(IIF), ANA 1+ mottled, ANTIDNA -, antiCCP 6 / ml, PR3 and MPO negative, negative ENA profile, normal complementr. PPD 0, direct Coombs 2+, hepatitis B and C serologies negative, HIV negative, negative cryoglobulins. A chest CT scan performed showed nodular images in the left upper lobe and bilateral interstitial pneumonia. Echocardiogram showed mild pericardial effusion. Skin biopsy showed neutrophilic leukocytoclastic vasculitis of small and medium vessels compatible with rheumatoid vaculitis. Xray film of the hands was performed that showed no evidence of erosions or secondary changes of rheumatoid arthritis. Treatment was initiated with prednisone 50mg day and methotrexate 20 mg weekly, with satisfactory resolution of skin and joint symptoms. Cyclophosphamide was planned, however fibro bronchoscopy was performed with bronchoalveolar lavage that reported positive for Mycobacterium Tuberculosis, so treatment for tuberculosis was initiated and methotrexate was discontinued. Patient presented at 6 weeks of initiation of antituberculous treatment episode with diffuse alveolar hemorrhage and died.

Conclusions: This case highlights the difficulty in differentiating rheumatoid arthritis and granulomatosis with polyangiitis in patients with rheumatoid arthritis who show signs of systemic vasculitis. The positivity of ANCA by IIF has been shown to have a prognostic value for the course of early rheumatoid arthritis, by predicting rapid destruction of the joints and increased inflammatory activity, but it has a low diagnostic value. Our patient did not develop erosive activity.

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CORRELATION BETWEEN CLINICAL ACTIVITY MEASURED BY DAS-28, CDAI AND ULTRASOUND IN PATIENTS WITH RHEUMATOID ARTHRITIS BEING CARE FOR AT THE RHEUMATOLOGY CLINIC AT THE NATIONAL HOSPITAL ARZOBISPO LOAYZA DURING JANUARY TO JUNE 2019.

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The aim of this work is to establish the correlation between clinical activity measured by DAS-28, and ultrasound in patients with rheumatoid arthritis (RA).

A descriptive, longitudinal study was carried out on patients with RA who were cared for at the Rheumatology service of the Arzobispo Loayza National Hospital. The study included female patients diagnosed with RA, aged 18 years or older, who met the 1987 ACR classification criteria (patients with RA duration ≥ at 2 years) or the 2010 ACR and EULAR criteria (patients with RA duration < at 2 years) in the period between January and June 2019. Exclusion criteria include patients with overlapping syndromes, active infectious processes, pregnant patients, having undergone recent surgical procedures and/or having sequelae of wrist or finger/foot fractures.

A non-probabilistic sample was defined for convenience. Patients were included into the study after meeting the selection criteria (dynamic cohort).

The variables were: disease activity by DAS-28, and disease activity by musculoskeletal ultrasound with gray scale (GS) and Power Doppler (PD).

To determine the disease activity, the DAS28 was obtained in all patients by a rheumatologist who was unaware of the ultrasound results.

All patients underwent a musculoskeletal ultrasound (US), which was performed by a rheumatologist specialized in this technique and, who was blinded to the results of DAS-28.

The hand joints were evaluate ultrasonographically, using the score 5 (US5) (wrist, 2nd and 3rd MCPs, 2nd and 3rd PIP) using a linear high frequency probe (6-18 MHz). Synovitis was evaluated in each joint, both in GS (synovial hypertrophy) and PD (inflammatory activity).

In order to calculate ultrasound DAS by gray scale (DASECO-GS) and ultrasound DAS by power doppler (DASECO-PD), the variables, NAS-GS (number of joints by gray scale) and NAS-PD (number of joints that capture power Doppler), were replaced in the formula of DAS-28 by NAI (number of inflamed joints). The results obtained were interpreted in the same way as the DAS28.

Spearman correlation analysis was performed for clinical and ultrasound variables. We found a high positive correlation between DAS28 and gray scale ultrasound DAS (DAS ECOGS) with r = 0.9669 (p <0.01); a high positive correlation between DAS28 and ultrasound DAS by PD (DAS ECOPD) with r = 0.9823 (p <0.01) and a high positive correlation between DAS ECOGS and DAS ECOPD with r = 0.9718 (p <0.01).

Our conclusions are: Clinical evaluation using DAS 28 correlates with DASECOGS, DASECOPD.

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KIKUCHI-FUJIMOTO DISEASE ASSOCIATED WITH SJOGREN'S SYNDROME; CASE REPORT IN GUATEMALA

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Objectives: Kikuchi-Fujimoto disease (KFD), also called necrotizing histiocytic lymphadenitis, was described in 1972, and is characterized by cervical lymphadenopathy, fatigue, prolonged fever and leukopenia; It is extremely rare, benign and self-limiting, predominantly occurring in women, with an average age between 20 and 30 years. its pathogenesis is still unknown, but it is believed to relate to viral or autoimmune processes. We describe a case associated with Sjogren's syndrome (SS).

Material and Methods: A female patient of 20 years of age, without important past medical history, presented with a 4-month history of fever, fatigue, presence of left axillar nodes; for these manifestations she was admitted to a private hospital and treated with antibiotics for suspected infectious process experiencing, however, no clinical improvement. Studies carried out: WBC 2,640/mm^3, hemoglobin 13.20g/dl, hematocrit 39.50%, platelets: 149,000 10^3/UL, SGPT 740.4U/L, SGOT 802.05 U/L, DHL: 1289.25, TORCH: negative, HIV and hepatitis: negative. Imaging studies: axillary lymph nodes. Resection of 23 lymph nodes was performed: 16 had follicular and sinus hyperplasia, in 8 had areas of necrosis that mainly involved the cortex and paracortex; in some nodes necrosis was observed. A diagnosis of necrosing lymphadenitis was proposed and the diagnosis of Kikuchi- Fujimoto's disease, was made. An autoimmune condition was suspected. During interview, the patient complained of dry eyes and mouth present for 4 months. Rheumatoid factor 8 IU/MI, C3: 124, C4: 65 CRP: 12mg/dl, anti-Ro: >200, anti-La: 8.90, ANA: Reactive 1:80 speckled pattern.

Results: By clinical findings and criteria this patient was diagnosed with KFD, associated with SS. This association has been rarely described in the literature. Although KFD usually has a benign course, the patient persisted with fatigue (ESSDAI 6 POINTS)despite 3 months of immunosuppressant treatment with azathioprine, hydroxychloroquine and prednisone; therefore, biological therapy was added. After 2 months of Rituximab (2 doses), ESSDAI score was 1.

Conclusions: There are few reported cases of association of both pathologies, despite the presence of autoimmunity as a probable cause of KFD, a greater association with lupus has been found, even with similar histological presentation. There are few reports of KFD with Sjogren's syndrome, even fewer reports of an aggressive nature of Sjogren with this condition. There are no treatment guidelines, so the case described posits a treatment challenge, and its course should be adequately monitored for the risk of the development of other malignant or inflammatory pathologies.

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CARDIOVASCULAR RISK IN PATIENTS WITH ESTABLISHED RHEUMATOID ARTHRITIS

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OBJETIVE: To determine the presence of traditional cardiovascular disease (CVD) risk in patients with established Rheumatoid Arthritis (RA), to stratify them according to the 2008 Framingham Risk Score and determine the relationship with clinical and serological features.

Materials and Methods: Descriptive, cross sectional, study, in a Paraguayan cohort of patients with RA meeting the 2010 ACR/EULAR criteria. This study had two phases: the first one included a standardized questionnaire according to the variables included in the Cardiovascular Risk project (PINV15-0346), from the National Sciences and Technology Council (CONACYT), and physical examination; the second one included laboratory sample collection performed by a specialized laboratory for serum biomarkers measurement for cardiovascular risk prediction. The 2008 Framingham Risk Score was used for CVD risk stratification. All patients signed informed consent. SPSS 23rd version was used for data analysis. Quantitative variables were presented as means and qualitative as frequencies. Chi square test was performed for comparisons between dichotomous variables and Student's t for continuous, and p ≤ 0.05 for statistical significance.

Results: 100 patients were included, 87% were women, mean disease duration 130.9±102.64 months, 77% were RF positive, and 84.4% were ACPA positive, 43.4% had bone erosions, mean ESR-DAS28 was 3,42±1,1; 30% had remission criteria. 39% had extra-articular manifestations. 33% had arterial hypertension, 8% diabetes mellitus. The mean weight 72.77±16.22 kg, and BMI 28.20±4.9, 30% were obese. Mean waist circumference was 100.2±90.9 cm, hip circumference 103.27 ±10.93 cm. 54% were sedentary. When traditional CVD risk was assessed, 13%