L. Sammut: injury. need for physicians to maintain a high level of suspicion if a patient on EPOSTERS haematuria was consistent with HSP. She was started on Prednisolone stage was 131mg/L. Clinically the rash on the legs, abdominal pain and had further abdominal pain. She had taken co-codamol which led to arteritis. Adrenal haemorrhage has been reported characterised by IgA deposition. Adrenal haemorrhage is a rare complication of HSP and should be recognised as part of the differential diagnosis in such patients presenting with acute abdominal pain and vasculitic rash.

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Methods

Results

Conclusion

Adrenal haemorrhage is a rare complication of HSP and should be considered as part of the differential diagnosis in such patients presenting with acute abdominal pain and vasculitic rash.

Disclosure

The authors have declared no conflict of interest.

Reference

PO27 A CASE OF HENOCH-SCHONLEIN PURPURA COMPLICATED BY ADRENAL HAEMORRHAGE

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Background/Aims

Henoch-Schonlein purpura (HSP) is a small vessel vasculitis characterised by IgA deposition. Adrenal haemorrhage has been reported previously in HSP, but is rare.

A 33-year-old lady was admitted with myalgia, pyrexia, a faint petechial rash on her legs, a CRP of 92mg/L (0.5-5). No signs of meningism were found. A throat swab for viral pathogens (taken prior to the Covid-19 pandemic) returned negative, and blood culture showed no growth. Within a few days she returned to the Accident & Emergency Department with worsening of the rash but was again discharged. The following week she was admitted with abdominal pain and a prominent purpuric rash on her legs.

Full blood count, Rheumatoid Factor, Anti-Nuclear Antibodies, ANCA and Anti-Glomerular Basement Membrane Antibodies, serum Trypsin & C1 esterase inhibitor were all within normal limits. Urine culture grew E.coli. Complement C3 was raised at 2.24g/L (0.75-1.65) and C4 was within normal range. Her blood pressure was raised at 173/104 mmHg. Antistreptolysin O serology was also normal. Urine analysis revealed haematuria and mild proteinuria. Urine Protein/Creatinine ratio of 22mg/mmol (normal <50). Her purpuric rash had progressed, and she had further abdominal pain. She had taken co-codamol which led to nausea & constipation. She had avoided NSAIDs. Her CRP by this stage was 131mg/L. Clinically the rash on the legs, abdominal pain and haematuria was consistent with HSP. She was started on Prednisolone 10mg od, tapering in 2.5mg per week decrements. The patient was discharged home but returned the following weekend with cramping abdominal pain radiating to the back. Abdominal Xray showed dilated colon at the splenic flexure. After review by the Surgical on call team, a CT Abdomen & Pelvis showed a right adrenal haemorrhage, and inflammatory change in both adrenals. Although she did not display clinical signs of Addisonian crisis or sepsis, she was transferred to HDU for monitoring. Her blood pressure was 151/86 mmHg and her serum urea & electrolytes were normal. The Prednisolone dose was changed to Hydrocortisone, and the dose increased to cover stress of acute illness. MRI of the adrenal glands confirmed right adrenal haemorrhage but showed no evidence of aneurysms or tumours. Antiphospholipid & Cryoglobulins screens were negative. Further blood cultures, pneumococcal and legionella antigens returned negative. Viral Hepatitis screen (A, B & E) was negative. Synacthen test revealed a suboptimal response (Cortisol 10–181nmol/L, t30=260nmol/L, normal response >420nmol/L). Adrenal Autoantibodies returned negative. She was discharged home on oral hydrocortisone and fludrocortisone and remained well at Rheumatology and Endocrine follow up.

Conclusion

Adrenal haemorrhage is a rare complication of HSP and should be considered as part of the differential diagnosis in such patients presenting with acute abdominal pain and vasculitic rash.