was concluded that the carpal tunnel syndrome in the right hand occurred most likely also as a consequence of joint swelling which is frequently disregarded as an important and easily treatable cause of carpal tunnel syndrome. However, the situation was less clear due to the fact that it occurred at the onset of rheumatoid arthritis.

**Conclusions.** Carpal tunnel syndrome is the most frequent nerve entrapment condition associated with RA. Although diagnosis is at time tricky, one shouldn't prompt surgical approach since most cases are caused by flexor tenosynovitis which responds well to injections with corticosteroids. However to prevent development of such complication, effective disease modifying therapy should be in place.

**Key words:** arthritis, carpal tunnel syndrome, neurolysis

## 41. FAMILY CASE WITH FAMILIAL MEDITERRANEAN FEVER (FMF)

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**Background.** Familial Mediterranean fever (FMF) is an auto-inflammatory disease characterized by periodic episodes of fever and recurrent polyserositis. It is caused by a dysfunction of pyrin (or marenostrin) as a result of various mutations within the MEFV gene, some causing very severe cases, while others may result in milder signs and symptoms.

**Case report.** We report the case of a family in which 4 members displayed similar symptoms and were confirmed genetically with mutations characteristic for FMF. The 4 members displaying signs of FMF are the father and the 3 out of 6 siblings (2 males and 1 female). The main presenting complaint in all members is the recurrent abdominal pain. The father which tested genetically as follows - FMF-V726A carrier; FMF-E148Q homozygote, at the age of 45 started having recurrent attacks of unspecified abdominal pain, followed by diarrhea, and he was diagnosed with FMF, based on a family history of FMF in his brother. Later on the disease was confirmed genetically. Although, the onset is considered to be at the age 45, there is a history of left knee effusion at age 18 due to strenuous exercises in the army. Additionally he presents with polyarthralgia and stiffness over the day especially in left knee, both elbows and interphalangeal joints. Sibling no.1 – a 27 y.o. male with onset of disease at age 27 presents with attacks of appendicitis-like pain, cramps and flatulence, without diarrhea associated with recurrent left knee arthralgia. Average duration of attacks is of 2-3 days a month with milder symptoms after starting colchicine use. Has a history of knee arthritis at the age of 10, chest stabbing pain during deep breath (pleuritic chest pain), and one episode of erythema nodosum on both shins resolved within a couple of weeks after the attack. Genetic testing revealed FMF-V726A heterozygote; FMF-E148Q heterozygote. Sibling no.2 – a 26 y.o. male with disease onset at the age 23 with attacks of generalized peritoneal pain followed by diarrhea, stabbing chest pain aggravated by deep breath (pleuritic chest pain), no joints symptoms. Genetic testing revealed FMF-V726A heterozygote; FMF-E148Q heterozygote. Sibling no. 3 – a 15 y.o. female with onset of disease at age 9, with menstruation related attacks of generalized peritoneal pain followed by diarrhea, pain in both knees and generalized weakness. Genetic testing revealed FMF-V726A heterozygote; FMF-E148Q heterozygote. All patients manage to control the disease with diet and colchicine.

**Conclusions.** Although traditionally fever is a considered a hallmark of FMF, with the discovery of genetic mutations, we can confirm a greater variety of clinical presentation, not all cases presenting with all classical symptoms. The described family presents with mainly peritoneal symptoms and all siblings display the same mutations FMF-V726A heterozygote and FMF-E148Q heterozygote

**Key words:** Familial Mediterranean Fever, serositis, genetic testing

## 42. A CASE OF IGA NEPHROPATHY AND AMYLOIDOSIS IN PATIENT WITH ANKYLOSING SPONDYLITIS

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**Background.** IgA nephropathy is considered the most common cause of glomerulonephritis. Traditionally it presents with gross hematuria after an upper airway infection. However, there is a considerable population presenting asymptomatic microscopic hematuria. Patients with SpA are believed to be more affected by IgA nephropathy than the general population, as the two conditions share common etiopathogenic pathways. This mechanism might involve the decreased expression of the receptor responsible for the clearance of IgA 1 and its immune complexes on the surface of monocytes and neutrophils. Another frequent association for patients with systemic inflammatory diseases is renal amyloidosis.

**Case report.** Male patient B, 49 y.o., was admitted to the Republican Clinical Hospital in Apr 2017 with hypotension (75/50 mmHg), profuse edema of lower limbs up to inguinal area and confusional state. Patient was known with a history of Ankylosing Spondylitis since the age of 14, with IV x-ray stage of sacroiliitis, coxofemural and spine involvement. Since 1991 the patient followed regularly NSAIDs and intermittently corticosteroids in small doses. For a period of 6 years intermittent microscopic hematuria and mild proteinuria were noticed. The patient repeatedly tested with increased levels of serum IgAs, however refused kidney biopsy. In December 2016 he was admitted with fever, myalgia and arthralgia and HTA to a local intensive care unit. Upon that admittance the patient displayed oliguria, microscopic hematuria, mild proteinuria, and accelerated ESR, with a creatinine of 249 mcmol/L. Musculoskeletal complaints prompted increased doses of NSAIDs and corticosteroids (Prednisone 40 mg, and Aceclofenac 100mg x 2 /day), considering his main disease, despite the modified pattern of myalgia and peripheral arthralgia. A week after he was discharged he developed profuse edema that consequently led to his admittance to the republican hospital. Hematology revealed severe anemia, leucocytosis and accelerated ESR. Urinalysis showed normal SD, with leucocyturia up to 27 HPF, microscopic hematuria up to 80 RBCs HPF, with a proteinuria of 30 g/24h. Serum chemistry showed hypoproteinemia (32 g/L) and hypoalbuminemia (8.6 g/L), and elevated creatinine – 409 mcmol/L. Kidney biopsy was performed revealing moderate amyloid deposits. Despite initiated hemodyalisis, the patient died within 1 month from multiorgan insufficiency.

**Conclusions.** long standing AS favored the development of IgA nephropathy in the given patient; most likely the co-occurrence of newly depicted high levels of creatinine, with hematuria and modified pattern on musculoskeletal complaints spoke about acute tubulo-