

**Conclusion:** Systemic manifestations were more prevalent in patients with TRAPS - 91.6%, and active articular syndrome was approximately the same in patients with JIA and TRAPS. In patients with TRAPS, the most common was the heterozygous version of the *TNFRSF1A* gene with the nucleotide substitution *c.362G> A*. Despite the fact that in 57.1% of JIA patients, variants of *TNFRSF1A* gene were identified, it is not possible to establish a diagnosis of auto-inflammatory syndrome in such patients. It is necessary to correctly interpret the results of molecular genetic research in accordance with the severity of the course of the disease, clinical manifestations.

#### Disclosure of Interest

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#### AB008

##### Does corona virus cause a specific inflammatory toe abnormality

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**Introduction:** During the recent coronavirus pandemic there was a description of inflammation of toes possibly related to Covid 19 infection. I have seen 4 patients present with inflamed toes.

**Objectives:** To ascertain if Covid-19 causes a specific toe inflammation or is this due to another problem

**Methods:** I reviewed the 3 patients who presented with toe inflammation doing a full rheumatological examination. They were all seen via Skype.

**Results:** None of the 4 patients had had any symptoms of Covid 19 and all had self isolated. Examination of the toes revealed chilblain type lesions and all 3 patients had evidence of Raynaud's syndrome with markedly delayed capillary refill times in the feet of around 10 seconds. 2 of the patients had had a previous diagnosis of Primary Raynaud's and the two were new patients both with Primary Raynauds and no underlying rheumatological disease. Hands were much less affected in the patients than feet with slight prolongation of CRT in hands compared to feet.

**Conclusion:** I think that although the weather was warm in the UK at the time of lockdown, indoor temperatures are significantly lower than outdoors. I think due to decreased exercise, lack of wearing socks and shoes indoors and cooler temperatures indoors these patients had suffered from acute Raynaud's syndrome with chilblains rather than immune mediated vasculitic type illness causing their toe problems. I question if 'Covid Toes' as it was described is actually a condition or a manifestation of lockdown and Raynaud's with chilblains. Once the patients wore socks and shoes and kept warm no further lesions occurred.

#### Disclosure of Interest

None declared

#### AB009

##### COVID-19 and relapsing Kawasaki disease: a case report during the pandemic

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**Introduction:** The pandemic of COVID-19 remains a global health alarm with high incidence of lethality, especially in older age groups who suffer from underlying medical conditions. However, children are less likely to manifest severe conditions.

**Objectives:** COVID-19 was correlated to a higher incidence and a suspected increased risk of Kawasaki Disease (KD) in children.

**Methods:** We describe the case of a 2.2-year-old infant admitted for fever (>5 days; > 39°C), pharyngitis, cheilitis, arthralgia, feet oedema, rash, perineal and scrotal region erythema, bilateral lymphadenopathy of the neck, cough, rhinorrhea. He was extremely irritable. Heart rate: 140/min; capillary saturation 99 % in air. Laboratory tests showed: leukocytes  $13.4 \times 10^3/\mu\text{l}$  (neutrophils:  $7.4 \times 10^3/\mu\text{l}$ ); platelets  $502 \times 10^3/\mu\text{l}$ ; haemoglobin 11.1 g/dl; increased inflammatory markers, with C-reactive protein (CRP) of 14.7 mg/dl (n.v.: < 0.5); hyponatremia (133 mEq/l). The nasal swab for respiratory viruses, IgM and IgG anti-EBV, CMV, Parvovirus, Mycoplasma, Chlamydia were negative. Anamnestic records revealed a previous KD, without coronary artery lesions (CAL), 1 year before.

**Results:** He was treated with antibiotics, intravenous infusion of Immunoglobulins (IVIG) (2 gr/Kg), acetylsalicylic acid (ASA) (50 mg/Kg in 4 doses/day) and reached defervescence into 2 days. Echocardiography excluded CAL. The nasopharyngeal swab for SARS-COV-2 was doubt. The second throat swab done the day after IVIG infusion, was negative; however, the third nasopharyngeal swab for SARS-COV-2, done 4 days after IVIG infusion, was positive. Chest x-ray showed a significant lung interstitial thickening. IL-6 levels were < 6.25 pg/ml (n.v. < 6.25 pg/ml).

He continued treatment with antibiotics, ASA (5 mg/Kg/day), with the progressive resolution of the clinical symptoms and of the normalization of laboratory findings.

**Conclusion:** The peculiar outcome of the patient is the correlation of COVID-19 with KD, recently reported as associated. KD is considered as a multifactorial autoinflammatory disease, induced by a cytokine hypersecretion with a systemic vasculitis. COVID-19 is considered a cytokine storm syndrome, with a severe systemic vasculitis. SARS-COV-2 infection could be the trigger that could lead to hyperinflammation of KD.

The IVIG infusion could explain the transient negative swab for SARS-COV-2, with the successive positive relieve lasting 7 days, and the normal levels of IL-6, detected after IVIG infusion.

Relapsing KD is rare (1.7-3.5%); in our patient this event could be triggered by the documented SARS-COV-2 infection.

#### Disclosure of Interest

None declared

#### AB010

##### Management of children with rheumatic diseases in covid-19 outbreak in the tertiary pediatric rheumatology center in Iran

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**Introduction:** The COVID-19 disease identified and reported from Wuhan, Hubei, China. At the time being, the disease is a pandemic and has involved the entire world.

**Objectives:** The aim of this study is reporting the planning and actions after the COVID-19 epidemic for prevention of spread of the disease, supporting patients, and managing the disease at our center's outpatient clinic as a referral center for children suffering rheumatic diseases.

**Methods:** Since the first report of disease, we tried to reply to the patients' questions in a virtual social network. We were following lab data, radiograms, sonograms, CT scans, and MRI results in this network and provided solutions for the management of the children's problems without need to encountering.

**Results:** In cases that were controlled and their diseases were in remission, we invited one of the patient's parents to come and receive the prescriptions. We put some instructive short films about COVID-19 in the virtual network and in LED screens of our outpatient hospital clinic to provide useful information. About the turn rating system (queuing system) we omitted manual turn-taking stands to prevent virus transmission. In the peak of the epidemic, we stopped outpatient