Background: Evidence from 4500 BC native Americans at Tennessee, 1500 BC Papyrus from Egypt to the first description of arthritis 400 BC from Hippocrates, Galen and many others, on the way from Paracelsus, Ayurveda, Sydenham, Beaumont to Benjamin Brodie’s description, Dr. Garrod in 1859 named the disease ‘Rheumatoid Arthritis’ and the struggle began officially. 1896s illustrated descriptions of Bannatyne, formation of ‘International Committee of Rheumatism’, Camrooe coining the term ‘Rheumatologist’ in 1940 & Hollander in 1949 ‘Rheumatology’, the struggle got its momentum and has been shown to correlate with radiographic findings. In this study, we aim to to acquire so early has cost others. We are all of us, debtors to our profession. ‘

Methods: The literature was reviewed from 100s of sites on internet with intricate details and various text books and Journals, systematically and methodically arranging events in chronological order of discover.

Results: There is astonishing wealth of information and inspiration is achieved, which we never realize while studying in Medical College or in Practice and we really understand the worth of it.

Conclusions: As per William Osler “...the knowledge which is your privilege today to acquire so early has cost others. We are all of us, debtors to our profession.”

Freedom Struggle Against Rheumatoid Arthritis
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Anti TNF–Alpha Therapy in Rheumatoid Arthritis Patients Disease Activation with, Correlation Between Serum Level of ESR and CRP Levels
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Background: RA is a chronic systemic disease manifest with multiple joint inflammation. Vasculitis, heart, lung disease, extra-articular symptoms can also be present. TNF-a, IL-6 and mediators such as cytokines, have been shown to have an important role in this inflammatory process. Anti-TNF drugs considered to be effective in preventing; RA, disability and joint destruction, CRP is one of the best indicators of inflammation, ESR is an indirect indicator of inflammation and ESR levels affected by age, sex, status and anemia. ESR and CRP levels in patients with RA, disease activity and has been shown to correlate with radiographic findings. In this study, we aim to to show the correlation between ESR, CRP levels with disease activity in patients receiving anti-TNF alpha therapy.

Methods: In this Retrospective study between January 2006 to March 2010 patients diagnosed with RA were evaluated in two groups. In the study group patients receiving at least one year of TNF-alpha were included where as in the control group patients only receiving DMARD were included. Only female patients were involved in both groups. There were 46 women in the study and 47 women in the control group. Disease severity and DAS 28 score was used to determine the disease activity. For statistical analysis Number Cruncher Statistical System 2007 & PASS 2008 Statistical Software (Utah,USA) was used.

Results: In patients receiving anti-TNF alpha therapy DAS 28 scores showed statistically significant correlation with the ESR. A statistically significance between DAS 28 and CRP were not found. In control group with only DMARD treatment, the DAS 28
showed no significant correlation between ESR nor CRP.

Conclusions: According to these results, in long-term follow-up; RA patients receiving, anti-TNF in significant correlation with ESR showed better disease activity.

**PS 0693**

**Rheumatology**

Safety of TNF Inhibitor Therapy in Patients Who Have Had a Prior Malignancy

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**Background:** According to the 2012 American College of Rheumatology Recommendations, it is possible to start biologic agent in patients who have been treated for solid tumor. But, there is no evidence in patients with history of a solid cancer treatment within the past 5 years. The purpose of this study was to explore the influence of TNF inhibitor (TNFi) therapy in this subgroup patients.

**Methods:** The medical records of all patients (n=859) that received TNFi therapy at a single rheumatology clinic between June 2005 and May 2014 were retrospectively reviewed. Among them, data from patients who had a history of solid cancer treatment before TNFi therapy were collected and patient outcomes were evaluated especially by thyroid, colorectum, liver, kidney, and breast. There was no recurrence of previous cancer during 40 (7.0-50.75) months of TNFi therapy. Especially, 10 patients started TNFi therapy within the past 5 years. The purpose of this study was to explore the influence of TNFi treatment in patients with history of solid cancer treatment within the last 5 years. The study used a single rheumatology clinic between June 2005 and May 2014. The data were obtained from patients who had a history of solid cancer treatment before TNFi therapy. There was no recurrence of previous cancer during 40 (7.0-50.75) months of TNFi therapy. Especially, 10 patients started TNFi therapy within the past 5 years.

**Results:** Of 859 patients who underwent TNFi therapy, 22 patients had a history of malignancy before initiating TNFi therapy for ankylosing spondylitis (AS) and rheumatoid arthritis (RA) (Table 1). The median AS, RA disease duration was 8 (3.75-12.25) years and median time to TNFi therapy after prior cancer treatment was 62.5 (21.25-140.25) months. Most common site of prior cancer is stomach (36.4%) and followed by thyroid, colorectum, liver, kidney, and breast. There was no recurrence of previous cancer during 40 (7.0-50.75) months of TNFi therapy. Especially, 10 patients started TNFi therapy before 5 years prior cancer treatment (Table 2). All of our 10 cases were limited in an early stage without distant metastasis. When they have been followed for 36 months, recurrence of cancer was not found.

**Conclusions:** Our results suggest that starting TNFi therapy in patients with history of solid cancer in locally limited stage is safe even less than 5 years after prior cancer treatment.

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**Rheumatology**

Appearance of Psoriasis after TNF-a Blocker and Use of Ustekinumab or Tocilizumab for Refractory Monoarthritis

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Nowadays, tumor necrosis factor-a (TNF-a) blockers are used for the treatment of RA, inflammatory bowel diseases (IBD), ankylosing spondylitis (AS), psoriatic arthritis (PsA), and psoriasis. Paradoxically, there are some reports of appearance of psoriasis after TNF-a blockers. We report a patient who have seronegative mono-rheumatoid arthritis (mono-RA) on knee joint that experienced psoriasis after TNF-a blocker therapy (adalimumab and etanercept). For the patient, oral medication is not available due to intolerance; thus, we tried ustekinumab which is an anti-IL-12/23 monoclonal antibody that has been used to treat psoriasis. After ustekinumab injection, psoriatic skin lesions and joint symptoms were much improved in the patient. But in the following period, joint pain and swelling aggravated and synovial fluid cytokine levels such as IL-6 and IL-17 were elevated. Treatment was changed to tocilizumab, humanized monoclonal antibody against IL-6 receptor. After injection, knee joint swelling rapidly subsided without worsening of psoriatic skin lesion.

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**Rheumatology**

Sarcoid Like Granuloma Developed during Adalimumab Therapy in Ankylosing Spondylitis

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**Introduction:** Adalimumab is a full human monoclonal antibody that inhibits tumor necrosis factor-alpha (TNF-a). It has recently been shown to be effective in the treatment of rheumatoid arthritis, ankylosing spondylitis (AS). As the pulmonary complication of TNF-a antagonist, infection, interstitial pneumonitis, sarcoidosis and pulmonary vasculitis has been reported. Sarcoidosis is a rare complication among them. Here, we report a patient who has developed sarcoid like granuloma confirmed by lung biopsy following adalimumab therapy for AS.

**Case Description:** The patient is a 26-year-old man with a history of ankylosing spondylitis evolving over the previous 9 years, who had received treatment with non-steroid anti-inflammatory drugs and sulfasalazin. Adalimumab was injected at a dose of 40 mg twice a month for 9 months with a very positive clinical response. He is admitted due to the patch opacity showed on the right upper and middle lobe at chest radiograph in annual medical checkup. Computed tomography (CT) of the chest revealed various sized multiple nodules on the right upper and middle lobe and lymph node enlargement in both hilum and right paratracheal area. The blood analysis determined ESR 19 mm/hr, CRP 2.16 mg/L with normal renal and hepatic function. The levels of the angiotensin-converting enzyme were 95.7 U/L (normal value 9.0-47.0). The tuberculosis skin test and the interferon gamma releasing assay were negative. Blood cultures and sputum analysis were negative. The microbiological analysis of...