Conclusion: Treatment with oral LNK01001 12 mg or 24 mg BID for 12 weeks in patients with active AS was generally safe and well tolerated with most TEAEs being mild to moderate. LNK01001 was effective in reducing the symptoms of ankylosing spondylitis over a treatment period of 12 weeks across multiple efficacy end points.

Anti-mda5 amyopathic dermatomyositis: A dermatologic mimicker not to be missed in Asian population

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Background: Anti-melanoma differentiation-associated gene 5 (MDA5) amyopathic dermatomyositis (ADM) is a rare form of DM that has the hallmark cutaneous features of DM but lacks clinical and laboratory evidence of muscle involvement. The prevalence of anti-MDA5 ADM ranges from 1.6 to 36.6%, more commonly affecting Asian women in their 50s. The diagnosis is often challenging with as many as 41% of ADM misdiagnosed during initial evaluations. Early and accurate diagnosis of ADM is vital, given its association with rapid-progressive interstitial lung disease in 39–100% of patients and high mortality rates (80%).

Case Report: A 33-year-old Iban lady with underlying hypertension presented in February 2024 with a three-month history of rashes on her face, bilateral hand knuckles, elbows and neck area. Additionally, she experienced excessive hair loss and joint pains distributed bilaterally over her hands, elbows, knees and ankles. The systematic review was otherwise unremarkable. She had no positive family history of connective tissue disease or malignancy. Physical examination revealed non scarring alopecia with an erythematous rash on her forehead, bilateral periorbital region as well as the malar area. There were erythematous papules on the dorsal part of metacarpophalangeal joints bilaterally (Gottron's papules) along with erythematous patches overlying the extensor aspect of bilateral elbows (Gottron's sign). There was no arthritis or Raynaud's phenomenon. Auscultations revealed bibasal end-inspiratory fine crackles with no loud P2. There were no signs of proximal muscle weakness. Vital signs: Blood pressure: 113/81 mmHg; heart rate: 82/min; SPO2: 96% under room air. Chest X ray showed bilateral lower zones pulmonary infiltrates. Laboratory investigations showed haemoglobin: 12.8 g/L, total white cell: 7.59 x 10^9/L, platelet: 254 x 10^9/L, urea: 4.3 mmol/L, creatinine: 62 μmol/L, total bilirubin: 8 μmol/L, AST: 55 U/L, ALT: 53 U/L, albumin: 36 g/L, creatinine kinase: 128 U/L. She tested negative for ANA, dsDNA and ENA, with normal C3 and C4. Muscle-specific antibodies (MSAs) showed positivity for anti-EJ (Glycyl-tRNA synthetase), anti-MDA5 and anti-PM-Scl-100. A high-resolution CT scan of the thorax showed irregular reticular opacities at bilateral basal and subpleural distribution with patchy ground glass opacities, consistent with non-specific interstitial pneumonia (NSIP). She was treated with intravenous methylprednisolone followed by oral prednisolone and intravenous cyclophosphamide infusions. No neoplasms were detected.

Conclusion: Potential misdiagnosis of ADM due to shared clinical phenotype with other autoimmune disorders might delay proper treatment initiation and lead to poor prognosis. Detection of MSAs can help in identifying DM subtypes accurately as well as prognosticate the patient.

Recurrent pericardial effusion: An extra-articular manifestation of undiagnosed seropositive rheumatoid arthritis

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Background: Rheumatoid arthritis (RA) is a multisystemic chronic inflammatory autoimmune disorder that predominantly affects peripheral joints in a symmetrical pattern. While extraarticular manifestations are rarely the first sign of undiagnosed RA, cardiovascular involvement can present as endocarditis, myocarditis, pericarditis, pericardial effusion (PE), valvular heart disease, amyloidosis, heart failure, and arrhythmia. Importantly, RA patients have a 50% higher risk of cardiovascular mortality compared to general population.

Case Report: A 41-year-old Malay lady admitted to Sarawak Heart Centre in October 2023 with a 2-week history of reduced effort tolerance and bilateral lower limb swelling. Upon arrival, her vital signs were: BP: 123/78 mmHg, HR: 100/min, SPO2: 98% under room air. Chest X-ray showed cardiomegaly with normal sinus rhythm from ECG. Laboratory tests showed haemoglobin: 9.3 g/dL, total white cell: 8.13 x 10^9/L, platelet: 489 x 10^9/L, urea: 8.5 mmol/L, creatinine: 67 μmol/L, total bilirubin: 8.3 μmol/L, AST: 20 U/L, ALT: 10 U/L, albumin: 32 g/L, CRP: 573.8 mg/L. Echocardiography revealed global PE, largest at left ventricular posterior wall (LV-PW) measuring 2.7 cm with normal ejection fraction. 590 mL haemorrhagic fluids was aspirated from pericardiocentesis. Analysis of the PE showed an exudative picture. Investigations for tuberculosis and malignancy were negative. A CT scan of the thorax, abdomen and pelvis was normal. ANA, C3 and C4 were normal. She received 2-week course antibiotics and was started on colchicine 0.5mg once daily. 1 month later, she was admitted to Bintulu Hospital, Sarawak for acute decompensated heart failure. Troponin I: 0.06 ng/ml. Repeated echocardiography showed moderate global PE, largest measured 1.5cm at LV-PW. Serial blood and fungal cultures revealed no growth. It was noted that she had right wrist pain for the past 16 years, followed by a 1-month history of multiple joint pains. Examination showed arthritis of the bilateral wrists, right 2^{nd}-4^{th} proximal interphalangeal joints, right elbow, right shoulder and bilateral ankles. There were no rheumatoid nodules. X-rays showed erosive changes over the right wrist. Serum rheumatoid factor was positive. She was finally diagnosed with seropositive erosive rheumatoid arthritis with pericardial effusion as the extra-articular manifestation. She was treated with a short course of steroids and weekly methotrexate.

Conclusion: Recurrent PE should prompt consideration of RA as a potential diagnosis once all infectious and non-infectious causes

have been thoroughly investigated. A comprehensive evaluation based on detailed history-taking and physical examination can greatly influence treatment outcomes.

Systemic lupus erythematosus in Sarawak General Hospital: A 10-year update

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Background/Purpose: Systemic lupus erythematosus (SLE) is a complex autoimmune disease with heterogeneous clinical presentation. We published the Sarawak Lupus Cohort in 2014. Since then there have been many advances in SLE diagnosis and management. We aimed to examine the clinical manifestations and gender differences of an updated SLE cohort in Sarawak General Hospital.

Methods: We collected demographics and clinical manifestation data in this prospective observational study from July 2018 until December 2023. All patients fulfilled the 2012 Systemic Lupus Collaborating Clinics (SLICC) Classification Criteria for SLE. Statistical analysis was performed using SPSS, with means ± SD, Chi-Square or Fisher's exact test. A p-value<0.05 is considered significant.

Results: There were 637 patients in our cohort, with 567 (89%) women and 70 (11%) men. The mean age at SLE diagnosis was 31.17 ± 13.6 years. There were 234 (36.7%) Chinese, 224 (35.2%) Malay, 107 (16.8%) Iban, and 58 (9.1%) Bidayuh patients. Common SLE clinical manifestations were acute cutaneous lupus in 420 (65.9%), followed by renal in 309 (48.5%) and leucopenia or lymphopenia in 307 (48.2%) patients. The common immunological SLE manifestations were antinuclear antibody (ANA) in 619 (97.2%) and anti-double stranded DNA (anti-dsDNA) in 366 (57.5%) patients. 285 (44.7%) patients had severe disease at presentation. There were 217 (34.1%) patients with a score of SLE Damage Index (SDI) >1, indicating the presence of at least one item of damage. There were 70 (11%) deaths in this cohort. The notable differences between men and women with SLE was a statistically significant higher percentage of men had renal manifestation (men 41 (58.6%) vs women 268 (47.3%), $p=0.04$) and serositis (men 18 (25.7%) vs women 91 (16.0%), $p=0.04$). There were more women than men with oral ulcers (women 220 (38.8%) vs men 15 (21.4%), $p=0.004$) and alopecia (women 278 (49.0%) vs men 13 (18.6%), $p<0.001$). More men had severe disease at presentation (men 42 (60%) vs women 243 (42.9%), $p=0.006$). Among patients with SDI>1 ($n=217$), there were more men with end-stage renal failure (ESRF) (men 7 (28%) vs women 11 (5.7%), $p=0.002$), myocardial infarction (men 2 (8%) vs women (0), $p=0.01$) and extensive skin scarring (men 3 (12%) vs women 4 (2.1%), $p=0.04$). There was no gender difference in death in this cohort.

Conclusion: This updated SLE cohort showed acute cutaneous lupus, renal, ANA and anti-dsDNA as the most common SLE manifestations. Men had more severe disease at presentation, with more renal and serositis SLE manifestation. Men had more ESRF, myocardial infarction and extensive skin scarring in the SLE Damage Index.

The changing landscape of telemedicine in Sarawak

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Background/Purpose: Healthcare providers in remote areas or in areas with limited rheumatologists depend on telemedicine for rheumatology consultations and shared patient management. The COVID-19 pandemic presented an increased challenge, where even previously accessible patients were rendered inaccessible due to travel restrictions. This required all of us to utilize available technology to provide comprehensive rheumatological management, and also presented a unique opportunity for a shift in telemedicine methods. One recently developed telemedicine method was conducting virtual rheumatology meetings with the district hospitals in Sarawak for rheumatology case discussions. We aimed to explore the various methods of telemedicine between district hospitals and rheumatologists and the participants' perception of the benefits of attending the virtual meetings.

Methods: We specifically examined the utilization of telemedicine in Rheumatology consultations and shared patient management in the Sarawak district hospitals. Regular virtual rheumatology inter-hospital meetings were started in August 2022 and a survey was conducted in January 2024 among the participants.

Results: When rheumatology services were first established in Sarawak in 2006, rheumatology consultatons via telemedicine were conducted using phone calls and emails. In 2009, the era of smartphones added instant messaging with attached photos of physical findings and laboratory results. During the COVID-19 pandemic, we increasingly relied on these methods for consultations.

Subsequently, virtual meeting platforms became increasingly. In August 2022 we started 2-monthly virtual rheumatology meetings via Google Meet. The objectives of the programme were to discuss challenging rheumatology cases and to expand rheumatology knowledge among participants. The case discussions between the participants from the various district hospitals and the panel of rheumatologists also allowed for a wider audience simultaneously.

We conducted a survey of 29 participants in a virtual meeting in January 2024, which comprised of 19 medical officers and 10 physicians. 11 participants (37.9%) attended for the first time, 11 participants (37.9%) have attended >3 times, while 7 participants (24.1%) have attended 1 or 2 times previously. 3 participants (10.3%) described the virtual meeting as having 'some benefit' in increasing their rheumatology knowledge, while 26 participants (89.7%) described the sessions as 'very beneficial'. All participants agreed that