

values (mean)	Baseline LH/ FSH (Follow up LH/FSH	Baseline E2	Follow up E2	Baseline AMH/ Inhibin B	Follow up AMH/ Inhibin B	Baseline Follicular count/ dominant follicle	Follow up Follicular count/ dominant follicle
Cases n=25	5.82/5.23	17.6/25.08	80.156	56.063	5.667/56.11	1.223/16.48	4/1	1/0.5
p value	0.14/0.043		0.13		0.003/0.001		0.001	
Controls n=25	9.41/4.78	8.28/6.1	89.622	112.9	6.3/53.07	5.78/82.87	3.5/1.1	4/1
p value	0.585/0.087		0.310		0.745/0.001		>0.05	
Comparison cases- controls	0.065/0.938	0.554/0.357	0.749	0.002	0.061/0.547	0.001/0.001	>0.05	0.001
p value								

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INDUCTION AND MAINTENANCE TREATMENT OF PROLIFERATIVE LUPUS NEPHRITIS: AN UPDATED COCHRANE REVIEW

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Background and aims Pharmacological treatments have improved survival in lupus nephritis. However, intravenous cyclophosphamide as first-line therapy has considerable toxicity and lacks evidence of efficacy to prevent end-stage kidney disease. The comparative efficacy of newer strategies compared with intravenous cyclophosphamide remains unclear.

Methods We updated a random-effects meta-analysis of randomised controlled trials on induction and maintenance therapy for proliferative lupus nephritis. Evidence quality was assessed using GRADE.

Results 59 trials (4465 participants) were eligible, including nine new trials. Compared with intravenous cyclophosphamide, mycophenolate mofetil (MMF) incurred similar risks of complete remission, mortality, or major infection, while risks of alopecia and ovarian failure were lower (Table 1) (evidence quality=moderate). There was no evidence combined MMF and tacrolimus had different effects on complete remission or major infection than intravenous cyclophosphamide (Table 1) (evidence quality=low-very low). In maintenance therapy (Table 2), MMF decreased risks of disease relapse compared to azathioprine (evidence quality=moderate), although there was no evidence of different effects between maintenance therapies on mortality, end-stage kidney disease, or major infection (evidence quality = very low –low).

Conclusions MMF is as effective as intravenous cyclophosphamide in inducing remission in patients with proliferative lupus nephritis, with lower risks of alopecia and ovarian failure, although comparative effects of treatment on end-stage kidney disease and mortality remain uncertain. MMF is the most effective maintenance treatment to prevent relapse.

Abstract 254 Table 1 Summary of findings for induction therapy

Intervention	Comparison	Outcome	Number of participants (studies)	Relative risk (95%CI)	Quality of the evidence (GRADE)
Mycophenolate mofetil	Intravenous cyclophosphamide	Complete renal remission	806 (7 studies)	1.26 (0.97, 1.64)	Moderate
		Mortality	800 (7 studies)	1.34 (0.65, 2.76)	Moderate
		Major infection	773 (6 studies)	1.09 (0.94, 1.26)	Moderate
		Alopecia	622 (3 studies)	0.29 (0.19, 0.46)	Low
		Ovarian failure	685 (5 studies)	0.35 (0.12, 0.98)	Moderate
Mycophenolate mofetil + tacrolimus	Intravenous cyclophosphamide	Complete renal remission	402 (2 studies)	3.23 (0.64, 16.45)	Low
		Major infection	402 (2 studies)	2.75 (0.99, 7.62)	Very low

Abstract 254 Table 2 Summary of findings for maintenance therapy

Intervention	Comparison	Outcome	Number of participants (studies)	Relative risk	Quality of the evidence (GRADE)
Mycophenolate mofetil	Azathioprine	Renal relapse	452 (4 studies)	0.63 (0.42, 0.95)	Moderate
		Mortality	452 (4 studies)	0.87 (0.26, 2.94)	Very low
		End-stage kidney disease	452 (4 studies)	0.75 (0.28, 2.04)	Very low
		Major infection	412 (3 studies)	0.92 (0.51, 1.67)	Low

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PREDICTORS OF REMISSION AND LOW LUPUS DISEASE ACTIVITY STATUS (LLDAS): DATA FROM A MULTI-ETHNIC, MULTINATIONAL LATIN AMERICAN LUPUS COHORT

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Background and aims Remission and LLDAS prevent the occurrence of damage accrual in SLE patients. The aim of this

study was to evaluate the predictors of remission and LLDAS in SLE patients.

Methods Three disease activity statuses were defined: Remission= SLEDAI=0 and a prednisone dose ≤ 5 mg/d and/or immunosuppressive drugs in maintenance dose; LLDAS=SLEDAI ≤ 4 , a prednisone dose ≤ 7.5 mg/d and/or immunosuppressive drugs in maintenance dose; and non-optimally controlled status= SLEDAI >4 and/or prednisone dose >7.5 mg/d and/or IS drugs in induction dose. Antimalarials were allowed in all groups. Patients with at least two SLEDAI reported and not optimally controlled at cohort entry were included in this analysis. Predefined outcomes were remission and remission/LLDAS. Potential predictors were gender, age at diagnosis, ethnicity, socioeconomic status, residence, health insurance, disease duration at cohort entry, organs/systems affected at or before cohort entry, treatment at or before cohort entry and SLEDAI at cohort entry. Univariable and multivariable Cox regression models with a stepwise selection procedure were performed for remission alone and for remission/LLDAS.

Results One-thousand one-hundred and forty patients were non-optimally controlled at cohort entry. One hundred and ninety-six patients achieved remission (17.2%) and 314 achieved remission/LLDAS (27.5%). Predictors of remission and remission/LLDAS in the multivariable models are depicted in Tables 1 and 2.

Conclusions Mucocutaneous manifestations, renal involvement and higher disease activity early in the course of SLE were

Abstract 255 Table 1 Predictors of remission. Multivariable model.

Predictor	Hazard ratio (95% CI)	p value
Socioeconomic status		
High/medium high	Ref.	
Medium	0.856 (0.543 – 1.348)	0.5023
Medium low/low	0.626 (0.407 – 0.961)	0.0323
Mucocutaneous involvement	0.638 (0.433 – 0.940)	0.0230
Renal involvement	0.716 (0.523 – 0.981)	0.0373
SLEDAI at baseline	0.975 (0.955 – 0.996)	0.0188