**PAIN IN RHEUMATIC DISEASE**

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**OA06  A COMPLEX CASE OF THIGH PAIN IN GRANULOMATOSIS WITH POLYANGIITIS (GPA)**

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**Introduction/Background:** Rheumatic pain can result from a multitude of aetiologies. We present a complex case of thigh pain as the presenting manifestation of GPA, which required a multi-disciplinary approach to investigate, diagnose and manage. The pain was attributed to lumbosacral plexopathy, a rare neurological manifestation of GPA. The case was further complicated by subsequent leg weakness secondary to steroid-induced myopathy underlining the challenges confronting clinicians in diagnosing and managing complex systemic...
Whilst peripheral nervous system involvement, most frequently mono-neuropathy) to unravel the complexity of this clinical scenario. Disciplinary teams (rheumatology, ENT, radiology, neurology, neuro-physiology) are variably sensitive to detecting muscle disorders, has limited specificity in distinguishing the type of myopathy and therefore is rarely performed in clinical practice to diagnose steroid-induced myopathy. MRI findings must be correlated with the clinical context. If in doubt, a muscle biopsy should be sought. This would form our next line of investigation if his thigh symptoms had not settled.

Key learning points/Conclusion: The International Association for the Study of Pain (IASP) has recently defined pain as “an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage”. Acute causes of pain are varied and include local and systemic aetiologies such as inflammatory, infective, traumatic, malignant and iatrogenic. Analgesic medications usually have little to offer other than side effects or are sequelae of treatment. The likelihood of developing acute myositis whilst on high dose steroids was less plausible than a steroid myopathy; always treat the patient and the clinical scenario. Interval scanning can be helpful to monitor progress and response to treatment; in this case it was reassuring that repeat MRI thigh showed a reduction in muscle oedema once steroids were decreased.

Whilst “common things are common”, rare presentations of rare conditions also occur; utilise the expertise of your MDT in these situations.
A 40-year-old attended our rheumatology clinic with a targeted oral small molecule as a possible treatment for his psoriatic arthritis. Due to persistent active disease clinically and on nuclear medicine scan, a clinical diagnosis of PsA was made and she was commenced on a biologic with a targeted oral small molecule.

**Description/Method:**
- Patients who do not achieve remission in all disease aspects on biologic monotherapy or combination of a biologic therapy with an oral small molecule are evaluated to induce deep and sustainable clinical responses in all domains of PsA.

**Introduction/Background:**
- In patients who do not achieve remission in all disease aspects on biologics and targeted JAKs, such strategies should be considered in debilitating cases of psoriatic disease who fail to respond to conventional therapies.

**Key learning points/Conclusion:**
- Identification of potential associated risks, particularly infectious risk, in patients with PsA.
- Involvement in clinical decisions regarding their disease is required.
- Our case highlights that a patient-centred approach with patient involvement in clinical decisions regarding their disease is required.

**Discussion/Results:**
- Pain scores typically drop later and can indicate significant disability, poor quality of life, and are not economically productive.
- Pain significantly reduced along with anxiety and depression scores also improving. Self-efficacy scores rose first with associated drops in catastrophization and kinesiophobia.

**Clinical Table:**

| Time       | Baseline | 2 weeks | 6 weeks | 7 months | 13 months |
|------------|----------|---------|---------|----------|-----------|
| Back pain  | 9        | 7       | 7       | 7        | 4         |
| Leg pain   | 2        | 1       | 0       | 1        | 0         |
| Leg numbness| 1      | 0       | 0       | 2        | 0         |
| Leg tingling| 1       | 0       | 0       | 1        | 0         |
| RMDQ       | 14       | 9       | 8       | 4        | 3         |
| EQ-SD-5L   | 18       | 18      | 16      | 12       | 10        |
| HAD-D      | 9        | 7       | 6       | 4        | 5         |
| HAD-A      | 8        | 8       | 5       | 3        | 4         |
| PSEQ       | 22       | 38      | 30      | 46       | 47        |
| PCS         | 29       | 20      | 15      | 13       | 11        |
| TSK-68     | 38       | 31      | 32      | 26       | 30        |
| Employment | Benefits | Benefits| Benefits| Full time| Full time |

**Notes:**
- RMDQ: Roland Morris Disability Questionnaire – lowest scores are healthiest.
- EQ-SD-5L: EuroQol’s 5 Dimensions with 5 Levels – lowest scores are healthiest.
- HAD-D: Hospital Anxiety and Depression – Anxiety Scale – lowest scores are healthiest.
- HAD-A: Hospital Anxiety and Depression – Depression Scale – lowest scores are healthiest.
- PSEQ: Pain Self-Efficacy Questionnaire – highest scores are healthiest.
- PCS: Pain Catastrophisation Scale – lowest scores are healthiest.
- Tampa Scale for Kinesiophobia – lowest scores are healthiest.