has significantly dropped and her complements are now almost in normal range.

Discussion: This is an interesting case demonstrating the need to consider, investigate and treat other causes of rash in pregnant SLE patient other than active lupus during pregnancy. This case highlights the need for multidisciplinary care and regular follow up in pregnancy to be able to monitor and treat complications, to ensure the best possible outcomes for mother and child. In addition allergy to a specific branding of hydroxychloroquine has not been reported in the literature to date.

Key learning points: The key learning points of this case are the need to have a wide list of potential differential diagnoses and to take a complete history, to ensure that all potential causes of rash are investigated and treated. The learning points from this case also complement the recently published BSR guideline on prescribing drugs in pregnancy and breast feeding and the soon to be published BSR guidelines on the management of SLE. nb The patent has provided consent and we have her permission to use clinical images

6. RASH IN LUPUS PREGNANCY

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Introduction: This case describes how an extensive rash was investigated and managed in a pregnant patient with lupus. It highlights the importance of investigating and treating other causes of rash in lupus patients, so appropriate management can be initiated.

Case description: A 23 year old lady with systemic lupus erythematous (SLE), which is controlled with prednisolone, hydroxychloroquine and azathioprine. When she initially presented with SLE in 2015, she had features of arthritis, leucopoenia, neutropenia, lymphopenia. She has no features of active lupus at the time of conception. During her pregnancy she started to develop mouth ulcers and a rash over her face and chest. There was also serological evidence of active lupus, with raised dsDNA (double stranded DNA) and dropping complements. This was initially treated by increasing her oral prednisolone from 15mg to 20mg and then 25mg. However the rash worsened to the extent, that she was hospitalised on the medical ward at 30 weeks gestation. She had general medical, rheumatological and dermatological reviews whilst an in-patient. It transpired that as well as the lupus being active the rash had got significantly worse following the change in her hydroxychloroquine branding, to the Barrett's laboratory film coating. It was felt that the rash was due to a combination of active SLE and a reaction to an alternative hydroxychloroquine branding. The hydroxychloroquine was stopped and she was given two doses of intravenous methylprednisolone to treat her active SLE. The rash improved but remained very active despite her having also increased her oral prednisolone to 40mg. In view of this a third dose of intravenous methylprednisolone was given as an outpatient. The rash than got worse with the addition of a sticky discharge, a swab was taken which identified pseudomonas. She was than readmitted for intravenous antibiotics on the advice of the microbiologists to treat the super-added infection. Her rash improved following antibiotics, oral prednisolone and using an alternative brand of hydroxychloroquine. She remained on 35mg of prednisolone until she was induced at 37 weeks. She had an uneventful labour and delivered a healthy baby girl. Two weeks after delivery the rash worsened and she was readmitted to hospital, the rash had become more extensive, affecting her face, chest, back and upper arms. There was no discharge or other evidence of infection. She had chosen not to breastfeed, so azathioprine was stopped and mycophenolate was commended. She has been on mycophenolate for the last 6 weeks, with a rapid improvement in her skin and steroids have been reduced to 30mg. In addition her dsDNA