headache, easy fatigability and insomnia. She was initially managed as SLE with musculoskeletal activity, with concomitant RA, and Fibromyalgia was entertained. Pregabalin 75 mg tab BID was started and prednisone was increased to 20 mg tab OD. Despite the intervention, her joint pains persisted, now associated with dysuria, hematuria, myalgia, arthralgia and insomnia. She was eventually admitted and diagnosed with complicated UTI and comorbid FM with Rhupus. The patient was discharged improved after one week of antibiotic and pregabalin.

FM can coexist with both SLE and RA making its diagnosis a challenge. Thorough history and PE can differentiate these three conditions. Laboratory work-up aid in differentiating between active inflammatory autoimmune disease and pain from fibromyalgia. Importantly, clinical features should be recognized for early diagnosis and appropriate treatment to reduce long-term complications.

14.

FROM CLOTS TO CATASTROPHE: A CASE SERIES OF FILIPINO PATIENTS WITH CATASTROPHIC ANTIPHOSPHOLIPID SYNDROME

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Catastrophic Antiphospholipid Syndrome(CAPS) is a rare, life-threatening, and abrupt complication occurring in only 1% (0.4-1.6%) of patients with Antiphospholipid Syndrome (APS). About half of these patients succumb to death if not managed promptly and properly. CAPS is characterized by widespread venous and arterial thrombosis, with multi-organ involvement which may lead to organ failure. Infection is the most common risk factor. Among rheumatic diseases, systemic lupus erythematosus (SLE) is the most common disease associated with CAPS. Patients may still develop CAPS in the future after surviving the initial episode.

We are presented with three cases of APS who later developed CAPS. Case 1 had primary APS, Cases 2 and 3 had underlying SLE with duration of 17 years and 1 year respectively. Their ages ranged from 21 to 42 years old. Case 1 has no known comorbidities, case 2 has Chronic Kidney Disease (CKD), hypertension and history of Cerebrovascular Disease (CVD) infarct, while Case 3 has CKD.

During their admission, Case 1 had involvement in both lower extremities and abdominal aorta, Case 2 had cardiac and central nervous system (CNS) involvement, while case 3 had hepatic, renal, inferior vena cava (IVC) and CNS involvement. All cases received methylprednisolone pulse therapy (MPPT) for 3 days, while cases 1 and 3 received IVIg for 5 days. Case 1 underwent BKA due to worsening cyanosis and received cyclophosphamide prior to discharge. Case 2 received cyclophosphamide and was discharged improved, while case 3 expired post MPPT due to infection. The two cases followed up at OPD with no recurrence of symptoms.

RECOMMENDATIONS

Catastrophic Antiphospholipid Syndrome requires a high index of clinical suspicion and prompt diagnosis. The management is individualized and involves a multidisciplinary approach with treatment options including anticoagulants, glucocorticoids, IVIg, plasmapheresis and immunosuppressants. This case series may help in understanding this very rare, yet fatal disease to avoid irreversible organ damage and mortality.

15.

INFLAMMATORY BOWEL DISEASE-ASSOCIATED SPONDYLOARTHRITIS IN A 26-YEAR OLD FEMALE TREATED WITH VEDOLIZUMAB: A CASE REPORT

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IBD-associated Spondylarthritis is a distinct entity with a shared pathogenic process which may be difficult to recognize in its entirety. It is often managed as two separate diseases, a musculoskeletal and a gastrointestinal one, with a profound impact on patient quality of life.

Vedolizumab is a monoclonal antibody against integrin α4β7 which is unique among biologics used to treat IBD by specifically targeting the gastrointestinal tract. It was postulated that vedolizumab could improve articular symptoms by treating GI inflammation that may be driving the joint disease. However, it has modest if any benefit for treating inflammatory arthritis. Recent studies have suggested the possibility for vedolizumab to trigger new cases of inflammatory arthritis .

A 26-year-old female with Crohn's Disease for 2 years, treated with Vedolizumab was seen at Rheumatology OPD for inflammatory back pain that had been occurring for more than a year (VAS 6-7/10). Patient noted worsening of symptoms after three months of the drug treatment. The pain was occasionally noted to be radiating to the left groin, with alternating buttocks pain, nighttime awakening occurring four times per week, with morning stiffness of 30 minutes and relief with intake of NSAIDs. Review of systems was unremarkable.

On physical examination, remarkable findings were tenderness located over right and left iliac crest and lumbosacral area. Patient was also positive for Schober's Test with pain on flexion, abduction, external rotation, and extension of both lower extremities.

She was managed as a patient with IBD-associated Spondylarthritis and was advised work- ups prior to Methotrexate initiation. She was also started on Etoricoxib 90 mg ODHS and advised follow up.

The key to early recognition of IBD-associated SpA is a high level of suspicion from both Rheumatologists and Gastroenterologists to actively seek for peculiar indications that will prompt a tailored clinical evaluation and therapeutic approach.

16.

A CASE OF GOUTY ARTHRITIS IN A YOUNG FILIPINO FEMALE WITH BIOPSY-PROVEN LUPUS NEPHRITIS AND CONCOMITANT URATE NEPHROPATHY

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The coexistence of gout and autoimmune diseases is relatively rare. Such instances have been described in a small number of cases. Gout in the course of Systemic Lupus Erythematosus (SLE) is uncommon and is mostly seen in patients with long-standing disease. Although some patients with SLE may have hyperuricemia, particularly in those with concomitant renal insufficiency, they infrequently develop gout.

A 31-year-old Filipina with a 15-year history of Lupus nephritis in low disease activity and Chronic kidney disease, was admitted due to abnormal uterine bleeding secondary to adenomyosis. She was maintained on hydroxychloroquine, mycophenolate mofetil and low dose prednisone. She had a history of podagra 5 years ago, with pain becoming severe within 24 hours from waking up and resolving within 5 days with no medications. These attacks occurred infrequently and resolved spontaneously. She had no prior intake of colchicine nor urate-lowering medication. Kidney biopsy done 13 years prior showed urate nephropathy, Lupus Nephritis Class IV and V (Membranous and Diffuse proliferative glomerulonephritis). On physical examination, the right 1st MTP was swollen, warm and erythematous with grade 4 tenderness. Serum uric acid was elevated at 9.5mg/dl. She was managed as a case of acute gouty arthritis in monoarticular flare. Hydrocortisone was given at 1 mg/kg/day prednisone-equivalent, and colchicine was started. There was noted resolution of pain and swelling after 5 days.

Articular lupus flare can mimic crystal-induced arthritis. It is important to distinguish these two conditions since the long-term treatment would differ. This case report will increase the awareness that gout should still be considered in lupus patients presenting with acute monoarticular arthritis. The evaluation of these patients should include a diligent search for causes of hyperuricemia and gout in the young.

17.

A RARE CASE OF SUBSCAPULAR ABSCESS EXTENDING TO THE INFRA- AND SUPRA- CLAVICULAR REGION MANAGED WITH PERCUTANEOUS DRAINAGE

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Subscapular abscess is a rare occurrence where a collection of pus forms between the subscapularis muscle and the chest wall. To the best of our knowledge, only 17 cases are reported in the literature. The presentation may mimic many shoulder pathologies with subacute shoulder pain and may easily be mistaken for septic arthritis of the shoulder joint. Management involves both surgical drainage and antibiotic administration. Percutaneous drainage is a treatment option but is rarely used and has been previously reported in only 2 cases.

This is a case of a 45-year-old male with uncontrolled Diabetes Mellitus who presented with a 2- week history of progressive left shoulder pain accompanied by limitation of movement. NSAIDs and analgesics provided only minimal relief.On physical examination, there was a palpable firm mass with warmth and grade 3 tenderness over the left supraclavicular area, extending to the left anterior chest, axilla and upper back. He had pain-limited range of motion of the left shoulder both on passive and active movement, with abduction and flexion only up to 45 degrees and inability to perform internal or external rotation. Chest CT with contrast revealed an ill-defined multiloculated, septated peripherally enhancing predominantly hypodense mass in the infra to supraclavicular regions anterior to scapula causing mass effect measuring 9.3x8.7x8.5cm, suggestive of an abscess formation. He was started on Vancomycin and subsequently underwent ultrasound-guided percutaneous drainage of the subscapular abscess draining a total of ~1L. There was subsequent pain-relief and improvement in range-of-motion. The pigtail catheter was eventually removed and the patient was discharged improved.

Subscapular abscess may mimic other shoulder pathologies which may delay diagnosis and management. Awareness by clinicians may prompt vigilance in examining a patient with shoulder girdle pain and permit a lower threshold in requesting appropriate imaging. MRI is an essential imaging modality but CT scan may suffice in the absence of an MRI. In cases where prompt surgical management cannot be accomplished, percutaneous drainage may be a treatment option.

18.

A CASE OF MIXED CONNECTIVE TISSUE DISEASE IN A 30-YEAR OLD FILIPINO FEMALE

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Mixed Connective Tissue Disease (MCTD) is a rare autoimmune disorder characterized by overlapping clinical features from various connective tissue diseases, presenting a diagnostic challenge due to its heterogeneity.

This is a case of a 30-year old female who had a 2-year history of cutaneous, musculoskeletal and pulmonary complaints. Works-up showed:ANA-IF >1:640 speckled pattern, low serum C3, negative Scl70, anticardiolipin and DRVVT. Echocardiography showed pulmonary arterial hypertension. Sildenafil, Spironolactone and Carvedilol were given by a Cardiologist. No other consultations were done, she was subsequently lost to follow-up. Over time, she noted cyanosis of the fingertips, occasional gastroesophageal reflux, progressive dyspnea and 2 pillow orthopnea. She eventually sought consult and was subsequently admitted due to dyspnea at rest, severe joint pains and swelling of both hands and feet. Physical examination showed erythematous, swollen hands with taut skin and pallor on the fingertips with grade 4 tenderness on bilateral wrists and hand joints with pain-limited movement, erythematous papules and bullae on dorsum of feet and elbows, vasculitic lesion on both palms and soles. She also had malar rash sparing nasolabial folds and telangiectasia on face and chest. Further work-up while admitted revealed Anti-RNP>240U/ml, normal C3, UPCR 3.87g/g, negative anti-dsDNA. Skin biopsy revealed leukocytoclastic vasculitis and vasculopathy. High-resolution chest CT scan showed ground glass opacities both lower lungs and biapical fibrosis, treated as Pneumonia and Pulmonary Tuberculosis respectively. She was managed as a case of MCTD(Raynaud's phenomenon, high-titer ANA and U1RNP, PAH and ILD) given methylprednisolone pulse therapy and Cyclophosphamide therapy.

The patient met Alarcon-Segovia criteria for MCTD. This case shows the diverse nature of MCTD, where overlapping features of SLE, SSc, and other connective tissue diseases manifest sequentially over time. Nephritis and vasculitis, although commonly found in SLE, are uncommon clinical features of MCTD and are poorly described in literature. This case underscores the necessity for increased awareness and identification of severe manifestations of MCTD hence resulting in reduced likelihood of misdiagnosis and delivery of prompt treatment.

19.

A CASE OF ORBITAL MUCORMYCOSIS IN A 21-YEAR OLD FILIPINO FEMALE WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Orbital mucormycosis is a rare and aggressive fungal infection primarily caused by Mucorales, with Rhizopus species being a common culprit. It usually affects patients in immune compromised states. A few cases of patients with Systemic Lupus Erythematosus and Mucormycosis have been reported, and among these the primary manifestation is its rhinocerebral form.

This case report describes a 21-year-old female with Lupus nephritis on cyclophosphamide therapy who presented with proptosis of the right eye. She had a 7-month history of blurring of vision and intermittent pain on the right eye accompanied by right-sided headache. She eventually noted gradual proptosis of the right eye. Imaging revealed a fairly- defined non-enhancing hyperdense retrobulbar mass in the right orbit measuring 2.2x2.7x3.0 cm displacing the right globe anteriorly. It also appeared to communicate with the maxillary sinus eroding the orbital floor. She underwent right orbital mass incision biopsy which showed fibroadipose and fibrocollagenous tissues with xanthogranulomatous inflammation, focal abscess, granulation tissue and foreign body type multinucleated giant cells positive for fungal elements, suggestive of Mucormycosis. She was then admitted for Amphotericin B infusion. During the course of her admission the patient was diagnosed with tuberculosis and was started on anti-tuberculosis therapy. She also developed acute kidney injury from antifungal therapy and underwent short-term hemodialysis which improved her renal function. ENT service performed endoscopic sinus surgery with right gingivobuccal incision, minicaldwell and uncinectomy with biopsy of the mass. Amphotericin B was completed for 21 days. The proptosis significantly improved and she underwent cyclophosphamide infusion.

Patients with SLE are susceptible to severe infections, the presence of which complicate diagnosis and management. Infection caused by atypical organisms should be included in the differentials especially where clinical features overlap with other disease, as in Murcomycosis. A multidisciplinary approach, involving rheumatologists, infectious disease specialists and surgeons, is crucial for successful management. The complex nature of this case emphasizes the need for heightened awareness and collaborative efforts in managing challenging clinical scenarios.

20.

SHRINKING LUNG SYNDROME IN A 25-YEAR OLD FILIPINO FEMALE WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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This is a case of a 25-year old female diagnosed with SLE with musculoskeletal and mucocutaneous activity for two years and maintained on daily low-dose prednisone, hydroxychloroquine and calcium + vitamin D.She consulted for a month history of nonproductive cough, easy fatigability, dyspnea on exertion, weight loss and pleuritic chest pain.Chest radiograph revealed an elevated right hemidiaphragm with no infiltrates.Patient was treated with unrecalled antibiotics with no resolution of symptoms. During the interim,dyspnea progressed to even at rest, prompting admission.On physical examination, there was note of crackles on lower lung fields with note of episodes of desaturation.

Work-up revealed an elevated right hemidiaphragm with poor inspiratory effort on repeat chest radiography.She tested positive for anti-Ro and had elevated anti-dsDNA and ESR(95 mm/h).She was unable to tolerate pulmonary function tests.Chest CT scan revealed bilateral pulmonary fibrosis,passive and subsegmental atelectasis.Other work-ups were unremarkable.

The patient was managed as a case of possible shrinking lung syndrome,SLE with musculoskeletal and mucocutaneous activities and pulmonary tuberculosis,clinically diagnosed.She was given prednisone, hydroxychloroquine and calcium+vitamin d with noted improvement of dyspnea.She was also started on anti-Koch's treatment. Patient was discharged improved with a plan to initiate azathioprine after two weeks of PTB treatment.

It is therefore essential to include SLS in the differential diagnoses of patients with SLE who remain symptomatic with declining lung function, as early detection and prompt action are vital in avoiding unnecessary morbidity and mortality.

Shrinking lung syndrome (SLS) is a rare pulmonary condition with a prevalence rate of only about 0.5%-1.1% among patients with Systemic Lupus Erythematosus(SLE).It is characterized by progressive dyspnea, elevation of the diaphragm, pleuritic chest pain, decreased lung volumes on imaging, and restrictive patterns seen in pulmonary function tests (PFTs).The challenges associated with diagnosis of SLS is due to its rarity having only less than 100 reported cases. Thus, increased awareness and suspicion are critical for early diagnosis and treatment.

21.

BLEED AND BLISTER: A CASE REPORT OF 40-YEAR-OLD WOMAN WITH HEMORRHAGIC BULLOUS HENOCH-SCHONLEIN PURPURA

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BACKGROUND Henoch-Schonlein Purpura (HSP) is a rare immune vasculitis affecting small blood vessels, predominantly in children. Hemorrhagic-bullous conversion of HSP is even rarer, especially in adults, and remains poorly studied. We present a unique case of a 40-year-old female with Hemorrhagic-Bullous HSP in Northern Luzon, Philippines.

CASE PRESENTATION The patient presented with macular, papular, and vesicular rashes, progressing to bullae predominantly on the bilateral feet and legs. Past history included a similar episode at 17 years old. Laboratory findings showed elevated inflammatory markers, microscopic hematuria, and fecal occult blood. Colonoscopy revealed an ileal ulcer. Skin biopsy confirmed leukocytoclastic vasculitis.

MANAGEMENT AND OUTCOME Immunosuppression with hydrocortisone, colchicine, and azathioprine was initiated. Methylprednisolone pulse therapy was given, transitioning to prednisone. Concurrent urinary tract infection and nephrolithiasis were addressed. Lesions regressed, and the patient was discharged on a tapering prednisone regimen.

DISCUSSION AND CONCLUSION HSP, particularly the hemorrhagic-bullous variant, is a diagnostic challenge. Standard criteria aid diagnosis, but management remains varied. Early recognition and immunosuppressive therapy are crucial. This case contributes to understanding this rare manifestation and emphasizes the importance of a multidisciplinary approach for optimal patient outcomes.

22.

EYE CAN'T EAR YOU: A CASE REPORT OF SCLEROMALACIA PERFORANS AS A COMPLICATION ARISING FROM RELAPSING POLYCHONDRITIS

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This is a case report of a 28-year-old male patient with relapsing polychondritis (RPC). The patient presented with ocular inflammation, including scleritis and peripheral ulcerative keratitis (PUK), as well as other systemic manifestations of RPC, including cauliflower ear and hearing loss. He was diagnosed with RPC based on his clinical presentation and laboratory findings. He was treated with intravenous and oral corticosteroids, as well as cyclophosphamide.

RPC is a rare autoimmune disease that can affect any part of the body that contains cartilage. The most common symptoms of RPC are inflammation of the ears, nose, and trachea. However, RPC can also affect other organs, such as the eyes, joints, and blood vessels. Scleritis and PUK can present as a single complication or as a part of a systemic inflammatory or infectious process. Both of these conditions can result in permanent vision loss, hence requiring early diagnosis and prompt treatment. Scleromalacia perforans as a complication of RPC is extremely rare, yet it is strongly believed to be associated with systemic disease.

The diagnosis of RPC can be difficult because there is no specific test for the disease. However, the diagnosis of RPC can be based on the patient's clinical presentation and laboratory findings. Treatment for RPC typically includes corticosteroids and immunosuppressive medications. The major objectives of treatment are to manage symptoms, avoid adverse drug reactions, preserve hearing and vision, prevent respiratory and cardiovascular problems, and stop cartilage degradation.

The prognosis for RPC varies depending on the severity of the disease and the patient's response to treatment. Some patients with RPC go into remission and have no further symptoms. However, other patients experience recurrent flares of the disease. Early diagnosis and treatment of RPC is important to prevent complications, such as vision loss, hearing loss, and respiratory problems.

23.

PSORIATIC ARTHRITIS PRESENTING AS PULMONARY EMBOLISM: A CASE REPORT

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INTRODUCTION Psoriatic arthritis (PsA) is an auto-immune, systemic, inflammatory joint disease. Lee et. al. in 2014, noted inflammatory rheumatologic diseases are all associated with high rates of venous thromboembolism (VTE), more than three times higher than in the general population. However, VTE event, that is pulmonary embolism before the diagnosis of psoriatic arthritis is not common. Thus, this case report.

CASE SUMMARY Patient is a 27/Male, presented with dyspnea. No palpitations or chest pain noted. Oxygen saturation was 72% at room air. Chest x-ray was unremarkable. He was managed as bronchial asthma in exacerbation. No significant relief noted, despite oxygen support, nebulization, antibiotics, and corticosteroids. Bronchoscopy was unremarkable. 2D echocardiography revealed high probability of pulmonary hypertension. He later developed right leg pain and swelling. Duplex scan of both lower extremities showed superficial and deep venous thrombosis, right leg. Pulmonary CT angiogram showed pulmonary thromboembolism. He was seen by Hematology service wherein further work-ups were done. HIV screening test was negative. Protein S was low. Protein C, Anti-thrombin III, Factor II and Factor V assay, Anti-cardiolipin IgG and IgM, Beta-2 Glycoprotein IgG and IgM, JAK2 gene mutation assay, C3, high sensitivity C-reactive protein, Rheumatoid Factor, Lupus anticoagulant, Partial thromboplastin time, ANA (IFA), and Erythrocyte Sedimentation Rate were all normal/negative.

Rheumatology referral as out-patient was advised. Upon consult with attending rheumatologist, history revealed episodes of dandruff, pruritic erythematous plaques, arthritis, and enthesitis for the past 2 years. Physical examination showed nail pitting. No other significant PE findings on first consult. During the course of his follow-up, he had 1 episode of erythematous plaques. Medications, particularly Methotrexate and Rivaroxaban resolved his symptoms. Significant family history showed history of autoimmune disease. His mother has Rheumatoid arthritis. His sister has Psoriatic Arthritis who later developed deep vein thrombosis.

CONCLUSION Psoriatic arthritis can present with and increases the risk of venous thromboembolism.

24.

A CASE 54-YEAR-OLD FEMALE WITH HEMATOLOGIC MALIGNANCY PRESENTING WITH POLYARTERITIS NODOSA

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OBJECTIVE To present a case of a 54-year-old female with Blood Dyscrasia who presents with vasculitic manifestation

BACKGROUND Hematologic case leading to vasculitic manifestations. This disease sequelae is probably due to immune complex or T lymphocyte responses and granuloma formation leading to ischemia which eventually present with necrotic lesions one of which is polyarteritis nodosa.

CASE A 54-year-old, female Filipino had previous complaints Raynaud's, associated with occasional numbness, and pain, which eventually progressed to ulceration of foot digit, wound debridement and amputation of 3rd digit right foot.

On admission, she had generalized weakness, and with painful left foot, with necrotic changes at 4th digit, left foot, and dry lesion at 1st digit, right foot, with +2 dorsalis pedis pulse. Neurologic exam, was all unremarkable. Complete Blood Count revealed leukocytosis at 74.97, thrombocytosis at 1927, Peripheral Blood Smear: mild anisopoikilocytosis, WBC no abnormal cells seen, Granulocytic leukocytosis with eosinophilia, Platelets: markedly increased. Whole abdomen ultrasound shows splenomegaly. This result, a diagnosis of Chronic Myelogenous Leukemia is considered. Anti-HCV & HBsAg are nonreactive; Foot AP/O left Xray revealed soft tissue infection with osteolytic changes. Arteriovenous duplex scan revealed left distal anterior tibial and dorsalis pedis artery thrombosis, findings suggestive of bilateral moderate peripheral arterial disease, mild atherosclerosis, mild venous insufficiency, bilateral. Skin punch biopsy revealed subcutaneous septa appear widened, with infiltrates seen within and around the vessel wall and subcutaneous fat. Fibrin formation seen in some vessels with the histopathologic interpretation of medium vessel vasculitis with panniculitis, Polyarteritis nodosa and thrombophlebitis may be considered.

CONCLUSION Vasculitis may be a presenting symptom of hematologic malignancy. Too much activation of the innate and adaptive immunity presenting with autoimmune manifestations has correlation with myelodysplastic syndromes. Even without the definitive criteria of hematologic and vasculitic disorders, high index of suspicion should always be present.

25.

MYCOPLASMA PNEUMONIAE ASSOCIATED HYPERINFLAMMATORY IMMUNE RESPONSE RESULTING TO MULTISYSTEMIC ABERRATION IN A YOUNG ANTI-NUCLEAR ANTIBODY POSITIVE MALE

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OBJECTIVE To report a case of Mycoplasma pneumoniae associated hyperinflammatory syndrome resulting to multisystemic involvement in a young ANA positive male.

INTRODUCTION Mycoplasma pneumoniae rarely results to severe or fulminant and extrapulmonary course. The exact mechanism of the extrapulmonary complications is not well understood, immune complex and autoantibody production are linked for this entity. Despite the severity, the outcome is quite good following a timely management.

CASE SUMMARY A previously well 57-year-old male, presented with an acute flu-like symptoms followed by a sudden altered mental status, generalized tonic-clonic seizures, dyspnea, and hypoxemia with bloody secretions All happened simultaneously on the day of confinement. Mechanical ventilatory support, anti-infectives and seizure controllers were immediately instituted, while investigating for the root cause of the multiorgan problem.

Initial workup was directed towards neurological and infectious causes. Neuroimaging studies revealed negative intracranial pathology. CSF studies were unremarkable. Chest CT revealed ground glass densities on both lungs, with central distribution and peribronchial cuffing. Whole abdomen ultrasound showed hyperechogenic renal parenchyma and prominent bilateral medullary pyramids. Respiratory Pathogen Panel Test revealed presence of Mycoplasma pneumonia antigen. However, the inflammatory markers ferritin, LDH, liver function tests, CRPs all showed hyper response. Furthermore, urinalysis showed proteinuria and significant hematuria. Work up for autoimmune disease surprisingly revealed positive for ANA, while complement was normal and other autoantibodies were negative. He was given Azithromycin and cephalosporin IV for the infection and steroids for the hyperimmune response. The patient improved and discharged after two weeks. On follow up, he remained asymptomatic. He was advised to adhere to proper disease activity monitoring while on tapering doses of his anticonvulsants and steroids.

CONCLUSION This case demonstrated the link between infections and hyperinflammatory immune response. Apart from COVID, Mycoplasma pneumonia can trigger a severe multisystem dysfunction. The concomitant positive ANA in this case warrants an investigation whether it is a co-existence or a result of the hyperinflammatory process.

26.

AN UNUSUAL CASE OF SEPTIC ARTHRITIS OF THE KNEE CAUSED BY SALMONELLA SPECIE IN A 27-YEAR-OLD FILIPINO MALE

Andrea Hannah A. Valencia, MD; Dominic S. Dela Cruz, MD | Southern Isabela Medical Center

OBJECTIVE To present a case of an adult male diagnosed case of gouty arthritis who later developed Salmonella septic arthritis.
Background: Bacteria can enter joint from the bloodstream, from a contiguous site of infection in bone or soft tissue, or by direct inoculation during surgery, injection, animal or human bite, or trauma. Diabetes mellitus, glucocorticoid therapy, hemodialysis, and malignancy all carry an increased risk of infection with Salmonella aureus and gram- negative bacilli.

CASE SUMMARY A 27-year-old male Filipino presented with left knee swelling and pain. Two years later, he had severe bilateral knee pain. Managed as a case of acute gouty arthritis that is resolved with short course of prednisone and celecoxib. Ten months later, after binged alcohol drinking had recurrence of severe bilateral knee pain, self- medicated with prednisone and celecoxib. Continued alcohol consumption which he maintained prednisone. One month later, with worsening left knee pain, swelling and difficulty in ambulation, not relieved with prednisone. Arthrocentesis and arthrotomy was performed. Synovial fluid analysis revealed pink, turbid fluid, with 3.7% mononuclear cells and predominantly polymorphonuclear cells of 96.3%; leukocytosis of 113,60 cell/mm3, and red blood cells of 37 cell/mm3, gene Xpert: Mycobacterium tuberculosis not detected; negative for Acid Fast Bacilli; gram stain showed polymorphonuclear cells/LPF >25 and gram-negative bacilli/OIF 0-2; culture revealed Salmonella specie.

CONCLUSION Definitive therapy is based on identity and antibiotic susceptibility of bacteria isolated in culture. Timely drainage of pus and necrotic debris from the infected joint is required for a favorable outcome. Salmonella septic arthritis is rare entity with cases mostly prevalent in patients with sickle cell disease, immunocompromised state, and advanced age. Salmonella septic arthritis is rare, thus physicians need to be aware of this unusual presentation in young patients. Adequate antibiotic therapy along with surgical decompression should be performed at the time of diagnosis in order to prevent permanent joint dysfunction.

27.

"MY TOES, MY KNEES, MY SHOULDERS, MY HANDS": A RARE RHEUMATIC DISORDER IN A 21-YEAR-OLD FILIPINO WITH LUNG CANCER WHO EXPERIENCED POLYARTHRALGIA, A CASE REPORT

Julius Jerome D. Jose, MD; Harold Michael P. Gomez, MD | Our Lady of Mt. Carmel Medical Center

INTRODUCTION Hypertrophic osteoarthropathy is characterized by abnormal growth of bone and skin at the distal ends of the limbs. Clinical manifestation includes digital clubbing, tubular bone periostosis, and synovial effusions.

CASE SUMMARY A case of a 21-year-old Filipino female who presented with a 1-year history of intermittent polyarthralgia on both ankles, knees, shoulders, elbow, wrists and hands and clubbing. She was managed initially with Non-steroidal anti- inflammatory drugs and corticosteroid. Chest X-ray was done showing hilar densities on right apical lobe, treated as case of Pulmonary Tuberculosis with HRZE (intensive phase). She was subsequently admitted due to worsening of joint pains was initially underwent pain management. Patient was referred to Pulmonology due to worsening of joint pains upon taking anti TB medications and was requested for Chest CT Scan with IV Contrast.

CT Scan showed two mass lesion one on right apical lobe and on left lower lobe. Patient was subsequently referred to Interventional Radiology for lung mass biopsy which was resulted to Non-Small Carcinoma Cells, Smears Adenocarcinoma, Poorly Differentiated, Cell Block. Patient was referred to Oncology for further management, the following medications were given: Zoledronic Acid 4mg + PNSS 250ml to run for 2hrs, Cyclophosphamide 1g + D5W 500cc to run for 4 hours and Cisplatin 100mg in PNSS 900ml to run for 4 hours. Patient condition improved, hence, she was discharged.

DISCUSSION A rare kind of rheumatic disease known as hypertrophic pulmonary osteoarthropathy manifests as arthropathy, clubbing, and periostosis, or progressive, bilateral, and symmetric new bone production. It frequently has anything to do with chronic infections or intrathoracic tumors. The typical presenting age ranges from 55 to 75 years old. Ninety percent of cases of hypertrophic osteoarthropathy that have been recorded are linked to cancer. The most frequent cause of secondary hypertrophic osteoarthropathy is non-small cell lung cancer (NSCLC), more specifically adenocarcinoma, which accounts for 0.7% to 17% of cases. We can infer from this case of a 21-year-old female who presented with bilateral clubbing, burning, or deep-seated chronic and symmetric polyarthritis that our patient is a second type of hypertrophic osteoarthropathy, and progression is quicker with malignancy.

CONCLUSION Clubbing, periostitis, and arthropathy make up the triad of hypertrophic osteoarthropathy. When considering a secondary kind of HOA, it is crucial to take an early diagnostic technique into account. Chemotherapy and tumor resection serving as the cornerstones of treatment. An uncommon rheumatic disease, lung cancer with HOA typically has a prevalence of 0.7%, a 1-year survival rate of 57%, and a median survival of 13.5 months for patients who have not undergone surgery.

28.

INSIDIOUS: A CASE OF INFECTIOUS AORTITIS WITH MYCOTIC PSEUDOANEURYSM IN A 68-YEAR- OLD FILIPINO FEMALE WITH RHEUMATOID ARTHRITIS

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A 68-year-old female with 4-day history of generalized crampy abdominal pain not relieved by over-the-counter pain medications was brought to the Emergency Department. Diagnostics revealed the following- Complete blood count showed leukocytosis with segmenter predominance; she had elevated FBS and HbA1c; proteinuria and ketonuria on urinalysis. An ultrasound of the abdomen was done showing short segment of dilated distal ileal loop in the right iliac fossa relating to segmental ileus; other organs were unremarkable. A whole abdominal CT scan with IV contrast was requested and revealed Calcified abdomino-iliac arteries; Hazy stranding in the left and anterior peri-aortic regions from the infrarenal to prebifurcation regions, with associated few locules of air and prominent sized lymph nodes; these findings may relate to infectious aortitis. She was later referred to Rheumatology. Clinical findings revealed negative Rheumatoid factor test; elevated anti-cyclic citrulline peptide antibody; negative ANA IMF; and nonreactive HBsAg. A CT Aortogram was later requested showing abdominal aortitis with saccular outpouching in the lateral wall of the abdominal aorta at the level of the inferior mesenteric artery, likely a pseudoaneurysm related to aortitis. The rest of the aorta is atherosclerotic. It was later found out that she tested positive for Typhidot. Initial plan was to refer the patient to Vascular Surgery due to risk of rupture however due to financial limitations, medical management was maximized which included Ciprofloxacin 500mg/tab taken twice a day. This report highlights the significance of having a high index of suspicion for infectious causes of aortitis among immunocompromised patients for initiation of antibacterial prior to a possible surgical intervention.

29.

MASQUERADE: A CASE OF LUPUS MESENTERIC VASCULITIS MASKED BY HEPATIC ABSCESS

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BACKGROUND Systemic lupus erythematosus (SLE) is an autoimmune disease that causes widespread tissue damage. At its onset, it may involve one or several organ systems such as the skin, joints or kidneys but it is extremely rare to observe intestinal vasculitis and thrombosis in newly diagnosed SLE. In these patients, the myriad of etiologies of abdominal pain makes diagnosis more difficult.

CASE SUMMARY A 28-year old female came in due to persistent epigastric pain despite adequate treatment. Initial work ups were done which showed hepatic abscess and was given antibiotics. However multisystemic involvement: malar rash, arthritis, autoimmune hemolytic anemia, thrombocytopenia and nephritis prompted further investigation which eventually revealed Systemic Lupus Erythematosus with Antiphospholipid Syndrome. The diagnosis of mesenteric ischemia was made due to the presence of severe abdominal pain, minimal ascites on CT scan and a prompt response to high dose glucocorticoids.

CONCLUSION Early diagnosis and subjecting a patient to autoimmune testing requires a high index of suspicion since manifestations of SLE may be masked by several other conditions. Therefore, a careful history and PE should be done to reveal the multisystemic nature of SLE and initiate appropriate management.

30.

HEPATIC ARTERY ANEURYSM, MEDIUM-VESSEL VASCULITIS VERSUS FIBROMUSCULAR DYSPLASIA, IN A 25-YEAR-OLD FEMALE

Carmelindelle P. Maternal, MD ; Jose Paulo P. Lorenzo, MD | Makati Medical Center

BACKGROUND Hepatic artery aneurysm is rare yet relevant due to risk for increased mortality if it ruptures. This condition is associated with two considerations: fibromuscular dysplasia (FMD) and medium-vessel vasculitis, specifically polyarteritis nodosa (PAN). While arterial biopsy is the gold standard for diagnosis, characteristic angiographic findings and clinical features can contribute to accurate identification. This is a case report on a patient with sudden severe epigastric pain, multiple hepatic artery aneurysms diagnosed by arterial angiogram and clinically managed as PAN. Results:

CASE SUMMARY We present a case of a 25-year-old female with no comorbidities, presented with sudden severe epigastric pain and recurrent hematemesis. Imaging revealed acute cholecystitis and biliary obstruction, leading to emergency surgery for open cholecystectomy and common bile duct exploration. Hemobilia and blood clots in the common bile and left hepatic ducts were identified. A T-tube drain was inserted into the common bile duct. Histopathological examination of the gallbladder revealed hemangioma. Six days postoperatively, fresh bleeding was observed from the T-tube drain prompting celiac angiogram with findings of “rosary bead appearance” characteristic of aneurysms in the hepatic arteries and possible “nippling”, an evidence of a previous site of arterial rupture and bleed. Embolization of the right hepatic artery using Target-Nano-Detachable coils stopped the bleeding. Hepatic and arterial biopsies were omitted due to potential risks of bleeding. Erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) were elevated with antineutrophilic cytoplasmic antibody (ANCA) tested negative. In a Japanese provisional diagnostic criterion for PAN, the patient fulfilled four (4) criteria (92.3% sensitivity; 91.7% specificity), but this needs to be validated in a larger cohort. The patient was treated with corticosteroids, and regular consultations were advised to monitor disease progression.

CONCLUSION Hepatic artery aneurysm, a life-threatening condition causing intra-hepatic bleeding, requires timely recognition for appropriate management. While arterial biopsy is the definitive diagnostic tool, its bleeding risks prompt reliance on clinical parameters for diagnosis and treatment, underscoring the importance of recognizing it in cases of severe epigastric pain and hematemesis.

31.

IGA NEPHROPATHY IN SYSTEMIC LUPUS ERYTHEMATOSUS

Carmelindelle P. Maternal, MD; Augusto O. Villarubin, MD | Makati Medical Center

BACKGROUND Systemic lupus erythematous (SLE) is a multisystemic autoimmune disease that commonly presents with renal involvement, particularly lupus nephritis. The occurrence of SLE with other renal pathology is rarely reported in literature. IgA nephropathy, widely recognized as the most common primary nephropathy, is unusually described in SLE in the absence of lupus nephritis, as established by renal biopsy. Biopsy findings predominant of IgA mesangial deposits are the characteristic morphological features of this disease.

CASE SUMMARY We present a case of 33-year-old female, diagnosed with SLE, presenting with the following features: malar rash, joint pains, proteinuria, autoimmune hemolytic anemia, ANA with 1:320 titer and nuclear speckled pattern and positive anti-dsDNA. Monitoring of urine protein, creatinine and ratio showed worsening urine protein spillage. Renal biopsy was requested to determine the etiology of proteinuria. Histologic findings revealed mesangial hypercellularity, segmental endocapillary hypercellularity and mild interstitial fibrosis with tubular atrophy (20%). Immunofluorescence microscopy showed IgA (1-2+) and IgM (1+) mesangial deposition with absence of C3 and C1q, which is consistent with IgA nephropathy. Due to the clinical features of the patient, including autoimmune hemolytic anemia with high urine protein, she was considered at high risk for disease progression. The patient was managed with mycophenolate mofetil, hydroxychloroquine and prednisone and was advised regular follow up to monitor disease activity closely.

CONCLUSION Renal diseases such as IgA nephropathy may coexist with SLE in rare cases as reported in the literature. Although IgA nephropathy may have similar pathophysiologic features with lupus nephritis, it should be emphasized that these are two different diseases with distinct pathogenesis, and therefore, may have different implications on therapeutic options and renal outcomes. This report highlights that other than lupus nephritis, proteinuria in SLE patients may be a consequence of other renal pathology such as IgA nephropathy.

32.

FALLEN CROWN: CALCIUM PYROPHOSPHATE DEPOSITION DISEASE WITH RETRO-ODONTOID PSEUDOTUMOR FORMATION PRESENTING AS NUMBNESS AND WEAKNESS

Eloisa Trina C. Generoso, MD, Jose Paulo P. Lorenzo, MD | Makati Medical Center

BACKGROUND Calcium pyrophosphate deposition (CPPD) disease is a crystal-induced arthritis commonly affecting the elderly. Termed as ”Crowned Dens Syndrome” when it occurs around C1-C2, this can lead to the formation of subchondral cysts, erosions, and odontoid fractures. This study reports an unusual presentation of CPPD, to serve as an important differential in patients complaining of numbness and weakness.

CASE SUMMARY Patient was an 85-year-old Filipino female known to have osteoarthritis and chondrocalcinosis. She was referred for one-week history of progressive numbness and weakness of all extremities. On admission, the cervical spine range of motion was normal, however manual muscle testing (MMT) was grade 2/5 on all extremities. Computed tomography (CT) scan showed an unfused odontoid process from the body of C2 with surrounding soft tissue thickening with calcifications protruding into the spinal canal at C1-2 level causing severe stenosis and cord compression, to consider CPPD. She received intravenous dexamethasone, which improved MMT to grade 4/5. Workup showed normal inflammatory markers, and negative anti-Jo-1 antibody, rheumatoid factor, and anti-cyclic citrullinated protein. Neurosurgery performed C1-C2 laminectomy with fusion on the patient. On the 1st postoperative day, she developed sudden-onset motor strength loss, generalized numbness, and respiratory depression. She then underwent transoral odontoidectomy and removal of pannus. Routine histopathology showed fibrocollagenous tissue and cartilage with calcinosis consistent with pannus formation, while light microscopy confirmed the presence of CPPD crystals. Postoperatively, patient had recovery of sensation up to the C1- C4 dermatomal level and movement of both upper extremities.

CONCLUSION CPPD disease involving C1-C2 potentially poses an elevated risk for odontoid fractures, which with increased movement can cause chronic irritation resulting in retro-odontoid pseudotumor formation. Crystal deposition with pseudotumor development may be a potential cause of cervical myelopathy.

33.

A CASE OF DISSEMINATED TUBERCULOSIS CO-OCCURRING WITH VITAMIN D DEFICIENCY IN A MALE WITH SYSTEMIC LUPUS ERYTHEMATOSUS

Eloisa Trina C. Generoso, MD; Andrei Rhoneil M. Rodriguez, MD | Makati Medical Center

BACKGROUND Patients with systemic lupus erythematosus (SLE) are at increased risk for tuberculosis (TB) infection with pulmonary, extrapulmonary, and disseminated disease. Vitamin D plays a role in the expression of cathelicidin, a microbicidal peptide for Mycobacterium tuberculosis. Coincidentally, decreased levels of vitamin D have been documented in patients with SLE. This study presents an SLE patient, who was diagnosed with disseminated TB and vitamin D deficiency.

CASE SUMMARY
A case of a male with SLE, who developed disseminated TB co-occurring with vitamin D deficiency, was reviewed at a Philippine tertiary hospital. A 21-year-old male was diagnosed with SLE with nephritis, initially presenting with fatigue, joint pains, and edema. He was placed on dialysis after developing infections during treatment with methylprednisolone pulse therapy and cyclophosphamide. He was maintained on hydroxychloroquine and prednisone. Three years later, patient complained of low-grade fever and joint pains for one month. Workup done showed severe anemia (Hb 6.5 g/dL, N 12.3-16.0), hence he underwent blood transfusion and was prescribed moderate-dose steroids to cover for lupus activity. Workup for fecal immunochemical test and Xpert MTB/RIF assay were positive, thus he was given dexlansoprazole and anti-Koch's medications. One week later, he consulted at the emergency department for severe right upper quadrant abdominal pain. Further tests revealed: presence of sputum acid-fast bacilli; circumferential bowel wall thickening involving the ileum, cecum, and colon, and lymphadenopathy on whole abdominal computed tomography scan; and low vitamin D level (13.73 ng/mL, N >30.00 ng/mL). He was diagnosed with disseminated TB, and vitamin D deficiency. Anti-Koch's medications were continued, and the patient received vitamin D supplements. On the 7th hospital day, fever and abdominal pain resolved, while hemoglobin stabilized. Patient was discharged improved.

CONCLUSION TB is an important cause of morbidity in patients with SLE, as a dysregulated immune system further compromised by immunosuppressive drugs contributes to higher incidence and increased severity. Given its immunomodulatory property, vitamin D may serve as an adjunct in SLE patients undergoing treatment for TB.

34.

METHIMAZOLE-INDUCED LEUKOCYTOCLASTIC VASCULITIS

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OBJECTIVE To discuss a case involving a patient with drug-induced vasculitis secondary to methimazole

BACKGROUND Vasculitis is a diverse autoimmune disease that can affect the small, medium and large vessels and may occur in individuals of all ages. In particular, small vessel vasculitis may develop after certain infections or medications. Clinical features include palpable purpura affecting the lower extremities. Specifically, drug-induced vasculitis is one of the major adverse effects of antithyroid drugs and has been rarely observed with methimazole.

CASE SUMMARY We describe a case of a 51-year-old woman who was prescribed methimazole for thyrotoxicosis. After one week of therapy, the patient developed palpable, non-blanching patches on the lower extremities. Autoimmune serology tests were unremarkable. A diagnosis of leukocytoclastic vasculitis was confirmed after skin punch biopsy. Methimazole was discontinued and intravenous corticosteroid was initiated and with resolution of symptoms. The patient was discharged improved with tapering doses of oral corticosteroids.

CONCLUSION We report an unusual case of methimazole-induced vasculitis, which manifested after a week of drug exposure. Discontinuation of the culprit drug is the key to prevent disease progression.

35.

MIDDLE CEREBRAL ARTERY STENOSIS AS AN UNUSUAL INITIAL PRESENTATION OF SJÖGREN'S SYNDROME: A CASE REPORT

Joseph Peter T. Lim, MD; Andrei Rhoneil M. Rodriguez, MD | Makati Medical Center

BACKGROUND Sjögren's syndrome (SS) is an autoimmune disorder characterized by glandular inflammation, presenting with symptoms such as dry eyes, dry mouth, and parotid gland swelling. Although neurological involvement in the form of peripheral sensory neuropathy is common, central nervous system manifestations can also occur, as seen in a newly diagnosed patient with Sjögren's syndrome presenting with middle cerebral artery stenosis.

CASE SUMMARY A 28-year-old Filipina presented with a persistent, throbbing headache, blurred vision, and dry eyes. Further investigation with cranial imaging and CT angiography revealed stenosis in the left anterior cerebral artery. She was prescribed medications for headache relief and referred for evaluation. Laboratory results showed positive antibodies for Sjögren's syndrome and a history of Graves' disease.

DISCUSSION Sjögren's syndrome is characterized by autoimmune attack on exocrine glands, resulting in dry eyes and dry mouth. Vasculitis is a common extraglandular manifestation of the syndrome. Diagnostic criteria include ophthalmic and oral symptoms, histopathological examination, salivary gland tests, and autoantibody presence. Central nervous system complications in Sjögren's syndrome involve inflammation, as indicated by cerebrospinal fluid abnormalities. Treatment typically involves corticosteroids and immunosuppressive agents, and the patient was given prednisone, hydroxychloroquine, and vitamin D supplementation, resulting in improved headaches but continued dry eye symptoms.

CONCLUSION This case report highlights an unusual initial presentation of Sjögren's syndrome with middle cerebral artery stenosis. Although Sjögren's syndrome is primarily characterized as an autoimmune disorder affecting exocrine glands, it can also involve other organs, including the development of vasculitis. While peripheral neuropathy is a more common presentation, this case emphasizes the importance of considering unusual manifestations of Sjögren's syndrome in clinical practice.

36.

SILENT SWELLING: UNVEILING THE ENIGMA OF LUPUS NEPHRITIS WITH MEMBRANOUS INVOLVEMENT

Joseph Peter T. Lim, MD; Andrei Rhoneil M. Rodriguez, MD | Makati Medical Center

BACKGROUND Systemic lupus erythematosus (SLE) is a complex autoimmune disease characterized by immune system activation and the generation of autoantibodies. Musculoskeletal and cutaneous symptoms were most commonly observed, but renal manifestations were prevalent at 50% or more. Asians were found to have higher rates compared to white populations. The KDIGO guidelines indicated that Class V lupus nephritis accounts for 5%-10% of all cases. In a study by Venegas et al., among Filipinos with lupus nephritis, Class IV was the most prevalent. Extensive literature review revealed that there is a lack of reported lupus nephritis Class V among adult Filipinos despite.

CASE SUMMARY A 30-year-old nulligravid Filipina with impaired fasting glucose and polycystic ovarian syndrome presented with bipedal pitting edema and nephrotic range proteinuria. Work-up revealed ANA at 1:1280 (nuclear speckled), positive antibodies for anti-Smith, anti-RNP70, and anti-SSA, and negative results for anti-ds DNA, anti-SSB, and anti-JO1. Complement levels were low, with a random urine protein-creatinine ratio of 32.82. The patient underwent kidney biopsy and revealed Lupus nephritis based on International Society of Nephrology/Renal Pathology Society (ISN/RPS) criteria as Class V with an activity index of 0 and chronicity index of 3 characterized by 3% segmental glomerulosclerosis, mild interstitial fibrosis, and tubular atrophy. Immunofluorescence microscopy demonstrated the presence of anti-human IgG, IgA, IgM, C3, C1q, and fibrinogen deposition in 8 glomeruli. She was started with tacrolimus, prednisone, hydroxychloroquine, and calcium and vitamin D supplementation.

CONCLUSION This case report describes a patient with SLE who presented with nephrotic range proteinuria, diagnosed as a case of Class V (membranous) lupus nephritis. Treatment consisted of immunosuppressive agents, renin-angiotensin system blockade, and blood pressure control. Close follow-up is crucial for optimal management in lupus nephritis patients. The case highlights the importance of early diagnosis, kidney biopsy, appropriate treatment, and vigilant monitoring in improving prognosis and quality of life for individuals with Class V lupus nephritis.

37.

STEROID-REFRACTORY FULMINANT IMMUNE CHECKPOINT INHIBITOR (DURVALUMAB)-RELATED MYOCARDITIS IN A PATIENT WITH INTRAHEPATIC CHOLANGIOCARCINOMA

Abigail L. Ting, MD; Augusto O. Villarubin, MD | Makati Medical Center

OBJECTIVE To discuss a care involving a patient with intrahepatic cholangiocarcinoma who experienced durvalumab-related myocarditis and was treated with corticosteroids.

BACKGROUND Tocilizumab is a humanized monoclonal interleukin-6 inhibitor that is used for the treatment of many immune- mediated diseases including autoimmune, chronic inflammatory, and auto-inflammatory diseases. Durvalumab, a fully human immunoglobulin G1K monoclonal antibody targeting CD80 receptors and PDL-1, via T- cell inhibition, is an emerging treatment for cholangiocarcinoma. However, increased risk of catastrophic immune- related side effects such as myocarditis have been seen. Steroids continue to be the cornerstone for therapy for immune related myocarditis. However there is no consensus regarding immunosuppressive treatment for steroid- refractory cases.

CASE SUMMARY
A 46-year-old female with intrahepatic cholangiocarcinoma experienced fulminant immune-related myocarditis three weeks after the first cycle of PDL-1 inhibitor therapy, durvalumab. She experienced sudden-onset dyspnea with evidence of left ventricular global hypokinesia with a low ejection fraction and non-ischemic pattern comprising multiple areas of the myocardium on echocardiography and contrast-enhanced cardiac MRI were seen respectively, indicating fulminant myocarditis. Methylprednisolone 1 gram pulse therapy was given but there was no substantial improvement from baseline noted on repeat echocardiography. Tocilizumab was then administered and immediate improvement was noted.

CONLCUSION IL-6 is a key mediator of acute and chronic inflammation, promoting T-cell survival, expansion, and proliferation. It can promote increase in acute phase reactants as well as accummulation of mononuclear cells resulting to angioproliferation and vascular permeability. Tocilizumab, an IL-6 inhibitor, is being used in various theraupeutic strategies and is a recommended treatment option for steroid-refractory immune checkpoint inhibitor related myocarditis.

38.

PSEUDO-PSEUDO MEIG'S SYNDROME AS THE INITIAL PRESENTATION OF SYSTEMIC LUPUS ERYTHEMATOSUS IN A 41-YEAR-OLD FILIPINA: A CASE REPORT

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INTRODUCTION Systemic lupus erythematosus (SLE) is a chronic inflammatory autoimmune disease typically affecting women of childbearing age. It is a multigenic disease which involves immune complex deposition within organ systems leading to widespread subsequent complement activation and generation of antinuclear autoantibodies Serositis is seen in approximately 12% of patients with systemic lupus erythematosus (SLE), usually in the form of pleuritis and/or pericarditis. Ascites in SLE is rarely massive and ascites as an initial presenting clinical sign of SLE is even rarer. Ascites, when associated with pleural effusion and raised CA-125 levels in SLE patient, is known as Pseudo-Pseudo Meigs' syndrome (PPMS). This is a newly emerging manifestation of SLE and only a few cases have been published. To our knowledge, there have only been twenty-one other reported cases in literature. To date, this is the second case reported in the Philippines.

CASE SUMMARY We report a 41-year-old female, Filipino, with no known comorbidities.She presented with a 2 month history of abdominal enlargement with constitutional symptoms. Chest X-ray and whole abdominal ultrasound confirmed the presence of bilateral pleural effusion and massive ascites. The more common etiologies of polyserositis such as infection and malignancy were initially considered however work-up turned out negative. During her course, she started to develop malar rash and oral ulcers. The presence of ascites, pleural effusion, and elevated CA-125 in the absence of ovarian or pelvic tumors in a patient presenting with the more common manifestations of SLE led to the consideration of Pseudo-pseudo Meigs' Syndrome. Autoimmune workup was done and the presence of positive immunologic markers confirmed the diagnosis of SLE. . She was then started on steroids and hydroxychloroquine which led to the complete resolution of the pleural effusion and ascites.

CONCLUSION This case adds to reported rare cases of PPMS as the initial presentation of SLE. It is also only the second reported case in the Philippines. Physicians need to recognize PPMS earlier so that timely and appropriate treatment may be given to these patients.

39.

CASE REPORT: SYNDROME OF REMITTING SERONEGATIVE SYMMETRICAL SYNOVITIS WITH PITTING EDEMA IN A FEMALE PATIENT WITH OVARIAN MASS

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OBJECTIVE To describe a case of remitting seronegative symmetrical synovitis with pitting edema (RS3PE) syndrome and its correlation with malignancy.

CASE SUMMARY A 51-year-old female, Filipino, hypertensive and diabetic, presented with a 2-week history of pain and edema on both upper and lower distal extremities, resulting in difficulty in ambulation. Pertinent physical examination findings include pitting edema on the dorsum of both hands, as well as swelling and tenderness on both wrists, metacarpophalangeal, and proximal interphalangeal joints. Tenderness and swelling were also noted on both lower extremities, particularly the knees, ankles, and metatarsophalangeal joints. Cardiac, liver, endocrine, and infectious workups were unremarkable. Inflammatory markers were elevated, while rheumatoid factor was negative. Plain radiographs of extremities showed degenerative changes consistent with osteoarthritis; no erosions were evident. A diagnosis of remitting seronegative symmetrical synovitis with pitting edema (RS3PE) was made based on the following criteria: bilateral pitting edema of dorsum of the hands, sudden onset of polyarthritis, age >50yrs old, and a negative rheumatoid factor.

Patient was started on Prednisone 20 mg/day and a significant improvement of arthritis and edema were noted. She was then discharged with tapering doses of prednisone until it was discontinued over 4 weeks. Remission was sustained months after discontinuation of prednisone. Knowing its correlation with malignancy, diagnostic workups were done for surveillance of a possible tumor burden. Thyroid nodules were seen 5 months later, while an ovarian mass was seen on ultrasound 9 months later. She was then referred to the respective specialty for further evaluation and possible biopsy of masses.

CONCLUSION A diagnosis of RS3PE is made based on appropriate clinical criteria. A good response to corticosteroid is expected. Once the diagnosis is made, prompt surveillance for malignant tumors is essential in managing this case.

40.

A CLOSER LOOK: GRANULOMATOSIS WITH POLYANGIITIS COMPLICATED WITH NECROTIZING ANTERIOR SCLERITIS AND PERIPHERAL ULCERATIVE KERATOPATHY

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INTRODUCTION Ocular symptoms are observed in 40% of individuals with granulomatosis with polyangiitis (GPA). In up to 20% of patients, these may serve as the initial manifestation of the disease.

CASE SUMMARY A 42-year-old female was referred by her ophthalmologist to rheumatology for work-up after a 10-month history of progressive blurring of vision, redness, and photophobia on the left eye. She was initially managed with topical antibiotics and anti-inflammatory medications which did not improve her eye symptoms. Visual acuity was 20/20 on the right and hand movement with good light projection on the left eye. Slit lamp examination showed areas of scleral thinning on the right eye. The left eye showed thinning of the conjunctiva and scleral edema superiorly, thin and hazy cornea with bullae, and neovascularization. Rheumatology service found that she was experiencing rhinitis and exertional dyspnea concurrently with her eye problems. She also had a saddle nose deformity. C-ANCA, ANA, and Rheumatoid factor were positive. She was diagnosed with Granulomatosis with Polyangiitis, complicated with diffuse necrotizing anterior scleritis with peripheral ulcerative keratopathy (PUK) of the left eye and scleromalacia perforans on the right eye. She was managed with high-dose corticosteroids and pulsed cyclophosphamide infusion. On her most recent consult, visual acuity remained the same for both eyes, with no new areas of scleritis or scleral thinning of the right eye. Conjunctival hyperemia and scleral edema of the left eye were also decreased.

DISCUSSION Ocular manifestations of GPA include scleritis, PUK, and orbital inflammation that are severe enough for other symptoms key to the diagnosis to be disregarded by the patient and missed by clinicians. Delay in diagnosis and treatment may lead to irreversible damage in up to 8% of patients.

CONCLUSION This case highlights the importance of recognizing the ocular involvement in GPA, which may serve as its initial presentation. Failure to recognize these may result in treatment delay and complications.

41.

A TALE OF TWO SYNDROMES: A CASE OF MAY-THURNER SYNDROME IN SYSTEMIC LUPUS ERYTHEMATOSUS WITH ANTIPHOSPHOLIPID ANTIBODY SYNDROME

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INTRODUCTION May-Thurner Syndrome (MTS) is a rare condition in which a patient develop iliofemoral deep vein thrombosis (DVT) from an anatomical variant where the right common iliac artery overlies and compresses the left common iliac vein against the lumbar spine. In Systemic Lupus Erythematosus, (SLE) there is an increased risk of thrombosis especially in the presence of antiphospholipid antibodies. We present a case of MTS in SLE successfully treated with immunosuppression, anticoagulation, and endovascular surgery.

CASE SUMMARY A 31 year old female admitted for 2 day history of sudden left leg swelling associated with pain, bluish discoloration of the digits, and decreased pulse. DVT screening showed an acute to subacute DVT of the left distal external iliac vein to distal popliteal vein. On baseline laboratory examination, she had a hemoglobin of 6.6g/dl and a platelet count of 61,000, peripheral blood smear of dimorphic red blood cells with marked anisocytosis, and a positive direct antiglobulin test. She was then diagnosed with Evan's Syndrome. On further work up, antinuclear antibody was positive with high titer of anticardiolipin antibodies, diluted Russell viper venom time, and lupus anticoagulant. She was diagnosed with SLE with secondary antiphospholipid antibody syndrome (APS) and received methylprednisolone pulse therapy 500mg for 3 days. Computed Tomography angiography (CTA) showed a thrombus from left proximal end of external iliac to popliteal vein overlying the lumbar spine with only 10-20% lumen patency, consistent with May-Thurner Syndrome. She underwent AngioJetTM thrombectomy, venography, venoplasty and stenting and discharged with prednisone 30mg/day, warfarin 5mg/day, hydroxychloroquine 200mg/day and folic acid 5mg daily.

DISCUSSION Because of the turbulent flow created by this rare anatomic variation, it is probable that the development of May Thurner Syndrome was worsened by the hypercoagulable state from SLE with secondary APS. The standard of care involves combination of endovascular intervention, thrombolytics, and a lifelong oral anticoagulation with target INR 2.0-3.0 and immunosuppression.

42.

INTESTINAL BEHCET'S DISEASE COMPLICATED WITH ILEAL TUBERCULOSIS

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INTRODUCTION Among the multisystemic manifestations of Behcet's Disease (BD), gastrointestinal BD is associated with significant morbidity and mortality. It shares the same clinical picture with gastrointestinal tuberculosis (GITB) making its diagnosis a challenge and pose misdiagnosis.

CASE SUMMARY We report a case of a 58-year old female with BD presenting with recurrent oral and genital ulcers, and positive pathergy test and was treated with oral prednisone 0.5mg/kg/day and colchicine 500mcg/tab BID. 14 months after diagnosis, she had recurrent abdominal pain and hematochezia. Initial colonoscopy showed an irregularly shaped clean based ulcer at the terminal ileum and non-specific proctocolitis. Histopathology revealed a chronic active inflammation with lymphocytic vasculitis, ulcer debris and granulation tissue with mucosal change, negative for dysplasia. Ileal TB Polymerase Chain Reaction (TBPCR) was negative and was given oral prednisone at 0.5mg/kg/day, azathioprine 100mg/day, and mesalazine. After a month, she was readmitted for severe abdominal pain, hematochezia, and fever. Abdominal Computed Tomography showed distal ileum enteritis and acute appendicitis. She was diagnosed with acute appendicitis reactive to active intestinal BD which she underwent laparoscopic appendectomy and methylprednisolone pulse therapy 1000mg for 3 days. Repeat colonoscopy showed clean-based ulcers at the distal ileum near the ileocecal valve. Repeat Ileal TBPCR now tested positive for Mycobacterium tuberculosis (MTB) and was started on quadruple Anti-Koch's regimen.

DISCUSSION The diagnosis between GITB from BD remain a diagnostic challenge as the role of TBPCR in intestinal biopsies has been less studied, with 8.1% sensitivity and 100% specificity. The possibilities in this case is that the patient had concomitant GITB from the onset or the patient contracted GITB from prolonged steroid use.

CONCLUSION GITB and BD exhibit similarities but treatment differs substantially. This highlights importance of suspicion of GITB in BD with chronic steroid use. The case also demonstrates that with negative TBPCR, the diagnosis of GITB should be considered despite colonoscopic features consistent with BD.

43.

AN UNSUAL CASE OF GOUT AND SEPTIC ARTHRITIS DUE TO CANDIDA TROPICALIS IN A SINGLE JOINT OF A PATIENT WITH ACUTE MYELOID LEUKEMIA

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INTRODUCTION
Arthritis in Acute Myeloid Leukemia (AML) patients can arise from the disease itself or treatment-related factors, including secondary gout and, rarely, infections. Septic arthritis due to Candida infection is considered rare, with limited case reports available. However, the coexistence of gout and fungal arthritis in the context of AML has not been well-documented. In this case presentation, we describe the unique case of a 42-year- old male with AML who developed acute right knee pain, later diagnosed with both Candida tropicalis and gout.

CASE SUMMARY A 42-year-old male, diagnosed with AML a year ago, underwent chemotherapy during the past year. Gouty arthritis was identified earlier due to knee pain, swelling, and elevated uric acid levels. Treatment with febuxostat and colchicine was initiated. In a recent chemotherapy session, he experienced warmth, erythema, and limited movement in the right knee on the second day. Arthrocentesis revealed inflammatory arthritis with a synovial fluid white blood cell count of 15,000 X 106 and 99% neutrophils. Monosodium urate crystals were seen thus confirming Gouty Arthritis. Culture revealed Candida tropicalis, indicating concomitant fungal arthritis. Treatment with fluconazole, amphoteric B, colchicine, and prednisone led to the resolution of arthritis. Unfortunately, the patient developed shock due to bacterial pneumonia and succumbed on the 39th hospital day.

DISCUSSION Candidal arthritis is infrequent, often associated with immunodeficient responses and joint diseases. Previous reports have linked Candida arthritis to AML, insulin-dependent Diabetes Mellitus, and neurinoma removal. However, there is limited literature on the simultaneous coexistence of Candida arthritis and gout in AML.

CONCLUSION This report highlights a rare case of acute right knee pain in AML with the coexistence of Gout and Candida tropicalis. While cases of Candidal arthritis are documented, the simultaneous presence of Gout in the context of AML is exceptionally rare. Despite intensive antifungal and antibiotic therapy, the patient succumbed to infection-related complications.

44.

A RARE COEXISTENCE: CUTANEOUS POLYARTERITIS NODOSA AND SYSTEMIC LUPUS ERYTHEMATOSUS

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INTRODUCTION While cutaneous polyarteritis nodosa (cPAN) is already a rare subset of polyarteritis nodosa, its occurrence alongside with systemic lupus erythematosus (SLE) is infrequently documented in the medical literature.

CASE SUMMARY A 25-year-old female presented with a 4-month history of ulcerative non-healing wounds on both feet, accompanied by pain. The initial lesions were described as erythematous to violaceous macules and papules, which gradually progressed to form hemorrhagic bullae. Subsequently, these bullae ruptured spontaneously, leaving tender round ulcers on the dorsal aspect of both feet. Examination revealed multiple, well- defined, tender, round to ovoid ulcers with a red base, serous fluid, minimal yellow fibrinous exudate, and undermined violaceous borders, measuring on bilateral ankles and dorsum of the feet. Laboratories showed elevated ESR (49), CRP (5.3), and persistent proteinuria in urinalysis, with a UPCR of 2g/day. Antinuclear antibodies were positive +2 homogenous using immunofluorescence 1:80, anti-dsDNA was elevated at 20.4, and lupus anticoagulants antibodies were high. Biopsy results showed septal panniculitis with vasculitis, suggestive of polyarteritis nodosa. A diagnosis of cutaneous polyarteritis nodosa associated with systemic lupus erythematosus was made. She was started on prednisone and daily wound care was done in which she responded well and surgical intervention was not warranted. She was discharged with prednisone and methotrexate. Patient is yet to follow up in the outpatient clinic for further work-up of the probable nephritis and additional immunosuppressive drug needs.

DISCUSSION This case emphasizes the significance of recognizing and addressing rare coexisting autoimmune disorders, contributing to a better understanding of their intricate relationships and aiding in the development of tailored treatment strategies. Currently, there is no existing report of an adult patient with cPAN and SLE.

CONCLUSION Understanding the mechanisms underlying this uncommon association could provide valuable insights into the complex interplay of autoimmune diseases. Further research is needed to explore the potential links between cPAN and SLE, shedding light on shared pathogenic pathways.

45.

NAVIGATING LIMB ISCHEMIA: A CASE OF TAKAYASU ARTERITIS WITH PROBABLE ANTIPHOSPHOLIPID ANTIBODY SYNDROME

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INTRODUCTION Takayasu arteritis (TA) and antiphospholipid antibody syndrome (APS) are two diseases that affect the vasculature through different mechanisms, inflammation and hypercoagulability. This report aims to describe the unusual coexistence of both conditions in a young Filipina with critical limb ischemia.

CASE SUMMARY In February 2008, a 29-year-old Filipino woman was admitted to the Philippine General Hospital with progressing bilateral lower limb claudication for 2 months, gradual onset of bluish to violaceous skin discoloration of the left foot, and difficulty in ambulation. Doppler examination revealed severe critical limb ischemia with total occlusion of the popliteal artery at the left leg and of the tibial artery at the right and stenosis of the popliteal artery at the right. The angiogram of the lower extremities showed bilateral peripheral occlusive disease and total occlusion of bilateral femoral arteries. She was simultaneously diagnosed with bilateral peripheral arterial disease and Takayasu arteritis, based on American College of Rheumatology criteria—age onset < 40, claudication of extremities, and abnormal angiogram results. Probable APS was also considered based on the history of two pregnancy losses and elevated lupus anticoagulant and weakly positive anticardiolipin antibodies. She underwent a femoral-posterior tibial artery bypass in the left lower extremity and ray amputation of the left big toe. During the next 15 years, she was maintained on prednisone, methotrexate, and warfarin. There was no recurrence of symptomatic leg ischemia or onset of other vascular events.

DISCUSSION Identifying TA in young patients with bilateral limb ischemia, especially those without conventional atherosclerosis risk factors, is crucial. The coexistence of APS adds complexity to the case, with limited literature on the TA-APS association.

CONCLUSION Clinicians should consider the possibility of multiple causes of limb ischemia, stressing the need for comprehensive differential diagnoses. Research is needed to investigate the effect of coexistent TA and APS in the clinical course and prognosis of patients with these conditions.

46.

ACUTE MYOCARDIAL INFARCTION SECONDARY TO TRIPLE VESSEL CORONARY ARTERY DISEASE IN A YOUNG FEMALE WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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INTRODUCTION Cardiovascular disease is the leading cause of mortality in systemic lupus erythematosus (SLE). The incidence of myocardial infarction (MI) in SLE is at 9.6/1000 person-years, with an onset of 10 years earlier than the general population. However, the occurrence of triple vessel coronary artery disease (CAD) as seen in our young patient with SLE has seldom been observed.

CASE SUMMARY A 31-year-old non-smoking Filipino female with a 13-year history of SLE nephritis, in low disease activity for 4 years, presented with acute chest pain. Comorbidities include hypertension and probable antiphospholipid syndrome. Troponin I was elevated, and the electrocardiogram showed inferior wall MI, consistent with ST-segment elevation myocardial infarction (STEMI). Coronary angiography revealed triple-vessel CAD, with 80-90% stenosis of the left circumflex artery, and total occlusion of the left anterior descending and right coronary artery. Other findings were an ejection fraction of 44% and segmental wall motion abnormalities on echocardiography, dyslipidemia, normal hemoglobin, platelets, white cell counts and serum C3, and low anti-dsDNA. The patient refused to undergo coronary artery bypass grafting. Medical management, consisting of dual antiplatelets, statin, and anticoagulation with enoxaparin then warfarin, was maximized. There was no recurrence of chest pain during the following 6 months of observation.

DISCUSSION The primary mechanism leading to accelerated atherosclerosis in SLE is immune-mediated inflammation. Presence of antiphospholipid antibodies, glucocorticoid use and traditional cardiovascular risks factors also contribute to the premature development of CAD in SLE.

CONCLUSION Current cardiovascular recommendations for rheumatic diseases are similar to the general population. However, clinicians should maintain a proactive approach by effectively managing disease activity and controlling traditional risk factors in patients with SLE.

47.

ADULT-ONSET STILL'S DISEASE IN A YOUNG ADULT PATIENT PRESENTING AS FEVER OF UNKNOWN ORIGIN TREATED WITH TOCILIZUMAB: A CASE REPORT

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INTRODUCTION Adult-onset Still's disease (AOSD) is a rare systemic inflammatory disorder characterized by quotidian pattern of fever in the absence of infections, malignancies, and rheumatic diseases. Other features include evanescent rash, arthralgia, sore throat, lymphadenopathy, splenomegaly, leukocytosis, liver dysfunction, and negative anti-nuclear antibody (ANA) and rheumatoid factor (RF). AOSD has been associated with markedly elevated serum ferritin concentrations.

CASE SUMMARY

We report a case of a 29-year-old female presenting with fever with maximum temperature of 40C for 1 month duration, evanescent rash, sore throat, myalgia, arthralgia, and rash. Laboratory examination showed leukocytosis (WBC 18,400), transaminitis (ALT 175, AST 281), and hyperferritinemia (63,281ng/mL). Extensive work-up to look for infectious and malignant causes were unremarkable. ANA and RF were both negative. She was able to fulfill the Yamaguchi classification criteria for the diagnosis of AOSD. Glucocorticoid therapy was started, however, she remained to be symptomatic. Increased levels of interleukin-6 (IL-6) and other pro-inflammatory cytokines have been shown in AOSD. Tocilizumab is an IL-6 receptor antagonist monoclonal antibody that can be used as an alternative to anakinra. The patient received tocilizumab at a dose of 8 mg/kg with immediate relief of symptoms. Serum ferritin and transaminase levels decreased to 5105ng/mL and 126 U/L, 85 U/L, respectively.

CONCLUSION In this case report, tocilizumab is an effective and well-tolerated treatment option for patients with AOSD with predominantly systemic symptoms.

48.

PSEUDO-PSEUDO MEIGS' SYNDROME AS THE INITIAL MANIFESTATION OF SYSTEMIC LUPUS ERYTHEMATOSUS IN A YOUNG FILIPINO FEMALE: A CASE REPORT

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INTRODUCTION Pseudo-pseudo Meigs' syndrome (PPMS) is characterized by the triad of ascites, pleural effusion, and elevated CA-125 in the absence of benign or malignant tumors. Few reports have cited it as a possible initial manifestation of systemic lupus erythematosus (SLE). Although its pathogenesis is unclear, it may be due to uncontrolled severe inflammation of the serosa. Thus far, only two cases have been reported in The Philippines.

CASE SUMMARY We present the case of a 31 year old Filipino female, who came in due to increasing abdominal girth. She had fever, vomiting, and epigastric pain. History revealed that she was previously diagnosed as having immune thrombocytopenic purpura, given corticosteroids. Physical examination showed ascites, with an abdominal girth of 89 centimeters. She likewise had bipedal edema.

One organ ultrasound showed 664 milliliters of fluid. Whole abdominal computed tomography scan revealed moderate ascites in the bowel regions. No abdominopelvic masses were visualized. Transvaginal ultrasound did not show any masses. Tumor markers revealed elevated Cancer Antigen - 125 (CA-125) and Human Epididymis Protein 4 (HE4). Further workup revealed pleural and pericardial effusion.

Serologies showed Anti-Nuclear Antibody (ANA) seropositivity, with a titre of 1:160, and a homogeneous pattern. Anti-dsDNA and Anti-SSA were seropositive. C3 and C4 were low. She met the SLE ACR/EULAR Criteria, with a score of 25 points. SLEDAI score was at 12 points, showing that she is in mild to moderate flare. No tumors were visualized in the workup.

She was given hydroxychloroquine and glucocorticoids, which addressed the lupus flare manifesting as abdominal symptoms.

CONCLUSION Despite its rarity, it is crucial to recognize PPMS as an initial manifestation of SLE. It is an important differential diagnosis in female patients with ascites, pleural effusion, and elevated CA-125. Treating the underlying SLE flare also addresses PPMS.

49.

ELDERLY-ONSET SYSTEMIC LUPUS ERYTHEMATOSUS FOLLOWING COVID-19 INFECTION PRESENTING AS PULMONARY FIBROSIS: THE FIRST REPORTED CASE IN THE PHILIPPINES

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INTRODUCTION Long-term effects of COVID-19 infection are still an area of ongoing research, with some reports postulating that immune reactions against viral antigens can lead to autoimmunity. In January 2021, Systemic Lupus Erythematosus (SLE) following COVID-19 Infection was first described. Paucity of data remains to be a concern, specifically in the elderly population in whom SLE is thought to be atypical.

CASE SUMMARY We present the case of a 71 year old female, Filipina, who presented at the Emergency Room for respiratory distress. She had pneumothorax secondary to ruptured blebs from COVID-19 fibrosis. Worsening sensorium and persistent desaturations prompted intubation. She had no known autoimmune disease. She acquired COVID-19 pneumonia fourteen months prior to hospitalization, with subsequent vaccination of the BNT162b2 mRNA vaccine for 2 doses. Her sister has SLE, and her daughter has Graves' Disease. Initial physical examination showed no alopecia, malar rash, mucosal ulcers, and active synovitis.

Ancillaries revealed Anti-Nuclear Antibody (ANA) of 1:160 with Speckled Pattern. Anti-Double Stranded DNA (Anti-dsDNA) was positive at 21.10 U/mL. She had the following features: fever, thrombocytopenia, autoimmune hemolysis, delirium, proteinuria, and positivity of Anti-dsDNA. SLE 2019 EULAR/ACR Criteria was met, with a score of 16 points. Perinuclear – Anti-Neutrophil Cytoplasmic Antibody (p-ANCA) was positive at a titre of 1:80. She was maintained on corticosteroids and hydroxychloroquine.

Mesenteric ischemia, new onset malar rash, and thrombocytopenia soon ensued. Disease activity of SLE was determined to be in severe flare (SLEDAI 25). Methylprednisolone pulse therapy was initiated and tolerated well. Worsening oxygenation status and cardiac arrhythmias prompted the relatives to seek advanced directives. The patient expired.

CONCLUSION To date, there are 8 globally-published cases of SLE developing after COVID-19 infection. To our knowledge, this is the first reported case of elderly-onset SLE following COVID-19 infection presenting as pulmonary fibrosis in The Philippines. With this, we challenge the long-held notion, shift the paradigm, and conclude that SLE may present in the elderly population in association with COVID-19 infection.

50.

SUCCESSFUL IVIG AND GLUCOCORTICOID TREATMENT IN A FILIPINO FEMALE WITH AUTOIMMUNE ENCEPHALITIS: A CASE REPORT

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INTRODUCTION Autoimmune encephalitis (AIE) is an immune mediated condition that causes acute brain inflammation . It is thought to be an overwhelming response to neuronal self-antigen. Antibodies in AIE induce inflammation by targeting specific neuronal proteins. The incidence of encephalitis in adult varies between 0.7 to 12.6 per 100,000. There is still limited data in autoimmune encephalitis due to its variable presentation and possible antibodies involved in its pathomechanism.

CASE SUMMARY A 35 year old female who initially presented with one week history of sleep disturbance and generalized malaise. She had no underlying systemic disease, nor intake of alcohol or substance abuse. On initial evaluation at the Emergency Department, she had stable vital signs and was afebrile, with good orientation and appropriately answers to questions . Work up showed hyponatremia at 127.5 with leukopenia 2,980. She was initially managed Primary Insomnia , Euvolemic Hyponatremia and Urinary Tract Infection. Six hours later, she developed new onset fever, tachycardia, with slow response time and blank stares. Examination demonstrated supple neck, MMTs 3/5 on upper and lower extremities.Cranial MRI and EEG were unremarkable. CSF fluid analysis revealed Total Cell count 0 , elevated CSF IgG 12,400 , CSF Protein elevated at 64.1 . Infectious work up and encephalitis panel were negative. Autoimmune workup revealed ANA 1:320 Homogenous pattern, Hypocomplementemia C3 42.80 , C4 13.70, pANCA positive, with elevated IL-6. IV Immunoglobulin for 5 days and Methyprednisolone pulse therapy 1 gram for 3 days was were initiated with marked improvement in her neurologic status. With continuous physical and occupational therapy, the patient was subsequently discharged improved . The patient is maintained on tapering oral glucocorticoids.

CONCLUSION Autoimmune encephalitis can manifest initially in various ways. Early recognition and treatment are needed to avoid neurological sequelae and complications. Delay in immunotherapy may contribute to poor outcomes.

51.

RHEUMATOID ARTHRITIS AND ACUTE PANCREATITIS INITIALLY PRESENTING AS JAUNDICE AND JOINT SWELLING IN A FILIPINO FEMALE WITH END-STAGE RENAL DISEASE

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BACKGROUND Few studies have cited the increased risk of developing acute pancreatitis in patients with rheumatoid arthritis.

CASE SUMMARY Here is a case of a 56-year-old female, hypertensive, diabetic, end- stage renal disease, hemodialysis requiring, who was initially admitted for pneumonia and cellulitis but during her course of admission developed jaundice, epigastric pain, fever, petechiae and symmetrical polyarthritis.

Initial work-ups done revealed predominantly conjugated hyperbilirubinemia (Total Bilirubin of 5.08 mg/dL Conjugated Bilirubin of 4.32 mg/dL Unconjugated bilirubin of 0.76 mg/dL) elevated alkaline phosphatase of 221 U/L and neutrophilic leukocytosis (WBC count of 17590, neutrophil count of 73%). Whole abdominal ultrasound revealed a partially contracted gallbladder, non-dilated common bile duct while the Magnetic resonance cholangiopancreatography (MRCP) showed prominence of the pancreatic head with peri-pancreatic stranding and minimal fluid is of concern for pancreatitis with no noted biliary ductal dilatation and filling defects to suggest intraluminal lithiasis.

Lipase was then requested which was > 28 times elevated (1496 U/L). Patient was then assessed to have Acute pancreatitis secondary to cholestasis secondary to passed out stone vs infection. Hydration with caution for congestion was initiated. On the 8th day of admission, patient presented with petechiae of the upper extremities accompanied by symmetrical polyarthritis of proximal interphalangeal joints of both hands.

Work up for Systemic lupus erythematosus and rheumatoid arthritis revealed elevated Rheumatoid factor of 71.8 IU/mL, positive anti cyclic citrullinated peptide (anti-CCP) of 22.1 U/mL, negative ANA. Patient was then started on Hydroxychloroquine 200 milligrams twice daily while management for acute pancreatitis were continued.

CONCLUSION Although rare, rheumatoid arthritis should be considered as a precipitating factor in patients presenting with signs and symptoms of acute pancreatitis especially those manifesting with swelling of the joints and cutaneous signs of vasculitis such as petechiae.

52.

SAPHO SYNDROME IN A 68 YEAR OLD FEMALE : A CASE REPORT

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INTRODUCTION Synovitis, acne, pustulosis, hyperostosis and osteitis (SAPHO) syndrome is a spectrum of heterogenous disease characterized by dermatological and osteoarticular manifestations. SAPHO is a rare disease with few data on its prevalence. It is predominantly found in patients with average age of 30-50 years .

CASE SUMMARY This a case of a 68 year old female who came in due to pustular skin lesions on bilateral upper and lower extremities . skin lesions has associated joint pains on both hands, myalgia and cervical lymph node enlargement. There were no associated fever, night sweats, alopecia, digital ulcers. Laboratory findings revealed elevated ESR, CRP . Patient underwemt biopsy of cerfvical lymph node showing necrotizing lymphadenitis and was started on Anti -Koch's medications for diagnosis of presumptive TB. However in spite of this , symptoms still persisted. Pertinent Physical examination showed: Erythematous pustular lesions on distal bilateral upper extremities and lower extremities ,Thickening and hyperpigmentation of sternoclavicular joint, Swollen and tender Proximal interphalangeal joints of 2nd and 3rd digit of right hand . Several tests were done with pertinent laboratories showing leukocytosis, elevated IgG4 and elevated inflammatory markers. She was then started on High dose prednisone until tapered and subsequently started on Etanercept biweekly.

CONCLUSION SAPHO syndrome is a rare type of inflammatory disease. Good knowledge of symptoms in general is important for pattern recognition in diagnosis and treatment .

53.

SEARCHING FOR THE CULPRIT: CEREBRAL HEMORRHAGE IN A YOUNG PATIENT WITH SINUS VENOSUS TYPE OF ATRIAL SEPTAL DEFECT AND SYSTEMIC LUPUS ERYTHEMATOSUS

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OBJECTIVE Present a case of an inferior sinus venosus defect in a patient with Systemic Lupus Erythematosus with cerebrovascular hemorrhage.

CASE 40/F with Systemic Lupus Erythematosus admitted for cerebrovascular hemorrhage managed at Tondo Medical Center, a tertiary government institution

CONCLUSION Systemic Lupus Erythematosus may be major predisposing factor in the development of Cerebrovascular disease, principally due to incidence of cerebral vasculitis, vessel dissection, thrombocytopenia, and secondary hypertension, among others. In addition, cerebrovascular events in general are among the main specific causes of death in SLE patients, representing 10–15% of all deaths in this population. SLE may have also been a contributory factor in the Atrial Septal Defect seen in this patient as studies have suggested that children born to women with SLE have an increased risk of congenital heart diseases.

54.

VARIABLE CLINICAL PRESENTATION OF ANTI-MDA5 ANTIBODY ASSOCIATED DERMATOMYOSITIS: A CASE SERIES

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BACKGROUND The auto-antibody against Melanoma Differentiation-Associated gene5 (or Anti- MDA-5 antibody) has distinct clinical syndromes associated with rapidly-progressing interstitial lung disease (RP-ILD), unique cutaneous lesions and with little to no evidence of myositis. This case series aims to illustrate the wide-spectrum of clinical presentation of anti-MDA5 associated dermatomyositis (Anti-MDA5-DM).

CASE SUMMARY We report five Filipino patients with Anti-MDA5-DM. Two females, age 43 and 36, presented with proximal muscle weakness, heliotrope rash, “shawl and V” sign, Grotton’s papules, mechanic’s hands and cutaneous ulcerations. The second case resulted in stillbirth but was negative for antiphospholipid antibodies. Both were positive for anti-MDA5 and Anti-Ro52 antibodies with normal muscle enzymes and ILD on high-resolution CT scan(HRCT). Both received high dose steroids with cyclophosphamide infusion while azathioprine and hydroxychloroquine were given to the latter patient.

A 56-year-old female with cutaneous ulcers and intermittent cough was treated as hypersensitivity pneumonitis as adverse effect to antibiotic. Anti-MDA5-DM with ILD was suspected and confirmed on further studies due to refractory symptoms. She received methylprednisolone pulse therapy and mycophenolate mofetil (MMF). Tacrolimus was added which led to significant improvement of both cutaneous and pulmonary symptoms.

A 54-year-old female was started on methotrexate due to symmetric polyarthritis, positive rheumatoid factor, and anti-CCP. A year later, she developed progressive cough, shortness of breath, “shawl & V” sign and periungual telangiectasia. She was positive for anti-MDA5 with non- specific interstitial pneumonia(NSIP) ILD. Her medications include prednisone, MMF, hydroxychloroquine and nintedanib.

Lastly, a 19-year-old male presented with fatigue, fever, Gottron’s papules, proximal weakness and clean-based painful cutaneous ulcers a month after receiving Ad26.COV2.S COVID-19 vaccine. Anti-MDA5-DM was considered though no biopsy or immunologic markers done. Despite on prednisone, azathioprine, hydroxychloroquine, and MMF, patient continued to deteriorate. He succumbed from respiratory failure despite ventilatory support due to massive pneumothorax with pneumomediastinum within 6 months of diagnosis.

CONCLUSION Anti-MDA5-DM is associated with unique cutaneous features, pronounced pulmonary involvement, and guarded prognosis. It is paramount to recognize and establish the diagnosis early on as treatment response is highly variable.

55.

SEVERE MITRAL AND AORTIC VALVE REGURGITATION IN LONG-STANDING RHEUMATOID ARTHRITIS: A CASE REPORT

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BACKGROUND The prevalence of valvular heart disease in Rheumatoid Arthritis (RA) varies from 30-80% for mitral valve regurgitation, and 9-33% for aortic valve regurgitation. Majority of patients are clinically asymptomatic and only <10% of patients develop a hemodynamic abnormality with diastolic dysfunction recognized as the primary cause of congestive heart failure in RA patients.

CASE SUMMARY We report a 45-year-old female diagnosed RA for 28 years, and managed with methotrexate, infliximab, tofacitinib, low dose prednisone at various periods of her illness. She also underwent bilateral hip and knee arthroplasty without complications. She does not smoke cigarettes nor drink alcoholic beverages; she is non- diabetic, and concomitant systemic arterial hypertension is well-controlled on metoprolol. Overall RA disease activity had been mild with function stable at Class II-III over the past few years, when she recently presented with bipedal edema with progressive exertional dyspnea accompanied by paroxysmal nocturnal dyspnea and orthopnea. Two-dimensional echocardiography showed concentric left ventricular hypertrophy with grade III diastolic dysfunction and bi-atrial dilatation. There was severe mitral regurgitation, moderate to severe aortic regurgitation and moderate tricuspid regurgitation; ejection fraction (EF) of 55% was relatively decreased in view of the severe aortic regurgitation. Other findings included aortic sclerosis and pulmonary hypertension (PASP 62 mmHg). Coronary angiogram was normal. She successfully underwent aortic and mitral valve replacement with tricuspid bicuspidization and closure of a patent foramen ovale (PFO). Histopathologic study of the resected heart valves revealed fibrohyaline and fibromyxoid degeneration with dystrophic calcification; rheumatoid nodules were not present. Heart failure symptoms resolved post-operatively and she is recovering well with progressive cardiac and physical rehabilitation.

CONCLUSION Valvular Heart Disease (VHD) is a severe prognostic involvement in RA and reflects long-standing valvular inflammation resulting in valvular damage, similar to RA synovitis. The acute onset of heart failure symptoms despite the chronicity of the histopathologic findings, is not unexpected due to lowered cardiac load from the patient’s sedentary lifestyle and probably some compensation from the PFO. This case highlights the importance of recognizing VHD in RA, as timely intervention including cardiac surgery can significantly improve symptoms and overall quality of life.

56.

ACUTE-ONSET CHOREA IN AN ELDERLY WOMAN WITH A LONG-STANDING SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)

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OBJECTIVE To present a case of a rare presentation of neuropsychiatric systemic lupus erythematosus (NPSLE) in an elderly Filipino woman with a long-standing SLE.

INTRODUCTION NPSLE presents diverse clinical symptoms and lacks distinct diagnostic criteria, posing a significant management challenge. Contributing factors to neurological symptoms include medications, infections, chronic disease-related stress, and direct effects of inflammation. Chorea, characterized by involuntary, dance-like movements, has a 0.6% cumulative incidence in NPSLE cases and is associated with various factors. Understanding these associations is crucial for effective NPSLE management.

CASE SUMMARY A 72-year-old woman with a 26-year history of SLE initially presented with classic manifestations, such as malar rash, polyarthritis, and severe anemia. She had positive ANA, elevated anti-dsDNA, anti-RNP, anti-Sm antibodies, and low complement levels. Treatment with prednisone and hydroxychloroquine (HCQ) provided periods of remission interspersed between occasional mild flares requiring medication adjustments. In recent years, she experienced neurological symptoms including brain fog, behavioral changes, and visual hallucinations, leading to further medication modifications. Her condition escalated with the abrupt onset of involuntary jerky movements associated with slurring, dysphagia, insomnia, and shooting pains. Physical examination revealed involuntary mouth and tongue movements, along with jerky extremity movements. Laboratory results showed anemia, elevated BUN and creatinine, increased HsCRP and ESR, decreased C3, and strongly positive anti-dsDNA antibodies. MRI revealed patchy T2W/T2 FLAIR hyperintensities in parietal periventricular white matter regions and atherosclerotic vessel disease on MRA. Treatment with hydrocortisone and methylprednisolone resulted in complete resolution of the chorea within two days. The patient was discharged and is currently on low-dose prednisone and HCQ with regular monitoring.

CONCLUSION This case sheds light on the diverse presentations of a long-standing SLE and the involvement of the neurological system. The sudden onset of choreiform movements underscores the importance of promptly identifying SLE-associated factors and ruling out non-SLE confounding factors that may contribute to the neuropsychiatric manifestations. By doing so, targeted treatment strategies can be employed to address the patient's condition effectively.

57.

SUCCESSFUL TREATMENT OF CALCINOSIS CUTIS WITH PAMIDRONATE IN SCLERODERMA-LUPUS OVERLAP SYNDROME

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OBJECTIVE To present a case of calcinosis cutis universalis in a patient with Scleroderma- Systemic Lupus Erythematosus (SLE) Overlap Syndrome responsive to intravenous pamidronate.

INTRODUCTION Calcinosis cutis involves the formation of calcium deposits in the skin or subcutaneous tissue and often occurs in various autoimmune diseases. While several drugs have been used to manage calcinosis cutis, there is no universally accepted treatment approach. This report presents a case of an adult female with calcinosis cutis universalis related to scleroderma and systemic lupus erythematosus (SLE) overlap syndrome, highlighting positive treatment outcomes.

CASE REPORT A 26-year-old female patient with an 8-year history of systemic lupus erythematosus (SLE) nephritis developed an overlap with diffuse systemic sclerosis 5 years after her initial diagnosis. During the course of her disease, she presented with patches of calcinosis on her legs, which gradually spread to involve her trunk and upper extremities. A skeletal survey revealed tissue calcifications in the upper and lower extremities, with a higher concentration observed on both elbows and knees. The calcinosis progressively worsened, eventually affecting the patient's face, back, abdomen, arms, thighs, knees, and legs. Occasionally, some of the calcinosis would rupture, extruding white pasty material and necessitating antibiotic coverage. The patient's SLE nephritis remained quiescent. Immunoassays revealed elevated titers of anti- dsDNA 607.43 (200 IU/mL), ANA 1:320 speckled pattern, anti-RNP (150.98 IU/mL), creatine kinase 1357 (<198 U/L), and lactic dehydrogenase 392 (280 U/L). Colchicine, diltiazem, and alendronate were initially prescribed for the calcinosis in addition to the patient's maintenance regimen of hydroxychloroquine and mycophenolate mofetil. A trial of minocycline was subsequently added to address the calcinosis but yielded minimal response. This prompted the administration of pamidronate for 6 sessions, which resulted in gradual resolution of the calcinosis.

CONCLUSION This represents one of the few reported cases of calcinosis cutis universalis in an overlap syndrome of systemic lupus erythematosus and scleroderma. Despite the availability of numerous therapies for calcinosis, patient responses vary. As such, the introduction of pamidronate as a viable therapeutic option for the resolution of calcinosis is noteworthy.

58.

REFRACTORY CHILDHOOD CUTANEOUS POLYARTERITIS NODOSA TREATED WITH TOCILIZUMAB AND CYCLOPHOSPHAMIDE: A CASE REPORT

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BACKGROUND Cutaneous polyarteritis nodosa (cPAN) is a form of vasculitis affecting small and medium- sized vessels essentially limited to the skin. There is no specific serologic test that confirms a diagnosis of cutaneous PAN. However, patients in whom clinical and skin biopsy findings suggest cPAN should have laboratory studies to assess for features suggestive of systemic involvement. This report presents a 6-year-old female with cutaneous polyarteritis nodosa refractory to methotrexate, colchicine, and nonsteroidal anti-inflammatory drugs (NSAIDs).

CASE SUMMARY This report presents a 6-year old female with prolonged fever, multiple erythematous tender nodules over upper and lower extremities, joint pain and swelling, elevated acute phase reactants, leukocytosis, thrombocytosis, and deep punch skin biopsy consistent with cPAN. She was given 3 doses of methylprednisolone pulse, methotrexate, colchicine, and NSAIDs without improvement of symptoms. She was started on cyclophosphamide and tocilizumab infusion which provided relief of symptoms.

CONCLUSION Cutaneous PAN is a benign self-limiting disease but may have a relapsing course. Treatment is difficult and there is no consensus on the best treatment. Because of the uncertainty regarding risk for progression to systemic PAN, long-term follow-up is essential.

59.

IDIOPATHIC HYPEREOSINOPHILIC SYNDROME (HES) WITH CARDIOVASCULAR COMPLICATION: A CASE REPORT

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OBJECTIVE To present a rare case of HES with cardiovascular complications in a 23-year- old Filipino male.

INTRODUCTION HES is a rare disorder, defined as persistent blood eosinophilia (>1.5 x 109/L) for at least six consecutive months with evidence of eosinophil-induced organ involvement excluding allergic, parasitic or malignant disorders as other causes of hypereosinophilia. It is commonly seen in young to middle-aged male patients. This condition frequently involves the skin, heart, lungs as well as the central and peripheral nervous system affecting more than 50% of cases with cardiovascular complications significantly impacting the patient's prognosis.

CASE SUMMARY: A 23-year-old male with no known comorbidities presented with persistent pruritus of hands and bipedal edema. He had erythematous pruritic patches on both legs, relieved intermittently on antihistamines for 3 months. He eventually consulted a dermatologist and was given triamcinolone cream, antihistamines and 7-day course of prednisone but symptoms persisted. Other than disturbing hand pruritus, he also developed bipedal edema, and Raynaud's phenomenon. He denied cardiopulmonary symptoms. Work-up showed leukocytosis with eosinophilic predominance (white blood count 31.73x109/L, eosinophils 19.9x109/L), skin biopsy revealed post-inflammatory pigmentary alteration with tissue eosinophilia. His 2D-echocardiogram showed global hypocontractility with an ejection fraction of 47%. Abdominal sonography showed normal sized liver and spleen. A consideration of HES was given. Since eosinophilia fluorescence in situ hybridization (FISH) panel was negative which ruled out myeloid and lymphoid disorders, he was managed as a case of idiopathic hypereosinophilia syndrome, placed on high-dose prednisone and imatinib resulting in symptom resolution as well as remarkable reduction in peripheral eosinophilia and improved cardiac function, less pronounced Raynaud's phenomenon. The patient is currently off steroids, doing very well, maintained on imatinib with regular monitoring.

CONCLUSION This case highlights the importance of a focused history, physical exam, prioritizing work up in an apparently healthy young patient with persistent eosinophilia, its main differentials and multidisciplinary team approach in the diagnosis, management, and follow-up care. Early intervention leads to favorable prognosis.

60.

TJALMA SYNDROME ASSOCIATED WITH NEUROPSYCHIATRIC SLE IN A 31-YEAR-OLD FILIPINO PATIENT: A CASE REPORT

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INTRODUCTION Tjalma syndrome, also known as "Pseudo-pseudo Meig's Syndrome", is a rare condition that is characterized as ascites, pleural effusion and elevated CA-125 associated with Systemic Lupus Erythematosus (SLE) but no connection to any benign or malignant tumor. Pubmed, Google Scholar and Medline were used for literature search revealed scarcity of data about this condition and 1 abstract for a Filipino female patient reported. We aim to present a possible Lupus Nephritis Filipino female patient who presented initially as Tjalma syndrome that progressed to Neuropsychiatric SLE.

CASE REPORT A 31-year-old female admitted for easily fatigability, massive ascites, pleural effusion and pedal edema associated with anemia and with urinary sediments. Extensive work-up revealed no infection and no hormonal, specifically thyroid hormone, abnormality as well as no malignancy. Further workup revealed high-titer Anti-nuclear antibody; thus, patient was managed as a case of SLE with possible nephritis. Patient was advised for kidney biopsy but not done. Subsequent follow-ups showed poor response to steroids and Hydroxychloroquine, hence, CA-125 was requested and showed elevated results. Patient was also readmitted due to seizure but Computed tomography (CT) scan of the brain showed normal results, therefore, patient was managed as a case of Tjalma syndrome with Neuropsychiatric SLE. Pulse steroids and subsequent Cyclophosphamide infusion, together with anticonvulsants. Patient dramatically improved and was discharged.

CONCLUSION Tjalma syndrome is an unusual presentation of SLE which makes it difficult to diagnose. Pattern recognition, which is essential in any connective tissue diseases, must be developed to increase the clinical acumen to identify Tjalma Syndrome. Precise recognition of this condition will lead to proper management of the patients.

61.

TAKAYASU ARTERITIS PRESENTING AS TRANSIENT LOSS OF CONSCIOUSNESS IN A 19-YEAR-OLD FEMALE

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OBJECTIVE To describe Takayasu Arteritis presenting as transient loss of consciousness in a 19-year old female.

CASE SUMMARY We report a case of Takayasu Arteritis in a 19-year old female from Kalibo, Aklan who presented with episodes of transient loss of consciousness. This was preceded by a 1 month history of dizziness and blurring of vision. Upon physical examination, there was absence of pulses at both upper extremities. CT angiogram showed total occlusion of the right upper lobar artery associated with right upper lobar oligemia, as well as bilateral common carotid arteries and proximal left subclavian artery. The was given methylprednisolone pulse therapy which resulted in significant improvement of the patient's symptoms. She was then discharged and was able to return for follow-up and Tocilizumab administration every month for 6 months with a report of no recurrence of transient loss of consciousness.

CONCLUSION This case report highlights Takayasu Arteritis presenting as transient loss of consciousness, preceded by headache and blurring of vision. It also emphasizes the careful inclusion of Takayasu Arteritis in the differential diagnosis when approaching patients presenting similarly since prompt case finding will allow early treatment which is crucial to improving prognosis.

62.

THE ROLE OF MULTIPLE NON-INVASIVE IMAGING MODALITIES FOR THE IDENTIFICATION OF VASCULAR LESIONS IN TAKAYASU'S ARTERITIS: A CASE SERIES

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INTRODUCTION Takayasu's Arteritis refers to the rare systemic vasculitis affecting the large vessels. It is also known as the "pulseless disease", although blood pressure discrepancies are not universal. Paucity of data is a concern in The Philippines.

CASE SUMMARIES We present the imaging findings of three Filipino females aged less than 40 years, all diagnosed with Takayasu's Arteritis by American College of Rheumatology (ACR) Criteria. We enumerate the non-invasive imaging findings documented in multiple modalities.
The first patient was diagnosed at 30 years. She presented with two episodes of cerebrovascular infarcts and blood pressure discrepancy of > 10 mm Hg. Arterial duplex scan showed left proximal subclavian artery thrombosis, femoral artery stenosis; venous duplex scan revealed right basilic vein thrombosis.

The second patient was diagnosed at 32 years. Initial symptoms included chronic chest pain and intermittent claudication. Chest computed tomography scan showed a proximal left subclavian artery aneurysm. Positron emission tomography scan showed left anterior circulation aneurysm, large aortic arch aneurysm, and saccular aneurysm in the ascending colon. Venous compression test revealed an acute deep vein thrombosis of the left internal jugular vein. Carotid duplex scan showed stenosis in the left proximal common carotid artery and left subclavian steal. Computed tomography angiography of the brain better delineated the saccular aneurysm. Computed tomography scan of the thoracic aorta showed multiple intraluminal filling defects.

The third patient was diagnosed at 31 years. She presented with epigastric pain and blood pressure discrepancy. Positron emission tomography scan showed hypermetabolic foci in the proximal descending aorta and bilateral vertebral arteries. Computed tomography scan demonstrated ectatic ascending thoracic aorta and thrombus at the distal abdominal aorta. Disease activity of all three patients is presently quiescent.

CONCLUSION We emphasize the pivotal role of multiple non-invasive imaging modalities in identifying vascular lesions in Takayasu's Arteritis. Detection and subsequent monitoring are warranted to prevent further complications.

63.

THE MYSTERIOUS NECK MASS: A CASE OF KIMURA DISEASE

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BACKGROUND Kimura disease is a rare chronic inflammatory condition which presents with multiple painless subcutaneous nodules especially in the head and neck with coexisting lymphadenopathy, salivary gland hypertrophy and peripheral eosinophilia. Hence this paper aims to describe a case of Kimura disease and to review the available literature regarding the treatment and outcomes of similar cases.

CASE SUMMARY This is a case of a 30-year old male who presented with multiple painless subcutaneous nodule. Excision biopsy revealed atypical lymphoid proliferation hence immunostains were requested. Immunohistomorphologic features of the specimen were compatible with reactive lymphoid hyperplasia with eosinophilia which highly suggests Kimura Disease. Patient was given with chronic systemic steroids which resulted to good effect in disease progression.

CONCLUSION This case protocol presented an overview of Kimura Disease, a rare chronic inflammatory disorder affecting the head and neck region. It discussed its epidemiology, clinical presentation, diagnostic evaluation, management, and potential complications. Early recognition and accurate diagnosis are essential for appropriate treatment and improved patient outcomes. Further research and advancements in understanding the pathophysiology of Kimura Disease may lead to more effective therapeutic options in the future.

64.

CATASTROPHIC ANTIPHOSPHOLIPID ANTIBODY SYNDROME PRESENTING AS ACUTE ABDOMEN IN A PATIENT WITH SYSTEMIC LUPUS ERYTHEMATOSUS AND RHEUMATOID ARTHRITIS OVERLAP SYNDROME

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INTRODUCTION Catastrophic antiphospholipid antibody syndrome (CAPS), is a rare and severe form of antiphospholipid antibody syndrome (APS), characterized by rapid, widespread organ thrombosis within a short period of time. Despite its infrequent occurrence, CAPS carries a high mortality rate, ranging from 20 to 50%.

CASE SUMMARY We present a case of a 37-year-old nulligravid Filipino woman diagnosed with systemic lupus erythematosus (SLE) and rheumatoid arthritis overlap (RA) 2 years ago after presenting with symmetric polyarthritis, positive rheumatoid factor, anti-cyclic citrullinated antibody, anti-dsDNA and ANA. She was off treatment for 9 months when she presented with a 3-day duration of severe abdominal pain. Initially managed as ruptured appendicitis, an operative exploration however revealed a necrotic small bowel, raising suspicion of mesenteric ischemia. A CT aortogram confirmed an extensive thoracoabdominal thrombus, non-opacified mesenteric arteries, splenic and adrenal infarcts, along with a prolonged lupus anticoagulant test, leading to a diagnosis of probable CAPS. Immediate anticoagulation with unfractionated heparin, along with steroid pulse therapy and intravenous immunoglobulin were initiated. Repeat laparotomy with histologic examination was performed, revealing small bowel hemorrhage, medium vessel thrombosis, and acute vasculitis. A follow-up CT aortogram showed no progression but an unchanged thrombus. Further immunosuppression was planned however, she eventually succumbed to septic shock from bacterial peritonitis.

DISCUSSION APS may occur as a primary condition or in a setting of a connective tissue disease such as SLE and RA, but is rare in overlap syndromes. Management of CAPS, regardless of the underlying condition, should focus on addressing the thrombotic event and suppression of cytokine storm.

CONCLUSION: This case underscores the importance of heightened suspicion for this fatal complication in patients with sudden systemic complaints. Comprehensive, multi-specialty approach is crucial to address both the acute thrombotic event and the prevention of complications.

65.

A RARE CASE OF DERMATOMYOSITIS WITH ROSAI-DORFMAN DISEASE COMPLICATED BY BACTERIAL AND TUBERCULOUS PYOMYOSITIS

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INTRODUCTION Lymphadenopathy in dermatomyositis is carefully evaluated due to its association to cancer in adults. Another rare cause is Rosai-Dorfman Disease (RDD) which is a proliferation and accumulation of histiocytes in the lymph nodes. Although benign, its coexistence with dermatomyositis adds complexity to the diagnostic and management approach and has not been reported yet.

CASE SUMMARY
A 30-year-old Filipino female presented with dermatomyositis exhibiting proximal muscle weakness, photosensitivity, heliotrope rash, Gottron's papules and cervical lymphadenopathies. Despite a normal creatine kinase-MM, skin biopsy and electromyography were consistent with Dermatomyositis. Neck CT scan showed multiple lymph nodes with biopsy showing sinus histiocytosis consistent with RDD. Treatment with azathioprine and high dose prednisone initially improved muscle strength and decreased cervical lymphadenopathies. However, 3 years later, a dermatomyositis flare prompted a shift to methotrexate. Three months later, she developed a gradually enlarging painful left medial thigh mass which on MRI revealed myositis with abscess formation. Surgical drainage and empiric Piperacillin-Tazobactam and Vancomycin were initiated. Aerobic and anaerobic culture was negative, but abscess GeneXpert was positive for drug-susceptible tuberculosis for which treatment with isoniazid, rifampicin, ethambutol, and pyrazinamide was started. She had a recurrence of proximal muscle weakness and increased cervical lymphadenopathies which improved after prednisone dose was increased to 0.5mg/kg/day and Methotrexate continued.

DISCUSSION A common presentation of RDD is cervical lymphadenopathy but diagnosis is often missed due to its rarity. There is still a lack of consensus regarding treatment but immunosuppressive therapy such as glucocorticoids, radiation and chemotherapy has been reported to be effective in multifocal nonresectable disease. While RDD is benign, its association with dermatomyositis necessitates vigilant monitoring for infectious complications like pyomyositis. Hence, recognition is key to tailoring immunosuppressive therapy that ensures optimal outcomes while keeping infection risk low.

CONCLUSION This case highlights the rare coexistence of dermatomyositis with RDD and emphasizes the need for a nuanced diagnostic and management approach.

66.

ACUTE NON-GRANULOMATOUS INTERMEDIATE UVEITIS: A RARE OCULAR FINDING IN SYSTEMIC LUPUS ERYTHEMATOSUS

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INTRODUCTION Uveitis is uncommon in systemic lupus erythematosus (SLE) with a reported prevalence of 0.1 to 4.8%. Although rare in SLE, it is associated with significant ocular morbidity, hence prompt recognition and treatment are crucial.

CASE SUMMARY We report a case of a 25-year old female diagnosed with SLE who initially presented with fever, myalgia, rashes, and thrombocytopenia. She was maintained on chronic, low-dose prednisone and hydroxychloroquine. However, she developed polyarthritis with acute visual symptoms presenting with bilateral eye floaters and accompanying redness and photophobia. On ophthalmologic assessment, she had best corrected visual acuity of 20/32 for both eyes. Slit lamp exam showed presence of retrolental vitreous cells. Indirect ophthalmoscopy revealed slightly hazy media with vitreous snowballs and condensations. On fluorescein angiography, hyperfluorescent perivascular leakages of the peripheral retinal vessels were seen on both eyes. With the presence of floaters and characteristic ophthalmologic findings, the patient was diagnosed with acute non-granulomatous intermediate uveitis. Treatment with high-dose steroids at 1mg/kg/day was immediately initiated and gradually tapered every 2 weeks. Additional immunosuppression with methotrexate was instituted. After a month, the patient's vision had significantly improved to best corrected 20/20 for both eyes with complete resolution of ocular symptoms.

DISCUSSION Uveitis, a condition characterized by inflammation of the uvea, is a rare ocular finding in SLE. It is further classified depending on which part is affected. Intermediate uveitis usually presents with floaters as the most prominent symptom. Diagnosis is confirmed based on characteristic vitreous findings such as presence of cells, snowballs and condensations. A step-wise approach ranging from corticosteroids to immunomodulatory therapy or surgery is indicated to prevent complications.

CONCLUSION As an uncommon ocular finding in SLE, intermediate uveitis warrants a high index of suspicion and prompt referral to ophthalmology. Once timely and appropriate treatment is instituted, favorable outcomes can be achieved.

67.

CONCOMITANT TB ARTHRITIS AND GOUT WITH UNUSUAL PRESENTATIONS: REPORT OF 3 CASES

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INTRODUCTION Tuberculous (TB) arthritis accounts for 3% of TB cases worldwide. It usually presents as mono-arthritis (76.9%) and is associated with hypertension, diabetes mellitus (DM), and chronic kidney disease (CKD). Currently, limited number of case reports have been documented about its co-existence. We report three cases of TB arthritis with gout presenting as oligo-arthritis and polyarthritis.

CASE SUMMARIES
Case 1: A 61-year-old male with CKD, gout, and chronic steroid use developed cough and decreased sensorium. On the 25th hospital day, he had pain and swelling on both knees. Synovial fluid appeared turbid, less viscous, red orange and lighter orange on the right and left knee respectively. Analysis of synovial fluid showed the presence of monosodium urate (MSU) crystals on both knees and positive for TB polymerase chain reaction (PCR) on the left knee.

Case 2: A 38-year-old male with gout and on 6th month of anti-TB medications for Pulmonary TB (PTB) experienced polyarthritis, jaundice, and abdominal pain. Synovial fluid appeared turbid, less viscous, and light yellow. Both knee effusions showed the presence of MSU crystals and were positive for TB PCR.

Case 3: A 48-year-old male with CKD, DM, PTB, and gout developed bilateral knee swelling and decreased sensorium. Synovial fluid appeared hazy, viscous, and whitish. Both knee effusions showed the presence of MSU crystals and were positive for TB PCR and acid- fast bacilli.

DISCUSSION TB arthritis with gout is rarely documented. It can present in different forms: ranging from acute to chronic onset, mono to polyarticular involvement, and different appearances of synovial fluid.

CONCLUSION A high index of suspicion is suggested especially in areas with high prevalence for TB, male patients, history of chronic steroid use and co-morbidities. Getting samples for synovial fluid TB studies from more than one site in patients presenting with oligo and polyarticular involvement are recommended.

68.

UNDIFFERENTIATED SPONDYLOARTHROPATHY INITIALLY PRESENTING AS INFLAMMATORY BOWEL DISEASE: A CASE REPORT

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INTRODUCTION Inflammatory bowel disease (IBD) can develop extraintestinal manifestations. It was seen in 10 cases (3.3%) in a study of 306 psoriatic arthritis (PsA) patients where it was the initial manifestation in five of them. We report a case initially presenting with gastrointestinal manifestations who developed arthritis and cutaneous involvement.

CASE SUMMARY A 23-year-old male had a chronic abdominal pain with episodes of hematochezia alternating with melena for one year. He later on developed pain and swelling on both knees and wrists and a gradually enlarging mass on the right lower quadrant (RLQ). He underwent right hemicolectomy with ileostomy. Tissue biopsy revealed xanthogranulomatous inflammation which was suggestive of Crohn's disease (CD). He was started with methylprednisolone and infliximab infusion with marked improvement on the symptoms. However, he had missed doses of infliximab on the succeeding consults. Three months after, he developed gradually enlarging ulceration on the right medial malleolar area. Biopsy showed granulation tissue and necrosis suggestive of pyoderma gangrenosum (PG). He was given clindamycin and meropenem. Infliximab infusion was done. There was seen improvement on the skin lesion. However, he had missed doses of infliximab again. Five months after, he developed scaly erythematous lesions extending to the hairline and scaly skin lesions on all extremities. He was diagnosed psoriasis and was started on methotrexate 12.5 mg per week while waiting infliximab procurement.

DISCUSSION Musculoskeletal, ocular, and cutaneous manifestations are common in patients with IBD. Tumor necrosis factor (TNF) inhibitors such as infliximab has become the standard of care for patients with IBD. It has also showed efficacy in achieving remission and low rate of adverse events in IBD patients with PG. The benefit was also documented in patients with spondyloarthropathy and IBD.

CONCLUSION This case highlights the importance of monitoring of extraintestinal manifestations in patients with IBD and the significance of adherence to its management.

69.

DISSEMINATED TUBERCULOSIS PRESENTING AS A NON-HEALING ULCER IN A PATIENT WITH SYSTEMIC LUPUS ERYTHEMATOSUS

Blessie Marie B. Perez, MD; Evelyn O. Salido, MD; Margarita Isabel Fernandez, MD; Chelsea Colleen Paris, MD | University of the Philippines- Philippine General Hospital

INTRODUCTION Tuberculosis (TB) in Filipinos with SLE has a seven-fold higher incidence and causes up to 31% of deaths, primarily from disseminated disease.

CASE SUMMARY A 30-year old female with SLE for four years, with a recent lupus nephritis flare, developed non-healing wounds after 12 weeks on high-dose steroids and hydroxychloroquine. She had abdominal bloating, polyarthralgia but no fever, cough, dyspnea, or bowel changes. The ulcers on the right thumb and right gluteal area were erythematous with minimal discharge. There was soft tissue swelling seen on radiograph of the thumb and a left gluteal abscess on pelvic MRI. Aerobic cultures of the blood and tissue AFB from the right thumb were negative. Treatment for active lupus with prednisone was continued and four cycles of wide-spectrum antibiotics were given over the next four months. However, the ulcers, abdominal bloating and polyarthralgia persisted. A repeat MRI showed no improvement in gluteal abscess size, and additional findings of intramedullary foci at T2- T4 and retroperitoneal lymphadenopathy. Colonoscopy revealed a transverse colon ulcer positive for chronic granulomatous inflammation and multinucleated giant cells. The stool AFB was positive. These confirmed the diagnosis of disseminated TB (gastrointestinal, spine, gluteus). She was given quadruple anti-tuberculous medications with healing of the ulcers and resolution of abdominal bloating and polyarthralgia after five months. Anti-dsDNA and C3 were normal, prednisone was tapered down and creatinine was stable with good urine output.

DISCUSSION TB in SLE patients is more likely to be extrapulmonary and predisposing factors found in cohort studies that are present in our patient include having lupus nephritis and a high cumulative corticosteroid dose.

CONCLUSION This case highlights how disseminated tuberculosis can mimic lupus disease activity and the difficulty in confirming its diagnosis because microbiologic studies may be negative. Further imaging and histologic work-up must continue when systemic manifestations and non-healing ulcers or abscesses do not resolve despite adequate immunosuppression and antibiotic coverage.

70.

CLINICAL PHENOTYPE AND OUTCOME OF FILIPINO CHILDREN WITH KIKUCHI-FUJIMOTO DISEASE: 15-YEAR STUDY IN A TERTIARY HOSPITAL

Adrienne Katrin M. Guiang-Valerio, MD; Christine B. Bernal, MD | University of Santo Tomas Hospital

OBJECTIVE Kikuchi-Fujimoto disease (KFD), or histiocytic necrotizing lymphadenitis, is a benign and self-limited disease that mainly affects young women. Patients present with localized lymphadenopathy, fever, and leukopenia in up to half of the cases. KFD can occur in association with systemic lupus erythematosus. The disease pattern or incidence of KFD has not been well studied in the Philippines. This study may be helpful to evaluate the pattern locally.

METHODS The clinical features of the 13 cases of Kikuchi-Fujimoto Disease diagnosed at a private tertiary hospital in the Philippines over a fifteen-year period were presented. The cases were identified from the clinic's electronic medical records using the search term "Kikuchi- Fujimoto Disease" or "Kikuchi" or "KFD".

RESULTS Nine out of the 13 patients included were female with a median age of 11 years (range 5- 16), and presented with fever and lymphadenopathy. Two patients demonstrated seropositivity for systemic lupus erythematosus. All patients had histopathological features of Kikuchi-Fujimoto Disease on excisional lymph node biopsy. There was spontaneous resolution of symptoms within one to six months in nine cases. Three patients were given corticosteroids, three patients were lost to follow up, and the two lupus paHents received hydroxychloroquine.

CONCLUSION The clinical features of patients with KFD have many provisional diagnoses on presentation. Early recognitioon and differentiation are imperative to avoid unnecessary aggressive treatment as KFD is a self-limiting condition. Systemic diagnostic approach is key.

IMAGES

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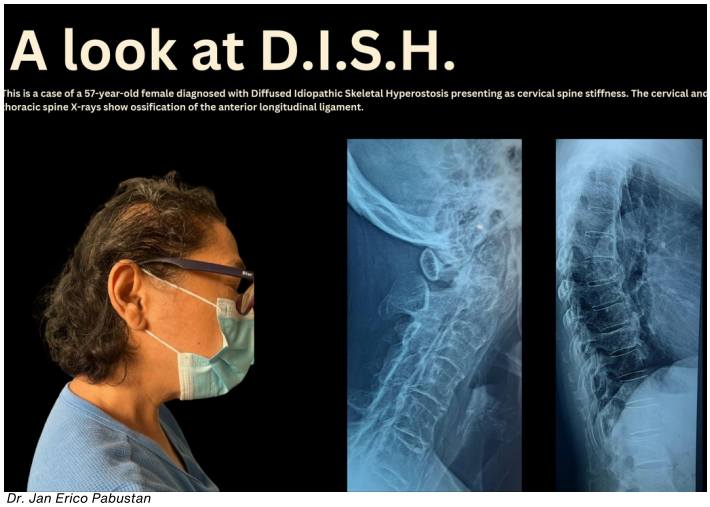

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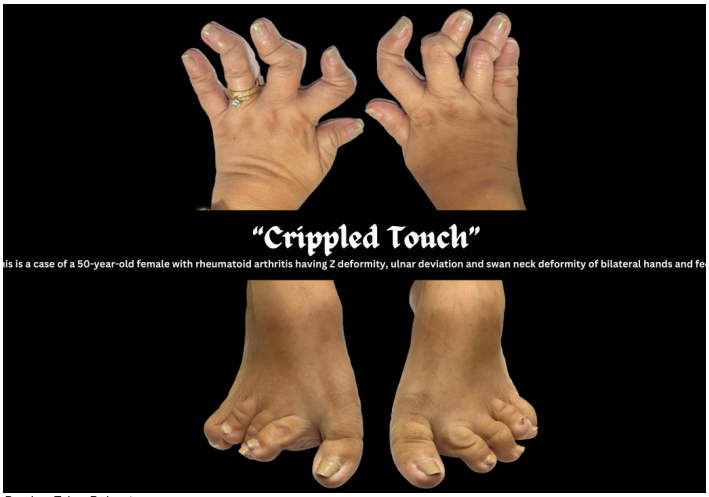

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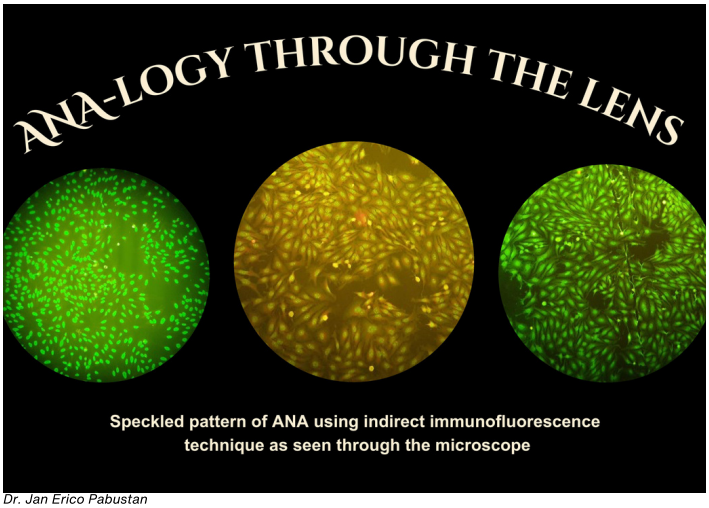

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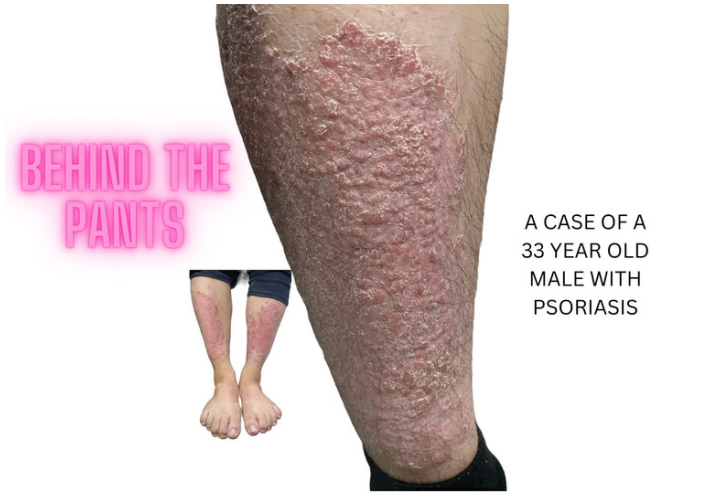

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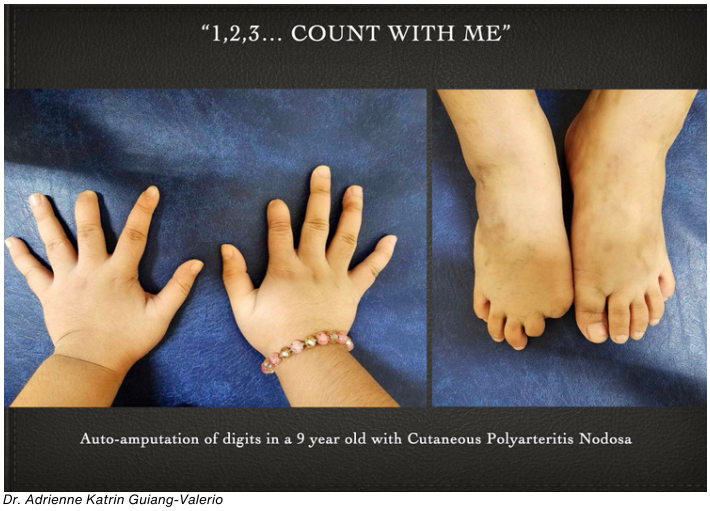

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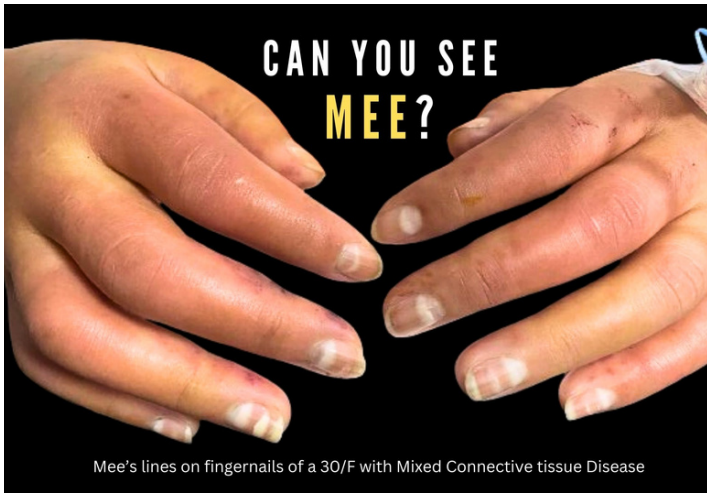

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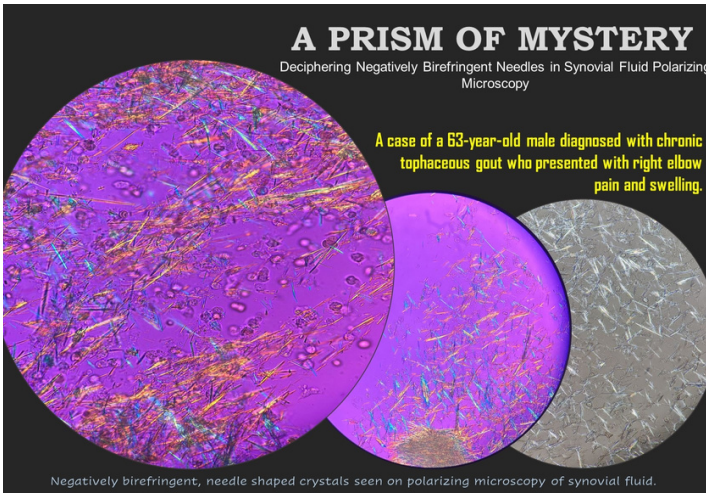

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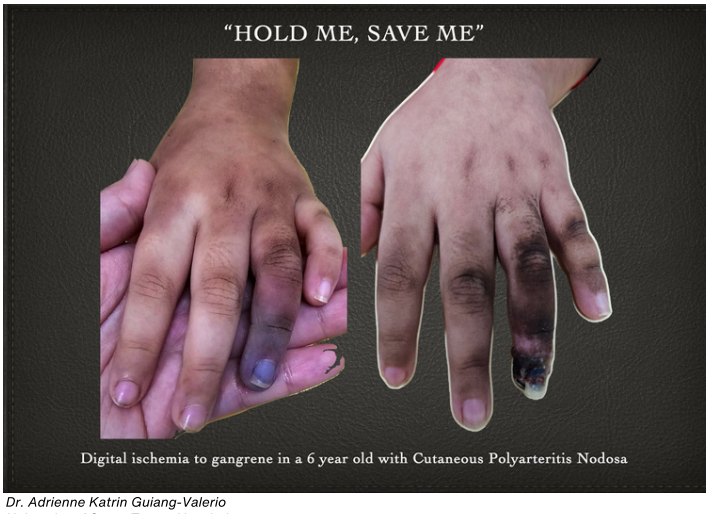

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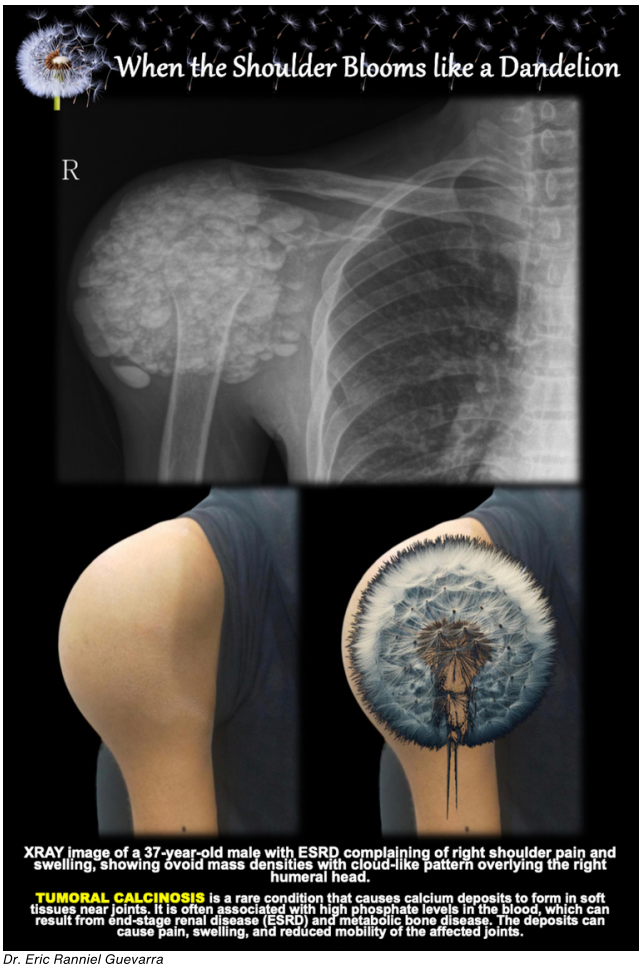

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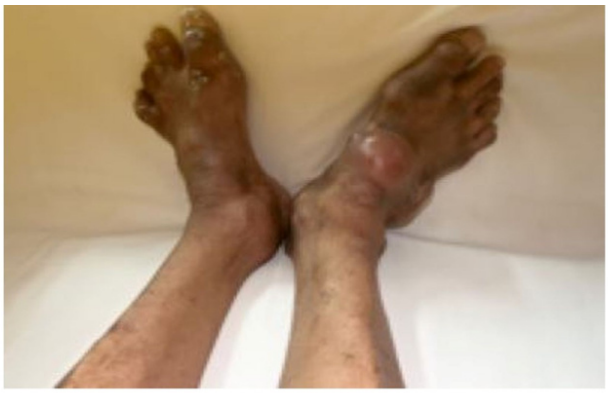
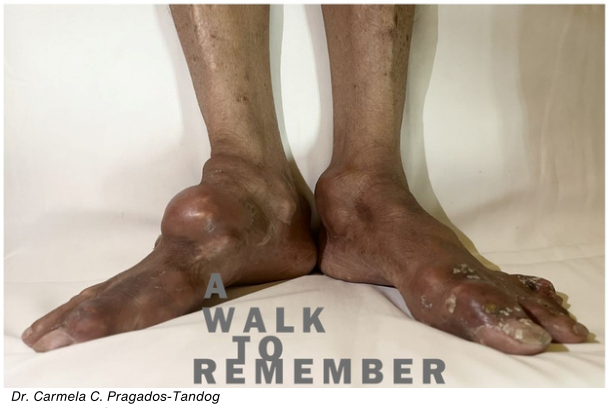


A 57-year-old male grapples with intermittent flares of chronic tophaceous gout. His medical journey began in his 30s, marked by episodic joint pain predominantly in the knee and ankle. These episodes, lasting five days and occurring at least thrice yearly, consistently resolved. Progressing into his 40s, a discernible transformation unfolded, revealing multiple nodules and masses on hands, feet, and knees. This evolution signifies a noteworthy chapter in his enduring battle with tophaceous gout.



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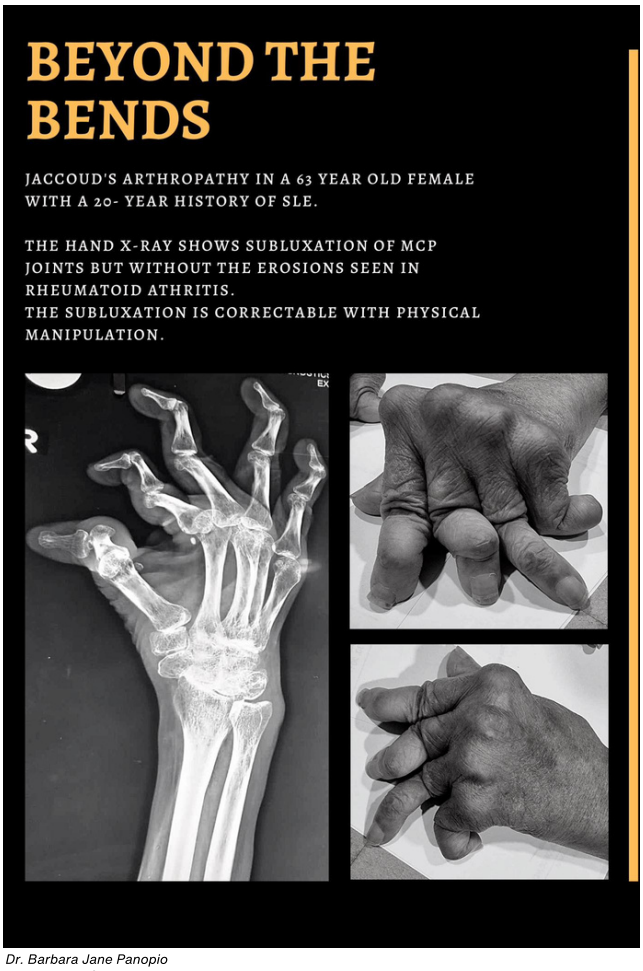

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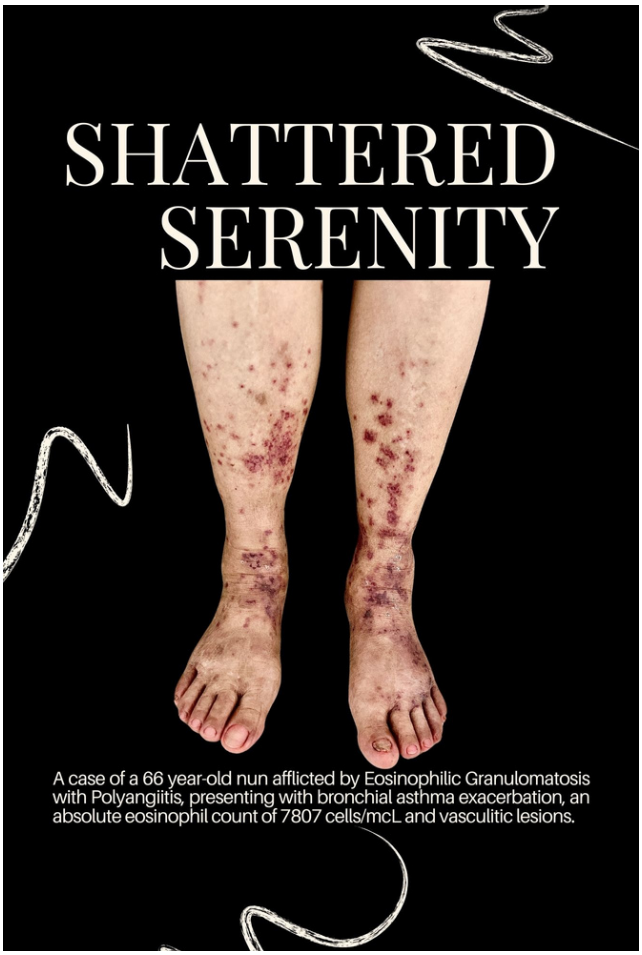

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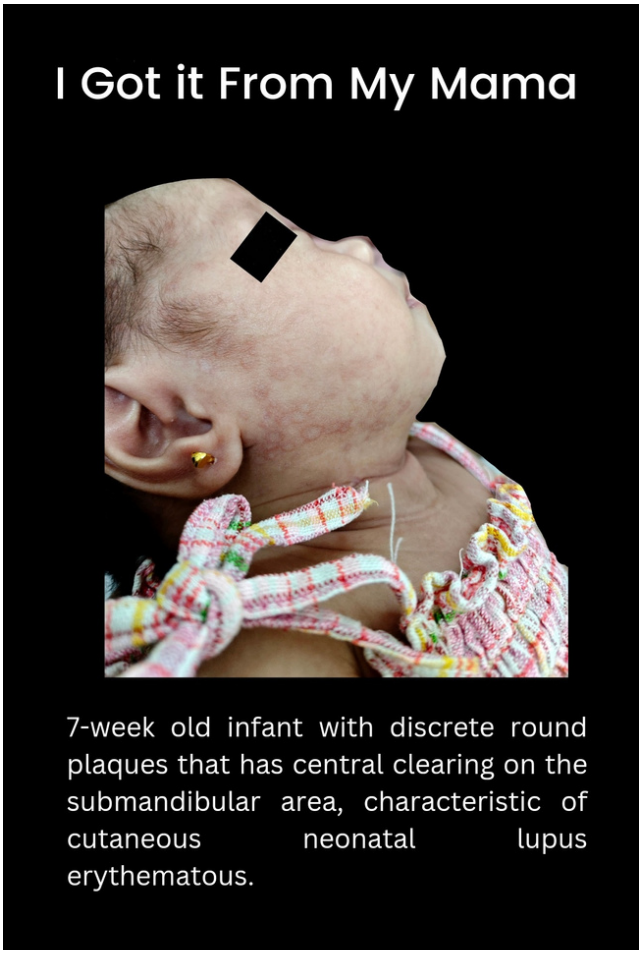

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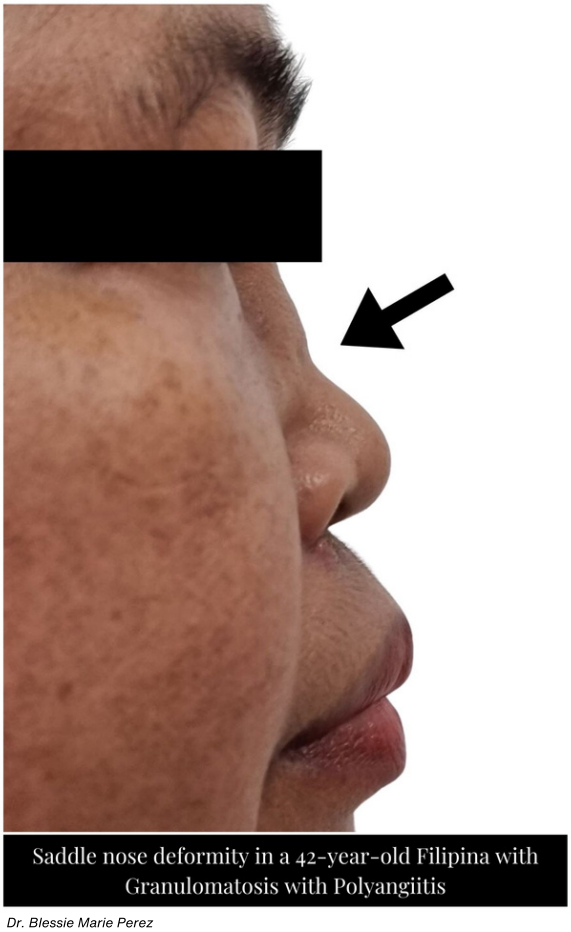

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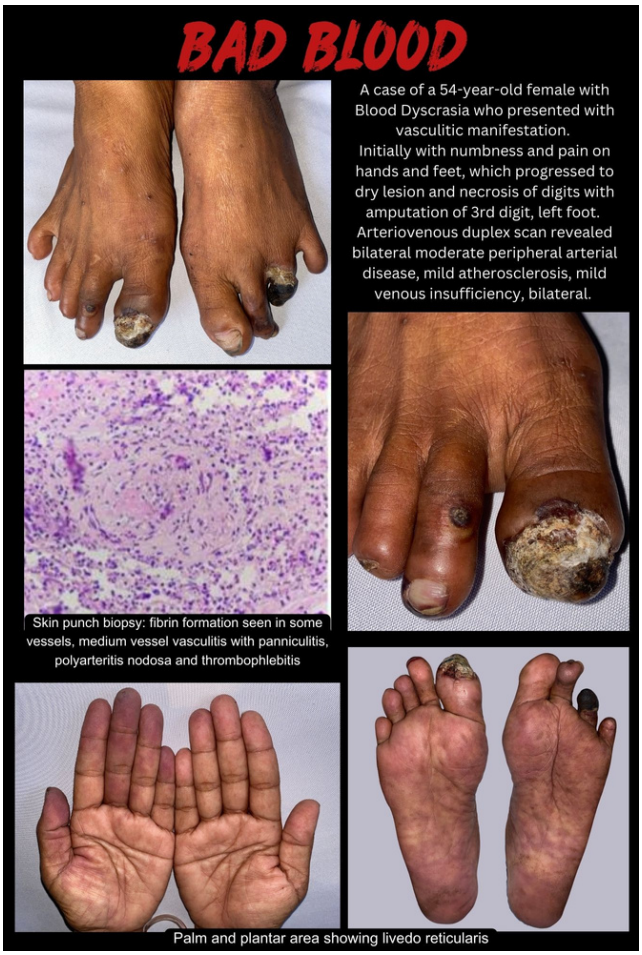

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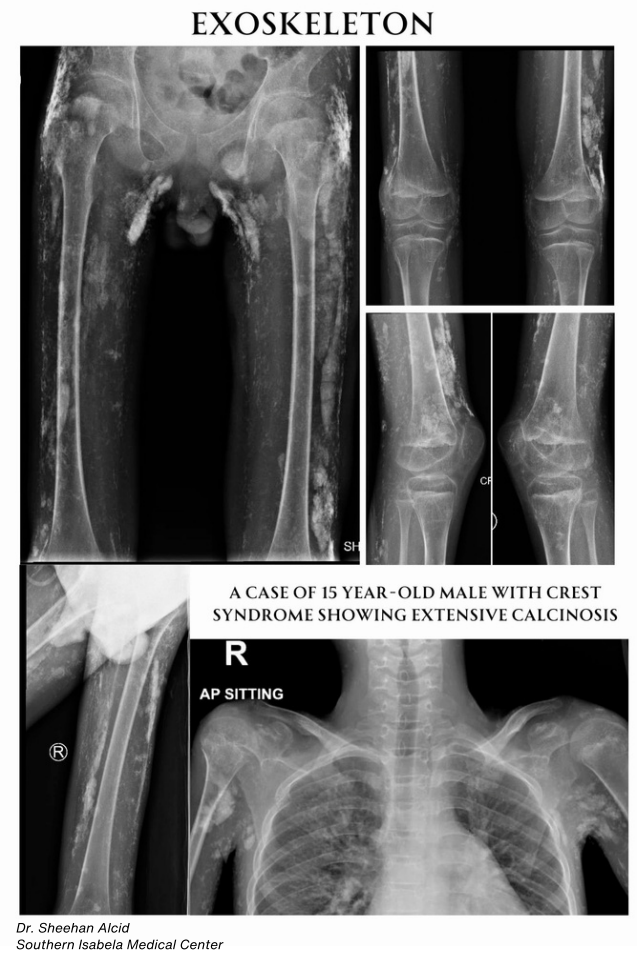

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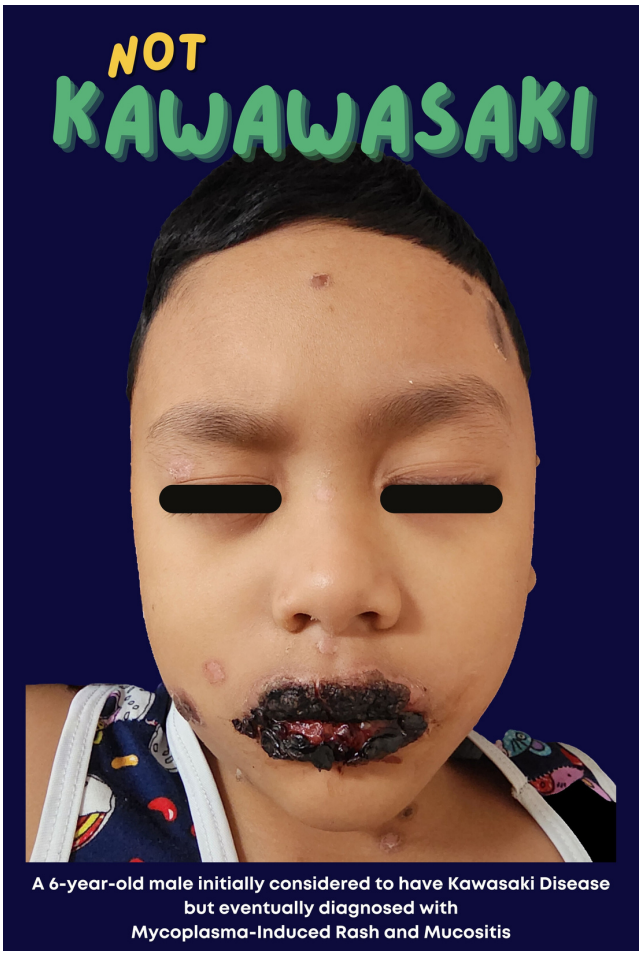

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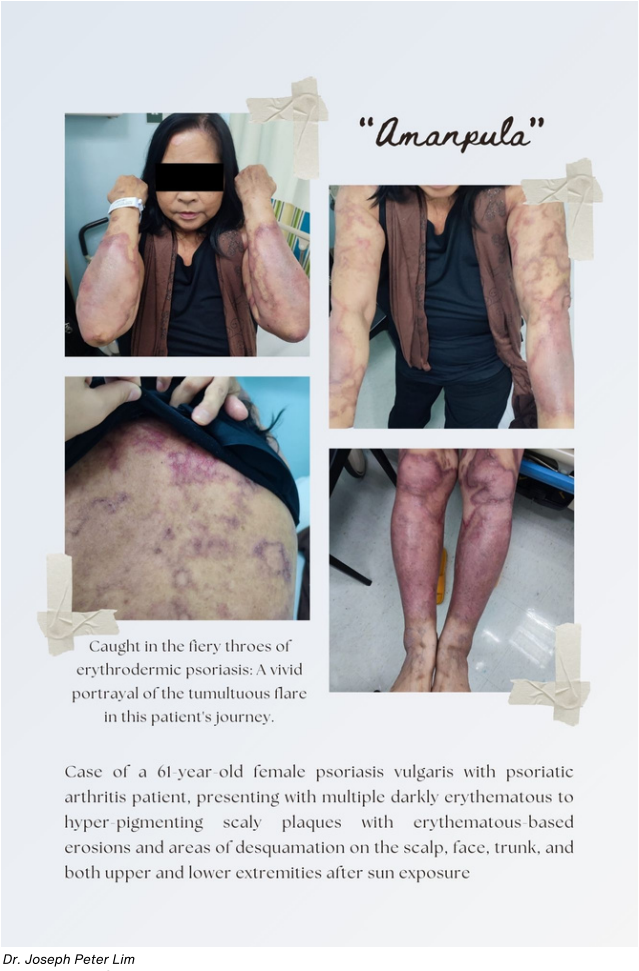

Dr. Joseph Peter Lim
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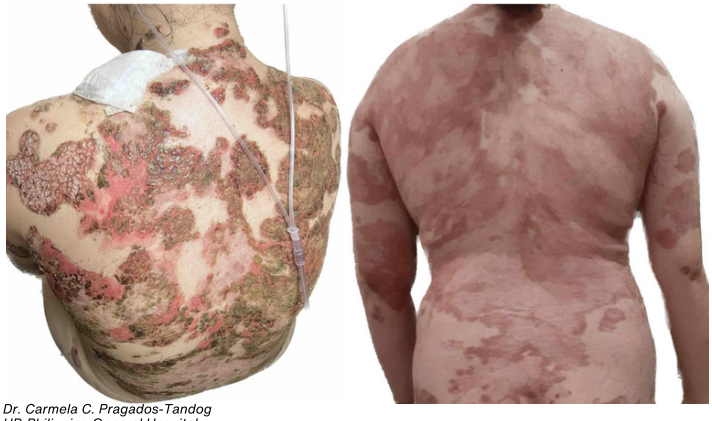
A severe case of pemphigus vulgaris treated with rituximab. This images illustrate the before and a month after the treatment.



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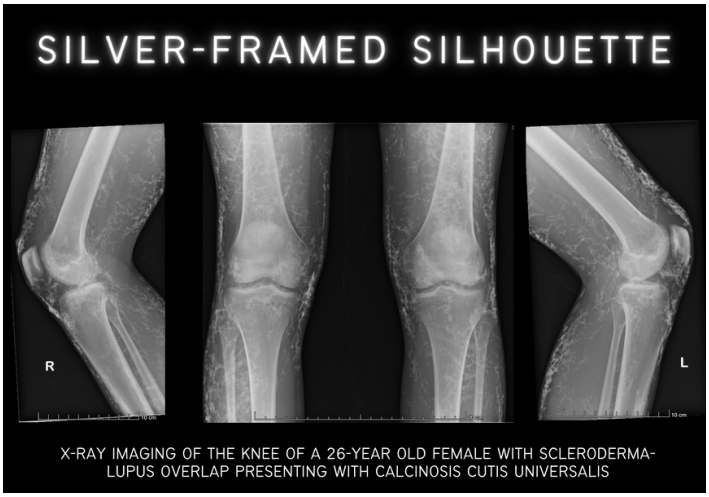

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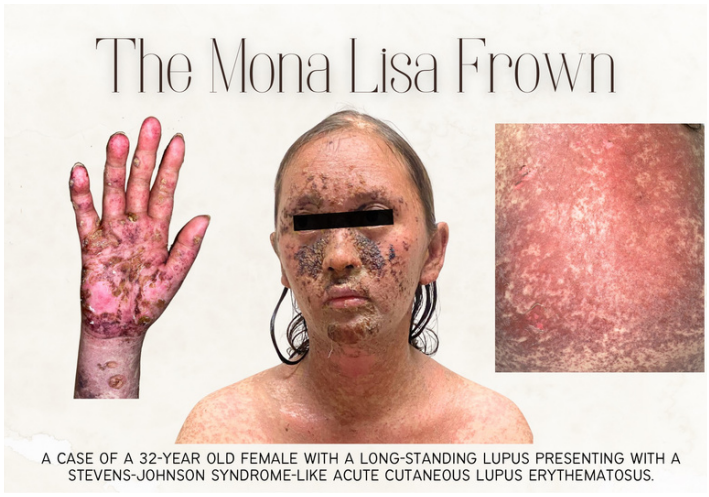

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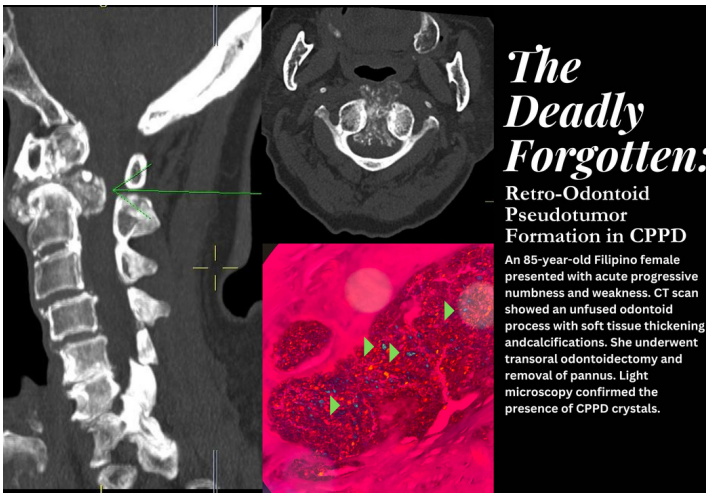

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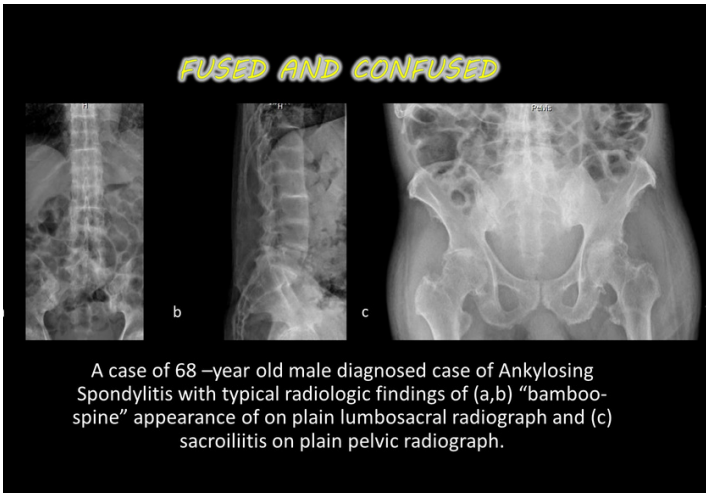

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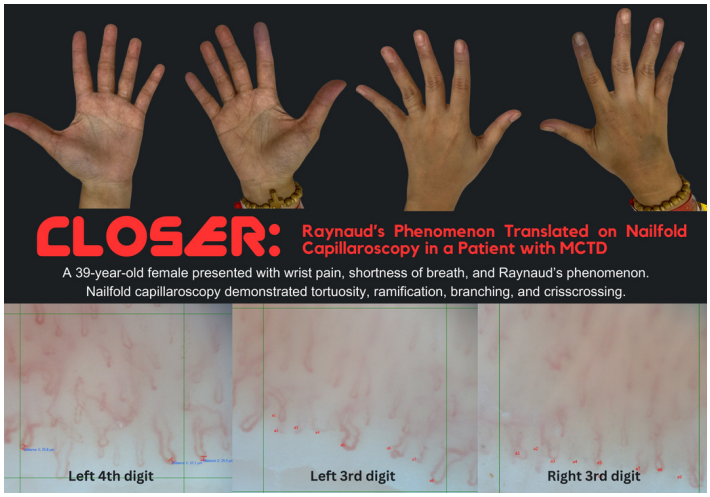
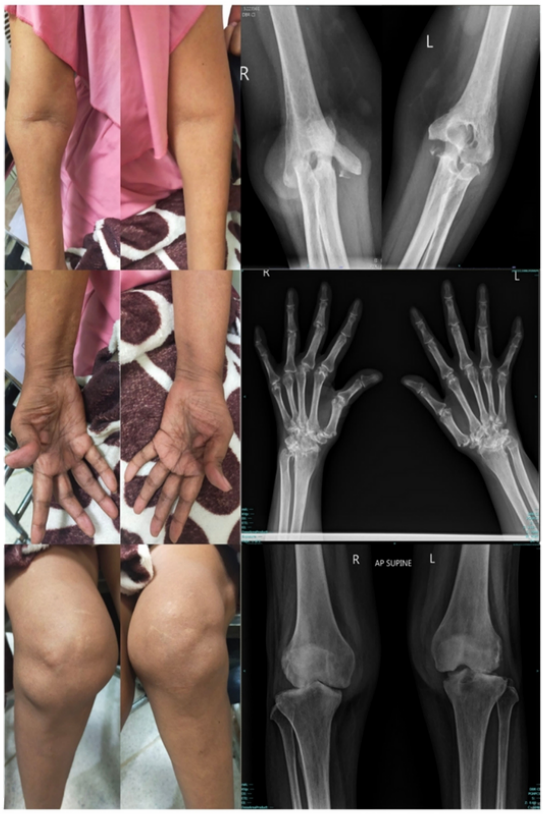


Dr. Eloisa Trina Generoso
Makati Medical Center

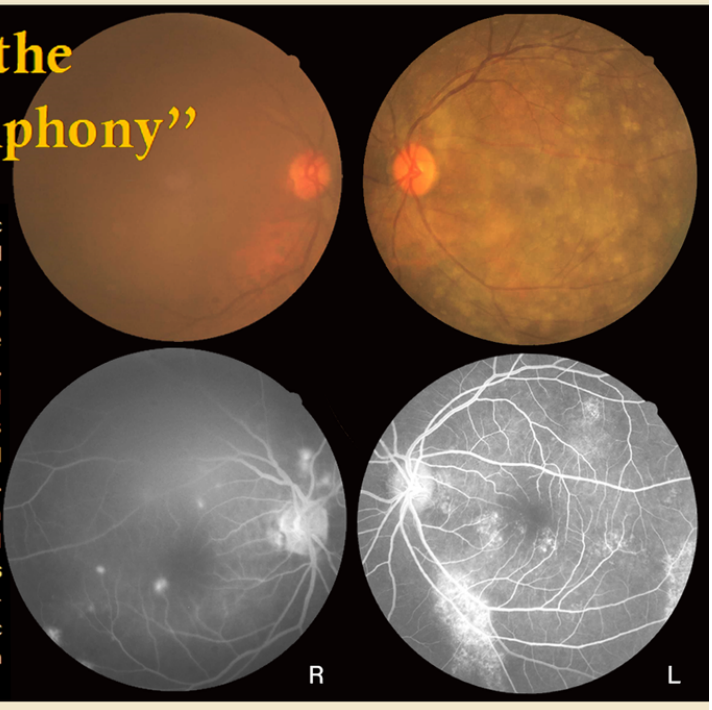
Deformity in Disguise



Dr. Jon Aubert Antigua
UP-Philippine General Hospital

A 50 year-old female came with a 6-year history of intermittent severe joint pain, tenderness, swelling, erythema on bilateral elbows, shoulders, wrists, metacarpophalangeal and interphalangeal joints of hands and knees. No fever and other systemic symptoms. Given Dexamethasone but self-discontinued. Progression with worsening of pain, causing difficulty in ambulation and standing up. On physical examination, noted with tenderness on these joints, crepitus on the elbows, wrists, and knees, with limitation in both active and passive range of motion. X-rays noted erosive changes, periarticular osteopenia, and gross subluxation and dislocation of elbows and knees.

"Capturing the Cosmic Symphony"



A 53 years old female with systemic lupus erythematosus developed Coombs positive hemolytic anemia, prednisone was increased to 40mg/day following which she complained of blurred vision, OU. Vision further deteriorated to hand movement when prednisone was increased to 60mg/day after an initial assessment of retinal vasculitis. Ophthalmologic re-evaluation with fluorescein angiography revealed **multifocal central serous retinopathy** as seen in steroid-associated CSR. There was dramatic resolution of ocular symptoms upon rapid tapering of prednisone.

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TFD The Filipino Doctor

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