Abstract CE-33 Table 1 Rates and Adjusted Subdistribution Hazard Ratios for Stroke, MI, or Stroke/MI Hospitalisation among Medicaid patients with SLE in the US, from 2000-2010, by Race and Ethnicity

Race/Ethnicity	Total individuals	Number of events	Person-years (mean, [SD])	Rate* [95% CI]:	Multivariable-Adjusted Subdistribution Hazard Ratio (HRsd)[95% CI]:
Stroke					
White	17113	273	3.36 [2.82]	4.75 [4.22–5.35]	1.0 (ref)
Black	17813	413	3.46 [2.83]	6.70 [6.08–7.38]	**1.36 [1.15–1.60]**
Asian	1296	26	3.97 [3.01]	5.05 [3.44–7.42]	1.05 [0.70–1.59]
Hispanic	6732	107	3.44 [2.86]	4.62 [3.82–5.58]	1.02 [0.81–1.29]
Native American	494	12	3.65 [2.96]	6.66 [3.78–11.73]	1.43 [0.80–2.57]
MI					
White	17113	218	3.37 [2.82]	3.78 [3.31–4.32]	1.0 (ref)
Black	17813	235	3.49 [2.84]	3.78 [3.33–4.30]	1.08 [0.89–1.30]
Asian	1296	14	4.00 [3.03]	2.70 [1.60–4.56]	0.93 [0.53–1.61]
Hispanic	6732	42	3.46 [2.86]	1.80 [1.33–2.44]	**0.59 [0.42–0.84]**
Native American	494	**	**	3.78 [3.31–4.32]	1.12 [0.53–2.36]
Stroke or MI (combined)					
White	17113	477	3.32 [2.81]	8.38 [7.66–9.17]	1.0 (ref)
Black	17813	625	3.43 [2.82]	10.22 [9.45–11.05]	**1.22 [1.07–1.38]**
Asian	1296	37	3.96 [3.01]	7.22 [5.23–9.96]	0.93 [0.66–1.31]
Hispanic	6732	142	3.43 [2.85]	6.16 [5.23–7.26]	**0.82 [0.67–0.99]**
Native American	494	19	3.62 [2.95]	10.62 [6.77–16.65]	1.33 [0.84–2.09]

* Rate per 1,000 person-years, ¥ HRsd= Sub-distribution hazard ratio from Fine and Grey proportional hazards competing risks model. Multivariable models adjusted for age, sex, U.S. region of residence, calendar year, area-based SES, and baseline comorbidities (including history of angina, coronary artery bypass graft, coronary atherosclerosis, percutaneous coronary intervention, hypertension, smoking, obesity) and SLE-specific risk adjustment index. **Cell sizes under 11 are suppressed in accordance with Federal data reporting requirements.

myocardial infarction (MI) and stroke among SLE patients compared to age-matched controls. The objective of our study was to examine the rates of non-fatal MI, stroke, and the combined endpoint of non-fatal MI or stroke, overall and by race/ethnicity, among SLE patients enrolled in Medicaid.

Materials and methods Within Medicaid Analytic eXtract (MAX), containing billing claims from 2000–10 for Medicaid patients from the 29 most populated US states, we identified patients aged 18–65 with prevalent SLE ($\geq$ 3 ICD-9 codes 710.0, $\geq$30 days apart) with >12 months of continuous enrollment prior to 3rd code (index date). Baseline data from 12 months prior to index date included age, sex, race/ethnicity, zip code, year, SLE-related and other comorbidities, including CVD risk factors (based on ICD-9 and DRG codes). Those missing race/ethnicity were excluded. Subjects were followed from index date to first MI or stroke event, death, Medicaid disenrollment, or end of follow-up. MI, stroke, and combined outcome per 1000 person-years with 95% CIs were calculated overall and by race/ethnicity. Subdistribution proportional hazards regression models, accounting for the competing risk of death, were used to calculate multivariable-adjusted hazard ratios (HRsd) for MI, stroke, and combined outcome.

Results Among 43,448 cases with prevalent SLE, 93.6% were female. Racial/ethnic breakdown was: 41% Black, 39% White, 15% Hispanic, 3% Asian, 1% Native American. Mean follow-up was 3.48 ± 2.86 years for all SLE patients. Overall crude rates were highest among Native Americans for MI, Blacks for stroke, and Native Americans for MI or stroke. Hispanics had the lowest overall crude rates for MI, stroke, and the combined outcome. After multivariable adjustment and accounting for the competing risk of death, Hispanics had lower MI risk (HRsd] 0.59 [95% CI: 0.42–0.84]) and Blacks had elevated risk of stroke (HRsd 1.36 [95% CI: 1.15–1.60]) as compared with Whites. For the outcome of MI or stroke, Blacks had an elevated risk (HRsd 1.22 [95% CI: 1.07–1.38], whereas Hispanics had a lower risk (HR 0.82 [95% CI: 0.67 to 0.99] compared to Whites.

Conclusions Marked race/ethnicity-specific variation exists in MI and stroke risks among Medicaid patients with SLE. Elevated CVD risks among Blacks and lower risks among Hispanics may account for some of the excess all-cause mortality observed among Black patients and lower overall mortality among Hispanics with SLE as previously described.

CE-34 AN ANALYSIS OF THE DEMOGRAPHIC DATA IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS IN SOUTH AND CENTRAL TRINIDAD

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10.1136/lupus-2016-000179.113

Background Very limited data is available on the epidemiology of systemic Lupus erythematosus (SLE) in the Caribbean. This study was aimed at analysing the demographic data among patients diagnosed with SLE in the South and Central regions of Trinidad.

Materials and method This was a retrospective analysis of patients attending the Rheumatology Clinic at the South-West Regional Health Authority. After written consent was obtained, a data capture sheet (DCS) was completed; collecting information from patients with suspected SLE. Each patient was given a unique identification number. From this DCS, patients with a confirmed diagnosis of SLE (defined by at least 4 criteria of the Systemic Lupus International Collaborating Clinics (SLICC) Classification Criteria for SLE, of which at least 1 clinical and 1 laboratory criteria OR biopsy-proven lupus nephritis with positive ANA or Anti- dsDNA) were identified. The information was

Lupus Sci Med: first published as 10.1136/lupus-2016-000179.113 on 31 August 2016. Downloaded from http://lupus.bmj.com/ on April 26, 2024 by guest. Protected by copyright.

entered into a specially designed excel database, which was later transferred into the SPSS version 22 for Windows for analysis. Frequent edit checks were done.

Abstract CE-34 Table 1 Demographic data among patients with SLE in South and Central Trinidad

Demographics		P value
Mean (SD) age/years [n = 91]	39.47 (15.22)	0.000[1]
Gender [n = 91]		
Male, n (%)	3 (3.30%)	
Female, n (%)	88 (96.70%)	
Ethnicity [n = 91]		
Indo Trinidadian, n (%)	46 (50.50%)	
Afro Trinidadian, n (%)	24 (26.40%)	
Mixed- Other, n (%)	15 (16.50%)	
Mixed- African and East Indian, n (%)	6 (6.60%)	
Chinese, n (%)		
Caucasian, n (%)		
Syrian/Lebanese, n (%)		
Portuguese, n (%)		
Indigenous, n (%)		
Other, n (%)		
Religion [n = 89]		
Hinduism	19 (20.90%)	
Pentecostal/Evangelical/Full Gospel	18 (19.80%)	
Roman Catholic	14 (15.40%)	
Baptist- Spiritual Shouter	8 (8.80%)	
Islam	8 (8.80%)	
Anglican	4 (4.40&)	
Seven Day Adventist	3 (3.30%)	
Presbyterian/Congregational	3 (3.30%)	
Jehovah's Witness	2 (2.20%)	
Orisha		
Methodist		
Atheists		
Other	10 (11.00%)	

Statistical Tests
t-test

Results Of the 169 patients on the database, to date, 91 were confirmed with SLE. Demographic variables are shown in Table 1. Among the patients with confirmed SLE 50.50% were Indo-Trinidadian, 26.40% were Afro-Trinidadian and 23.10% were of Mixed Ethnicity. Females accounted for 96.70% of the 91 patients. Mean (SD) age was 39.47 (15.22) years, the youngest was 5 years old and the eldest 74 years old. The most common religious affiliation was Hinduism (20.90%), closely followed by Pentecostal/Evangelical/Full Gospel (19.80%) and then Roman Catholic (15.40%).

Conclusion An unexpectedly high percentage of our patients were of East Indian origin. It is not clear whether this is a reflection of the ethnic background of the regional population being evaluated, or if this is a previously unidentified occurrence. Detailed epidemiologic studies would be necessary to address this question. Understanding this disease in our population has implications for resource allocation and access to subspecialty care.

Acknowledgements We would like to thank Mr. Darien Wong for his initial work on the DCS, which was later modified and used for data collection.

We would also like to thank Mr. Jared Ramkissoon for creating the excel database which was used to record all the data prior to its transfer to the SPSS program.

Special thanks to the Doctors of the Rheumatology Unit who aided in the Ethical Approval of our project as well as in the collection of data on the DCS- Dr Sobrina Mohammed, Dr Alicia Ramnath, Dr Malini Basdeo, Dr Amrika Samsundar, as well as the Interns who worked with us over the last five months.

Thanks to Dr. Peter Poon King for assistance with the rheumatology clinics.

Finally, thanks to Ms. Havisha Sankar for assisting with the collection of some of the data; and its inputting into the excel database.

CE-35 LOW PREVALENCE OF PCP IN HOSPITALISED PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS: REVIEW OF A CLINICAL DATA WAREHOUSE

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10.1136/lupus-2016-000179.114

Background In the era of powerful immunosuppression, opportunistic infections are an increasing concern in Systemic Lupus Erythematosus (SLE) patients. One of the best-studied opportunistic infections is Pneumocystis pneumonia (PCP); however, the prevalence of PCP in SLE is not clearly defined, and the low tolerance to trimethoprim-sulfamethoxazole in SLE presents a challenge for PCP prophylaxis in SLE patients. The objective of this study was to evaluate the prevalence of PCP in hospitalised SLE patients at a single medical centre, with a focus on validating PCP and SLE diagnoses with clinical information obtained from corresponding medical records, in order to better define the risk of PCP in SLE.

Materials and methods This is a retrospective cohort study evaluating the prevalence of PCP in all patients with SLE treated at Columbia University Medical Centre-New York Presbyterian Hospital between January 2000 and September 2014, using electronic medical record (EMR) data from the Clinical Data Warehouse. Patients with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and patients with renal transplants represented immunocompromised control groups. Patients with SLE, PCP, HIV/AIDS, or renal transplant were identified using diagnostic codes from the International Classification of Diseases, Ninth Revision (ICD-9).

Results Out of 2,013 hospitalised SLE patients, nine were identified with presumed PCP, yielding a prevalence of 0.45%. Three of the nine PCP cases were patients with concomitant SLE and HIV/AIDS. Only one of these nine cases was histologically confirmed as PCP, this too in a concomitant SLE and HIV/AIDS patient with a CD4 count of 13 cells/mm^3. The prevalence of PCP in renal transplant patients and HIV/AIDS patients was 0.61% and 5.98% respectively.

Conclusions Given the reported high rate of adverse effects of trimethoprim-sulfamethoxazole in SLE patients and our finding of low prevalence of PCP infections in hospitalised SLE patients, our data do not substantiate the need for initiating PCP prophylaxis in SLE patients except in those with concurrent HIV/AIDS.

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