Rheumatology

316 A Study of Rheumatic Manifestations in Leprosy
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Leprosy is not a single clinical entity, but rather a spectral disease that presents a diversity of clinical manifestations. Rheumatic manifestations are a common feature of leprosy. Musculoskeletal manifestations can occur at any time during the infection. Rheumatic manifestations may be the primary complaint delaying accurate diagnosis. The rheumatological manifestations of leprosy occur singly or in varying combinations. Arthritis in leprosy closely mimics rheumatic disorders. The present study was carried out to highlight the significance of rheumatic manifestations in leprosy and also to make aware every general physician that leprosy should be thought of in the differential diagnosis of rheumatic disorders.

Background: To fulfill the Jones criteria (updated 1992), for the diagnosis of rheumatic fever, apart from major/minor criteria evidence of antecedent streptococcal infection are required which is provided by positive throat culture or rapid antigen detection test and / or elevated or increasing streptococcal antibody test.

Aim: To analyze the significance of ASO titre in evidence of recent group A streptococcal infection.

Material and Methods: Thirteen (M-7, F-6) Rheumatic fever patient in the age group of 5-15 years and 23 (M-9, F-14) arthritis patient following acute streptococcal pharyngitis in the age group of 25-55 year were taken for the study. (From 1/6/2002 to 31/5/2003). Out of 36 patient, 12 (33.32%) patient had ASO titer more than 800 IU/ml, 24 (66.66%) patient had titre more than 400 IU/ml at the time of initial presentation. All the patient were given injection benzathine penicillin LA in view of suspected cases with Congo red staining under polarized microscope.

Results: Out of 13 rheumatic patient 8 (61.54%) had shown decreased ASO titre after one month and 9 (69.22%) patient had same value ever after 6 months of therapy. Out of 23 arthritis patient 6 (26.08%) had shown decrease ASO titre, 14 (60.88%) pt had no change, surprisingly 3 (13.04%) patient had shown increased ASO titre after 6 months. None of the patient had developed side effect with injection benzathine penicillin.

Conclusion: Persistence of ASO titer in a significant number of patient even after 6 month of therapy with benzathine penicillin in rheumatic fever plus arthritis patient due to past streptococcal infection raises the

317 ASO Titer - Relevance of it in Supporting Recent Streptococcal Infection - An Experience in Ordnance Factory Hospital Badmal, Bolangir
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318 Study on Pulmonary Manifestations of Rheumatoid Arthritis in Bikaner (North-West India)
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Introduction: This prospective study was conducted to find pulmonary manifestations of rheumatoid arthritis (RA).

Methods: Fifty patients who met the ACR criteria 1987 were subjected to clinical examination. Chest X-ray, pulmonary function test (PFT) and high resolution computed tomography (HRCT) were performed all the patients. Patients with previous respiratory illness were excluded from the study.

Results: Forty patients were females and 10 males with female to male ratio of 4:1. The clinical features were exertional dyspnoea in 5 (10%), cough with expectoration in 3 (6%), and fine respiratory rates in 3(6%), Chest-Xray abnormality was seen in 5(10%) commonest pattern being bilateral lower zone hazziness in 4(8%) and prominent pulmonary vasculature in 1 (2%). Twenty seven patients (54%) had abnormal PFT - restrictive pattern in 20 (40%), obstructive pattern 4(8%) and mixed pattern in 3 (6%). HRCT revealed abnormal findings in 20 (40%) commonest being ground glass pattern in both lower lobes in 12 (24%) sub pleural reticulations in 1(2%), both suggestive of early interstitial lungs disease (ILD), bilateral pneumonitis 2(4%) pleural thickening in 1(2), and pulmonary vascular prominence in 1 (2%) and pulmonary vascular prominence in 1 (2%).

Conclusion: Among the pulmonary manifestation of rheumatoid arthritis, ILD was the common presentation which was detected by PFT and HRCT. There was no clear relationship between the severity of RA and severity of lung disease.

319 Study of Renal Involvement in Rheumatoid Arthritis
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Aim: To find out the incidence of renal involvement in rheumatoid arthritis (RA) patients not exposed to disease modifying antirheumatic drugs (DMARDs) and analyse the pattern of renal disease in them.

Patients and Methods: Patients who satisfied the 1988 revised ARA criteria for classification of RA were selected for the study. Those who have already taken DMARDs, immunosuppressants or native medicine were excluded. Detailed history taking with special emphasis on renal symptoms and complete clinical examination were done. Laboratory evaluation included complete blood count, biochemistry profile, coagulation tests, Rheumatoid factor estimation by latex agglutination test, urine examination, 24 hours urine protein estimation and ultrasonogram abdomen. Renal biopsy was done and the sample was subjected to histopathological examination by light microscopy and in suspected cases with Congo red staining under polarized microscope.

Observation and Results: Among the total of 25 patients, in 5 cases the biopsy sample contained only tubules and so, the study population was restricted to 20. Among them, 18 were females and 2 were males. The age group ranged from 19 years to 65 years and the duration of illness from 2 to 10 years. Mild proteinuria with haematuria was present in 7(35%) patients. 1(5%) patient had nephrotic syndrome and 19 (95%) had mild to moderate proteinuria. Rheumatoid factor was positive in 16(80%) cases. Histopathological examination of renal tissue showed mesangioproliferative glomerulonephritis in 8(40%)}
patients, local segmental glomerulosclerosis in 3(15%), amyloidosis in 3(15%), membranous glomerulonephritis in 1(5%) and minimal change glomerulonephritis in 1(5%). The biopsy was normal in 4(20%) cases. **Conclusion:** Mesangiproliferative glomerulonephritis was the commonest abnormality in our study. Since all the patients did not like any DMARDS, the rheumatic process itself could be the cause for renal involvement in them and kidney is also frequently involved in RA as part of its systemic manifestations.

**320 Common Presentation of An Uncommon Disease**  

It has rightly said by someone that “uncommon presentation of common disease is more common than the common presentation of uncommon disease”, anaemia, low grade fever, weight loss, polyarthritis or melena are the common presentation but can represent as an underline rare disorder (amyloidosis). 52 yrs. non-diabetic, non-hypertensive female presented with 1) progressive swelling of legs and abdomen without facial involvement since last 3 months. 2) Asymmetrical small and large joints polyarthritis 3) Loss of 6 kg body weight within last 3 months. 4) History of low grade fever associate with single episode of black tarry stool without h/o jaundice abdominal pain, vomiting, hematemesis or NSAID intake. Her past, personal, family, drug history were insignificant. On exam bilateral pitting pedal oedema, pulse 74 per/min, BP 120/80 mmHg without postural drop, JVP engorged, upper body 5cm above sternal angle with prominent Y descent with positive Kussmaul’s sign. firm non-tender multinodular thyromegaly with bilateral xanthelasmas, firm non-tender hepatomegaly with span 20cm, free fluid present in the abdomen. CVS, Chest CNS, Locomotor, Lymphoreticular system non-contributory. Investigation shows CBC-WNL ESR=117mm 1st hr., total bilirubin 0.3 mg/dl, albumin 1.5 gm/dl, Globulin 4.5 gm/dl, ALP, ALT, AST 1931 u/l, 86 u/l, 95 u/l respectively. Prime 13.5/13 sec. Serum urea, creatine, Calcium, Na+, K+, cholesterol, triglyceride - WNL, urine RE/ME - albumin ++, no sediment, pus cell, 24 hrs urine albumin 23 gm, CRX increased CT ratio, ECG-WNL, UGI endoscopy, colonoscopy - normal, mantoux negative, USG abdomen-hepatomegaly with homogeneous ecotexture, IHBR, CBD not dilated, P 10.2 mm, both kidney 10.6 cm with increased cortical ecogeneity and altered CM differentiation. Ascitic fluid study-Low SAAG, no malignant cell found. HBsAg, anti-HCV, RF, ANF, anti dsDNA-negative, calcitomin, thyroid profile normal. Echocardiography-concentric LVH, I/Vs thickened, trivial MR, granular sparkle present. Urine for B-J protein negative, Ser-protein electrophoresis normal, FNAC from thyroid adenomatous goiter. Kidney biopsy with Congo red stain shows focal deposition of amyloid and tubules contain hyaline cast, deposition of amyloid material in arteries. Our final diagnosis-Primary Idiopathic Amyloidosis. **Conclusion:** Patient presented with common symptom with elevated ALP with massive hepatomegaly, proteinuria, thyromegaly, granular sparkle on echo, tissue biopsy from involving organ must be done to rule out amyloidosis.

**321 Pulmonary Manifestations in Systemic Lupus Erythematosus**  

**Aim of the study:** To study the clinical profile and pulmonary manifestations in patients with systemic lupus erythematosus. **Material and Methods:** Eighteen patients, presenting with SLE to the department of Medicine were studied. The diagnosis was made as per the revised criteria RHA 1982. Apart from history and detailed clinical examination, routine investigations including X-ray chest and ECG were done. Ultrasound abdomen, 2D echo, renal biopsy were done wherever relevant. Seriological tests including VDRL, LE cell, RA factor, ANA, anti ds DNA were done. Sputum examination was done for Gram’s stain, Z.N. stain for AFB and culture and sensitivity. Pleural fluid analysis for routine tests and ADA, ANA, Anti ds DNA were done. Pleural biopsy was done in relevant cases. Functional evaluation included PFT, DLCO (diffusing lung capacity for carbon monoxide). Patients were followed up once in 4 weeks. **Results:** Out of 18 patients 13 patients had Pleuro pulmonary manifestations Pleurisy / Pleural effusion in 8, (unilateral 3, bilateral 5). Lupus pneumonitis 2, shrinking lung syndrome 1, pulmonary hypertension 2, chronic interstitial fibrosis 1, restrictive lung pattern 3, small airway disease 8, decreased DLCO 10, pulmonary infarction 3, pneumothorax 2. (The subject in last five patterns were asymptomatic). Most common spirometric abnormality was reduction in FEF 25-75 % (MMFR) below 80% of predicted value. **Conclusions:** Asymptomatic involvement of respiratory system is common. Common respiratory symptoms include pleuritic chest pain and breathlessness. Thus every patient with SLE must have routine PFT and DLCO assessment and all young women with new onset pleurisy and effusion should be evaluated for SLE.

**322 A Young Girl with SLE Presented with Severe Haemolytic Uremic Syndrome**  
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A sixteen year old girl was referred from peripheral district Hospital for severe anemia, anaemia and acute respiratory distress of 1 month duration and oliguria of 15 days. Patient apparently asymptomatic 1 month back when she developed facial puffiness followed by swelling of the whole body in 2 days with distention of abdomen in 1 week. Shortness of breath started along with facial puffiness, which progressed from grade I to grade III. No H/o cough, chest pain, haemoptysis. No H/o PND or orthopnea. Oliguria since 15 days no H/o haematuria or dysuria or loin pain. H/o easy fatigability, giddiness and headache present. She was transfused 6 units of B +ve blood. **On Examination:** 16 year old female conscious, comfortable at rest for severe anemia and anaemia, no icterus, no cyanosis, no clubbing, no koilonychia, skin rashes, echymosis or purpura, no oral ulcers and no bony tenderness. P/A No organomegaly CVS Normal, CNS Normal, Haemopoetic System Normal, Musculo Skeletal system Normal Respiratory system-Bilateral decreased air entry in bases s/o of bilateral pleural effusion During hospital stay patient developed superficial thrombophlebitis of left UL. **Investigations:** Normochromic haemolytic anaemia, thrombocytopenia with raised renal parameters, 24 hrs. urine protein 2.6 gms, negative coombs test, RBC fragility test negative, G6PD screen normal. LFT suggestive of hemolytic jaundice. Upper GI endoscopy normal. ANA 1.4 and Anti ds DNA 250 IU positive. Renal biopsy suggestive of mild mesangial proliferative lupus nephritis She was started on prednisolone with improvement in renal function anaemia and anaesacra within 2 weeks.
323 Immunological Marker Study in Atypical Cases of SLE
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SLE is an autoimmune disease with multi-system involvement and a number of autoantibody productions in the blood. Though sophisticated means have now been developed to test these antibodies, the clinical evaluation is still the mainstay of treatment. We conclude from the present study that high degree of clinical suspicion gives the clue to the diagnosis of SLE. Antibody tests are only supporting evidences and may be sometimes misleading.

324 Unusual Presentation of Wegener’s Granulomatosis - Case Report
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45 years male presented with increased frequency of micturition with retention of urine of 6 days duration. H/o. pain and swelling (Rt.) cheek, 5 months. H/o. cough with streaky hemoptysis, h/o. repeated root canal treatment and tooth extraction present. There was h/o. 20 kg. weight loss, no h/o. fever. CT paranasal sinus showed pan-sinusitis, right antral wash done which is negative for malignant cells and fungus. Patient was a known diabetic on irregular mediation. On examination - mild swelling of Rt. cheek with tenderness present. Vitals were stable. Respiratory system creps present on (Lt.) basal region. Perrectal examination tender prostatomegaly was present, other system examination were normal. US abdomen showed grade III prostatomegaly and thickening of bladder wall. Radiographs and CT chest showed consolidation (Rt.) lower lobe. cANCA was strongly positive. Biopsy from prostate and bladder revealed necrotising granulomas with vasculitis. Patient was treated with cyclophosphamide and steroids, responded well on follow up. We are reporting this as a granulomas with vasculitis. Patient was treated with cyclophosphamide and steroids, responded well on follow up. We are reporting this as a granulomas with vasculitis.

325 Jaundice as a Clinical Marker in “Severe” Malaria
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Object of the Study: This study was undertaken to evaluate the strength of the association between a simple clinical marker like jaundice and falciparum malaria.

Material and Methods: This study was done over a 2 year period in a teaching hospital.

Criteria for Selection: 1. Only smear positive / QBC positive patients for malaria were included in this study. 2. Age > 12 years. 3. Hyperbilirubinemia was defined as serum bilirubin > 3mg/dL.

Exclusion Criteria: Past history of jaundice/clinical signs of chronic liver disease.

Results and Observation: Total number of cases in this study - 80.

Predictive value of jaundice for the diagnosis of P. falciparum.
Sensitivity = 0.53, Specificity = 0.83, Positive predictive value = 0.92, Negative predictive value = 0.34

Predictive value of jaundice for “severe malaria”
Positive predictive value =0.56, Negative predictive value=0.75

Conclusion: Jaundice is a fairly good predictor for the diagnosis of P. falciparum with a positive predictive value of 0.92. Jaundice was a reasonably sensitive and specific clinical guide for the diagnosis of “severe malaria” in adults. Mortality and “severe” illness were more in those over 40 years of age.

326 Cerebellar Ataxia in Typhoid - A Case Report
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Enteric fever is one of the commonest problems encountered in clinical practice. C.N.S. involvement is seen sometimes (10-40% of cases) in the form of confusion, encephalopathy, meningism, convulsions etc. Cerebellar ataxia has been reported only in a handful of cases. A 23 year old B.H.U. student came to the OPD with a history of high grade fever for 10 days and difficulty in walking and unsteadiness, abnormal movements of the limbs and dysarthria for 1 day. On general examination, the patient was toxic, had a temp, of 103°F, bradycardia, hypotension and had a confused look. Spleen was palpable. CNS examination revealed normal higher functions and cranial nerves. Sensory functions were normal. However, cerebellar signs were present like dysarthria, nystagmus, dysdiadichonesis, finger nose incoordination and ataxia. Routine haematology did not reveal anything significant. TLC. D.LC, Hb, ESR, blood sugar / urea, paracheck, urine routine examination, chest X-ray and CSF examination were normal. Blood culture showed the growth of S. typhi and Widal was strongly positive, showing antibody titres of 1 : 320 and 1 : 640 for O and H antigens. The patient was put on parenteral ceftriaxone daily on basis of sensitivity reports. The patient became afebrile after 1 week. However, cerebellar signs receded slowly and the patient became normal only after 6 weeks.

327 A Study of Complications of Falciparum Malaria in Delhi
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Introduction: Falciparum malaria has high prevalence in Eastern and