ABSTRACTS: CONCURRENT SESSIONS

29 Effects of cyclosporin in the treatment of Lupus Pulmonary Hypertension D.J. Yoshii, D.Q. Byrd, J. Joyce, MD, M. Keller, MD, C.K. Oh, MD Harbor-UCLA, Torrance, CA

Pulmonary hypertension (PHTN) is an uncommon complication of systemic lupus erythematosus typically occurring after years of active disease. Chronic Mucocutaneous Candidiasis (CMCC) is on the other hand a disease associated with recurrent cutaneous Candida infections. The two diseases have not previously been reported together.

We are reporting a 13-year-old Hispanic female who had previously been diagnosed with CMCC who developed Lupus PHTN. The patient first presented at 11mo of age with an extensive Candidal rash of the axilla. She initially was treated as an inpatient but was lost to follow up. During this time the child had persistent onychomycosis and thrush but was otherwise healthy. At 12 y/o the patient developed hemoptysis, malar rash, pericardial effusion, and difficulty breathing. She was hospitalized for evaluation and treatment. The ANA was strongly positive, and the patient was found to have suprasystolic PHTN. Lupus anticoagulants were negative.

The patient responded to methylprednisolone and the PHTN decreased to 50% of systolic pressures. When the patient was changed to oral prednisone her pulmonary pressures would increase to 80% systolic pressures within 1 week. She was admitted for more IV methylprednisolone. Steroids quickly became ineffective and pulse cyclophosphamide (CYT) was started. Pulse CYT did little to change the PHTN. Oral cyclosporin (CYA) was started at with daily CYT. The patient responded well to the new therapy, pulmonary pressures decreased to 50% of systolic blood pressure. However the patient then developed ARDS from a severe fungal and CMV pneumonia and died. In summary, our data suggests CYA but not CYT effectively suppressed PHTN in steroid resistant Lupus PHTN.

30 ERADICATION OF CHLAMYDIA PNEUMONIAE FROM BRONCHOALVEOLAR LAVAGE (BAL) FLUID ASSOCIATED WITH ASTHMA IMPROVEMENT: CASE REPORT. D.L. Hahn, MD*, E.L. Middleton, MD, Madison, Wisconsin; L.A. Campbell, PhD; S-P. Wang, MD, Oakland, Washington

Background: Chlamydia pneumoniae (Cpn) has been associated with asthma by serology and organism identification in upper respiratory secretions. Objective: Correlate Cpn PCR findings in upper and lower respiratory secretions with clinical status before and after antimicrobial therapy of adult-onset asthma. Methods: Nasopharyngeal swab (NP) and BAL fluid were obtained from a nonatopic, nonsmoking 65 year old male with stable moderate persistent adult-onset asthma before (week 0) and after (week 12) azithromycin therapy (1000 milligrams orally, once per week during weeks 1-5). NP and BAL were tested for Cpn PCR; BAL was also cultured for Mycoplasma pneumoniae, respiratory viruses and pyogenes. Baseline asthma status (FEV1, PEFR, symptoms, Juniper Asthma QOL and medication use) was compared to 8 months after treatment. Results: Baseline chest and sinus x-rays were normal. Pretreatment BAL was positive for Cpn PCR; no other pathogens were isolated and all post-treatment specimens were negative for pathogens. Cpn IgG antibody titers remained 1:512. Pre-bronchodilator FEV1 increased (2.77 L to 3.14 L); AM and PM PEFR increased (449 to 701 L/min and 484 to 537 L/min, respectively). Symptoms improved and Juniper Asthma QOL score improved from 3.97 to 4.94 (7 point scale). Medication use decreased (9 puffs to 6 puffs of ICS, inhaled preeutonin discontinued). Conclusions: This is the first report of asthma improvement following microbiologic eradication of Cpn from BAL fluid. Results of sampling the upper respiratory tract may not correlate with presence of Cpn in the lung.

31 URTICARIA AND THYROID CARCINOMA: A NEW ASSOCIATION? A. Segalene, MD* and A. Gewurz, MD, Rush-Medical Center and Cook County Hospital, Chicago IL

Although the pathogenesis of chronic urticaria may be linked to underlying infection or autoimmune disease, particularly thyroiditis, several studies have failed to show an association with carcinoma. We report a 59-year-old Hispanic woman who presented 1 yr ago with intermittent urticaria and dysphagia of 3 months' duration. Her only current medication was cetrizine 10 mg QD PRN. "A thyroid disease" had been diagnosed in Russia 20 years earlier, but no treatment was given. Her thyroid medical history was otherwise unremarkable. The family history was negative for urticaria or endocrinopathy. The social history was noncontributory, and review of all other systems was negative. Physical examination, including the thyroid gland, was completely normal, except for several small urticaria. Laboratory tests showed normal CBC, ESR, serum electrolytes and urinalysis. Testing for thyroid disease showed thyroid stimulating hormone 33.6 uIU/ml (normal, 0.4-4.2), T4 1.24 ng/dl (normal, 0.8-1.9), T3 <0.01 ng/dl (normal, <0.06), TSH >10 miu/ml (normal, 0.1-4.0), anti-thyroglobulin antibody <0.01 (normal, <0.04), and antithyroid peroxidase antibody <0.01 (normal, <0.04). Total serum cholesterol, HDL cholesterol, and triglycerides were normal (but polarographic analysis showed the presence of an abnormal protein). The patient was treated with partial thyroidectomy and thyroxine replacement. Within a week both the urticaria and dysphagia had diminished. He was discharged and asked to return in one month for follow-up. He returned with urticaria and dysphagia of 2 months duration. Repeated test results were within normal limits. Physical examination revealed diffuse nodular hyperplasia, and a biopsy revealed chronic lymphocytic thyroiditis and localized papillary adenocarcinoma (follicular variant). The patient was treated with partial thyroidectomy and thyroxine replacement. Within a week both the urticaria and dysphagia had diminished. It was concluded that she had urticaria associated with thyroid adenocarcinoma, autoimmune (Hashimoto's) thyroiditis and secondary hypothyroidism. As shown by this case, the clinical associations of chronic urticaria may include carcinoma, as well as autoimmune disease, of the thyroid. In a patient with hypothyroidism and thyroid autoantibodies, a coexisting thyroid malignancy could be overlooked without an ultrasonogram or other diagnostic test.

32 PANDAS OR PARÇ: A PERPLEXING PEDIATRIC PROBLEM. M. Devera, MD* and A. Gewurz, MD, Rush Medical Center-Cook County Hospital A/I Program, Chicago IL

An 11YO boy presented with frequent, spasmodic blinking, squinting, mouth stretching and occasional upward rolling and sideways twisting of the neck of 6 months duration. He was examined by a neurologist, who observed "multiple motor tics." There was no other indication of neuromotoric or psychiatric abnormality. The patient had high levels of serum IgG antibodies against streptococci and was given an initial diagnosis of pediatric autoimmune neuropsychiatric disease associated with streptococci or PANDAS (Am J Psychiatry 1997:154:100-2). Daily oral penicillin prophylaxis against streptococcal reinfection was initiated. The patient also complained of mild itching of the eyes and nose and postnasal drip with throat-clearing, which were partially relieved by diphenhydramine; he denied associated sneezing, nasal/sinus congestion, rhinorrhea or tearing. The past medical and family history were negative for atopic (rhinosinusitis, conjunctivitis, asthma or eczema) or rheumatologic diseases. The patient had no known hypersensitivity to foods, drugs or other antigens. He formerly had a pet cat. Physical examination showed a healthy-looking child with infrequent facial tics (staccato blinking, followed by a "startled" expression), allergic shiners, edema of the nasal mucosa, mild telangiectasis of the skin. Scleritis examination by an ophthalmologist revealed conjunctivitis with mild tarsal papillary reaction. Skin testing was positive for immediate reactivity to cat and dustmite allergens. Our diagnosis was blepharospasm secondary to perennial allergic rhinitis and conjunctivitis (PARC) masquerading as PANDAS. All symptoms improved following treatment with daily cetirizine, montelukast, intranasal mometasone and olopatadine eyedrops, environmental control, and twice-weekly dustmite allergen vaccine immunotherapy. We recommended discontinuation of oral penicillin prophylaxis.