Abstract 225 Table 1 Disease characteristics, treatment and outcome of 10 SLE patients with GI manifestations

Age	Gastrointestinal manifestations or involvement	Treatment	Outcome
34	Abdominal pain, nausea, vomiting, diarrhea	Dexamethasone	Improved
33	Recurrent abdominal pain, abdominal tenderness, atrophic gastritis, appendicitis	Methylprednisolone, cyclophosphamide, explor lap with appendectomy	Improved
45	Epigastric pain, abdominal tenderness, ileus with bowel dilatation	Dexamethasone	Improved
49	Abdominal pain, diarrhea, hematochezia, ileus, "double halo" sign by CT scan, rectal ulcers, necrotic rectosigmoid	Hydrocortisone, dexamethasone, abdominoperineal with ileal resection	Died
25	Abdominal pain, vomiting, ileus	Hydrocortisone	Improved
33	Abdominal pain, nausea, vomiting, ileus	Methylprednisolone	Improved
27	Abdominal pain, diarrhea	Hydrocortisone, dexamethasone	Improved
19	Abdominal pain, vomiting, ileus, "double halo" and "comb" sign by CT scan	Methylprednisolone	Improved
24	Abdominal pain, vomiting, diarrhea, mucosal inflammation, pneumoperitoneum, by CT scan, ileal perforation	Methylprednisolone, belimumab, ileal resection	Improved
28	Abdominal pain, ileus, ascites, diffuse enterocolitis with pancreatitis by CT scan	Methylprednisolone, cyclophosphamide	Improved

hypocomplementemia (60%), alopecia (50%), and hemolyticanemia (40%). All patients showed significant initial response to high dose corticosteroid. Three patients eventually required surgery including ileal resection, abdomino-perineal resection and appendectomy; post-op histopath findings confirmed vasculitis in all 3 patients. One patient with ileal ischemia and perforation requiring resection also received belimumab infusions which enabled successful tapering and discontinuation of steroid. Another patient with refractory protein losing enteropathy and ischaemic colitis underwent abdomino-perineal with ileal resection, but succumbed to anastomotic failure with fulminant bacterial peritonitis.

Conclusions Though rare, gastrointestinal flare in SLE can be potentially catastrophic. Because of nonspecific manifestations, diagnosis strongly relies on clinical assumption and response to steroids. In some cases, surgery can be life-saving and belimumab offers another effective therapeutic option.

226 RELAPSES OF LUPUS NEPHRITIS – RISK FACTORS, INCIDENCE AND IMPACT OF OUTCOME

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Background and aims The aim of this study was to review renal flare frequency, to identify potential risk factors for relapses, to assess the value of serological tests during flares and to analyse their impact of global outcome in lupus nephritis (LN) patients.

Methods Patients with biopsy proven LN were identified from our database. LN classes were defined according to the ISN/RPS classification. According to the response to treatment, LN patients were divided into 3 groups of complete remission (CR), partial remission (PR) and no response (NR). Those in remission were divided into 2 groups of relapsing and non-relapsing during maintenance period.

Results 218 (70,64%) of 276 SLE patients with biopsy proven LN (class I-18 patients, class II-45, class III-56, class IV-75, class V-54, class VI-2, mixed forms - 26) achieved either CR (55,8%) or PR (23,2%). 47 patients had one flare, 36 - two, 27 - three, 17≥4 flares. The maintenance immunomodulating drugs at the time of flare was low dose corticosteroids and/or azathioprine. Non-adherence to treatment at time of relapse was documented in 26 patients.

Conclusions Renal flares in patients with LN are common, have a negative impact on outcome, but cannot be readily predicted. Our study shows that 58,83% of LN patients develop at least one relapse after reaching remission, usually within 2 years. The length of time to flare tends to be shorter in cases of preceding PR than in CR. Lack of adherence to long term immunosuppression was identified as a significant factor in LN flare (20,47%).

227 PREVALENCE OF NPSLE IN NORTH-INDIAN SLE PATIENTS AND ITS IMPACT ON QUALITY OF LIFE

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Background and aims To look at the prevalence of neuropsychiatric manifestations in patients with SLE and assess its impact on qol

Methods We included consecutive patients with SLE above the age of 18 [(SLICC) 2012]. A diagnosis of an NP (neuropsychiatric) syndrome was made as per ACR 1999 definitions. Manifestations occurring at any point of time after the diagnosis of SLE were considered. Some modifications used were - headaches were included if >4 hours, mood disorders or anxiety was considered if the patient reported them to cause 'significant distress or impairment in functioning'. Cognitive testing was done by using the mini-mental state examination (cut-off of 23). Testing for autonomic neuropathy only involved blood pressure response to standing (>=30/15

Abstract 227 Table 1 Comparison of basic descriptors among patients with and without NPSLE

	All SLE patients n=101	Patients with NPSLE n= 33	Patients without NPSLE n=68	p value
Age, years ±SD	32.3±10.0	31.9±9.9	32.5±10.2	0.780
Duration, years±SD	4.6±4.5	4.5±4.1	4.7±4.8	0.837
Age at diagnosis, years±SD	27.8±9.1	27.5±8.7	27.9±9.4	0.837
Sex ratio (M/F)	9/92	1/32	8/60	0.148
Serum creatinine, mg/dl±SD	1.23±0.71	1.3±0.9	1.2±0.6	0.509
SLEDAI, ±SD	24.23±12.9	31.1±15.5	20.9±9.9	0.001
Hematological-no(%)	81(80.2)	24(72.7)	57(83.8)	0.189
Malar rash-no(%)	38(37.6)	10(30.3)	28(41.2)	0.290
Oral ulcer - no(%)	36(35.6)	12(36.3)	24(35.2)	0.925
Nephritis - no(%)	57(56.4)	15(45.5)	42(61.8)	0.121
ILD- no(%)	4(4.0)	1(3.0)	3(4.4)	0.738
Carditis- no(%)	10(9.9)	5(15.2)	5(7.4)	0.218
Serositis-no(%)	7(6.9)	3(9.1)	4(5.9)	0.552