Abstract citation ID: rkac067.028
P28   RECALCITRANT EXUBERANT DIGITAL CALCINOSIS CUTIS IN A PATIENT OF CREST SYNDROME - A CASE REPORT

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Introduction/Background: Calcinosis cutis is dystrophic soft-tissue calcification associated with connective tissues diseases, especially calcification associated with connective tissues diseases, especially...
Dystrophic calcinosis is the most common type of calcinosis cutis and is seen in association with autoimmune connective tissue diseases. It is thought to occur as a result of chronic local tissue injury and is a common complication of systemic sclerosis especially the limited form (CREST syndrome: calcinosis, Raynaud’s phenomenon, esophageal dysmotility, sclerodactyly and telangiectasia), affecting approximately 25% of these patients. Calcinosis may develop at any time during the disease course and may predate the diagnosis of scleroderma, but typically occurs at least 10 years following diagnosis. Lesions occur on the hands and feet, with a high predilection for fingertips and areas of microtrauma. Raynaud’s and digital ulcers are risk factors for calcinosis in scleroderma, suggesting a role for vascular ischemia. These lesions might be associated with pain, soft tissue swelling, ulcers with toothpaste-like material discharging or deforming tissues, which may lead to functional problems. Treatment of calcinosis cutis is tough and challenging as there is no gold standard treatment. Medical therapy for cutaneous calcinosis is limited and has variable benefits. Multiple treatment approaches with diltiazem, disodium etidronate, probenecid, colchicine, minocycline, low-dose warfarin, intralesional adenalin steroids, abatacept, rituximab, thalidomide have been explored, but no standard treatment has convincingly prevented or reduced calcinosis. Surgery is generally reserved for discrete lesions with problems of recurrent infection, severe pain, or functional impact. Despite concerns about recurrence of lesion due to mechanical trauma at the operative site, surgical resection has been effective in treating calcinosis. Treatment with extracorporeal shock wave lithotripsy and carbon dioxide laser therapy have shown promise in a few cases and need further study.

**Key learning points/Conclusion:** Pharmacological treatment of calcinosis cutis is difficult and a variety of drugs including bisphosphonates, intralesional corticosteroids, aluminium hydroxide, warfarin and diltiazem, have been tried with limited success. The local excision of painful or ulcerated nodule is the current existing therapeutic option but local recurrence is common. The present case is of interest because it has features of Raynaud’s phenomenon, heart burn, telangiectasia and sclerodactyly with microscopic finding of calcinosis cutis (CREST syndrome). Patient with crest syndrome often have better prognosis than diffuse systemic sclerosis. Pathologist should be aware about various clinico-pathological categories associated with localized calcium deposition in dermis.