Incomes / Medications	N	Mean	Std. Deviation	Median	Minimum	Maximum
Steroids						
No	91	43955	10357	40565	17946	67091
Yes	12	39702	8927	39643	32285	63629
Hydroxychloroquine						
No	11	40530	7320	40159	31013	52924
Yes	92	43810	10525	40159	17946	67091
Azathioprine						
No	85	43303	10028	40159	17946	67091
Yes	18	44199	11541	41050	31977	66374
Cyclophosphamide						
No	102	43454	10304	40159	17946	67091
Yes	1	44010		44010	44010	44010
Methotrexate						
No	95	43282	10351	40159	17946	67091
Yes	8	45567	9358	41625	38887	66374
Myocphenolate						
No	86	43809	10774	40362	17946	67091
Yes	17	41689	7035	39808	32566	51055
Belimumab						
No	100	43369	10380	40159	17946	67091
Yes	3	46468	3779	44574	44010	50819
Tacrolimus						
No	100	43709	10284	40362	17946	67091
Yes	3	35124	4361	32646	32566	40159
Any of the above*						
No	4	40431	9947	38893	31013	52924
Yes	99	43582	10296	40159	17946	67091

*p-value=0.592 (Mann-Whitney U Test)

400 ANA-NEGATIVE SLE: RE-EVALUATION IN AN INTERNATIONAL INCEPTION COHORT

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10.1136/lupus-2017-000215.400

Background and aims The prevalence of ANA-negative SLE is reportedly 5%–20%. Cytoplasmic or mitotic cell indirect immunofluorescence (IIF) patterns are usually reported as ANA-negative. This study examined the prevalence of ANA-negativity (no intracellular IIF pattern) and pure cytoplasmic and/or mitotic IIF patterns (CMP) in the Systemic Lupus International Collaborating Clinics (SLICC) inception cohort and examined demographic, clinical and autoantibody associations.

Methods Three groups were examined 1) ANA-positive (presence of nuclear IIF pattern), 2) ANA-negative (no IIF pattern), and 3) pure CMP. ANA were detected by IIF on HEp-2000 substrate, SLE-related autoantibodies by laser bead immunoassay, and anti-dsDNA and anti-dense fine speckles 70 (DFS70) by chemiluminescence immunoassay.

Results 1137 patients were included; 89.9% were female. 92.3% were ANA-positive, 6.2% were ANA-negative, and 1.5% had a CMP. In the multivariate analysis (Tables 1 and 2), patients from Canada (Odds Ratio (OR) 2.07 [95% CI: 1.28, 3.36]) or with anti-DFS70 (OR 4.45 [95% CI: 1.37, 14.39]) were more likely to be ANA-negative or have CMP. Patients of Asian descent (OR 0.34 [95% CI: 0.13, 0.86]) or with anti-dsDNA (OR 0.53 [95% CI: 0.30, 0.94]), anti-SSA/Ro60 (OR 0.51 [95% CI: 0.30, 0.87]), or anti-UI-RNP (OR 0.35 [95% CI: 0.17, 0.70]) were less likely to be ANA-negative or CMP.

Conclusions In newly diagnosed SLE, the prevalence of ANA-negativity was at the lower end (6.2%) of the range previously published and an additional 1.5% had a CMP pattern. The prevalence of true ANA-negativity will likely decrease as future guidelines are expected to recommend that non-nuclear patterns, such as CMP, are also reported.

401 HIGHEST FREQUENCY OF CLINIC VISITS AND HOSPITALIZATIONS IN SLE AMONG RHEUMATIC DISEASES: 8 YEAR CENSUS OF A TERTIARY RHEUMATOLOGY CENTRE

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10.1136/lupus-2017-000215.401

Background and aims We describe the frequency of clinic visits and hospitalizations among rheumatic diseases seen at a tertiary Rheumatology centre in Manila, Philippines

Methods The University of Santo Tomas (UST) Hospital is a tertiary care centre, with specialised subspecialty training in Rheumatology. This study is derived from the patient census of UST Hospital Rheumatology Clinics from 2008 to 2015.

Results Mean age of the total 15 730 rheumatic disease patients (10 808, 69% females; 13 607, 86.5% adults; 2123, 13.5% paediatrics) was 47.51±21.55 (range <1–103). Most common rheumatic conditions were osteoarthritis (OA) (2828, 17.98%), gout/pseudogout (2378, 15.12%) and systemic lupus

Abstract 400 Table 1 Baseline, univariate and multivariate associations of demographic and clinical profiles of ANA-positive (presence of nuclear IIF pattern), ANA-negative (no IIF pattern), and pure cytoplasmic/mitotic (CMP) groups

	ANA+ Mean or % n=1049	ANA- Mean or % n=71	Pure CMP Mean or % n=17	ANA- or Pure CMP Mean or % n=88	Univariate model Odds ratio 95% CI	Primary multivariate model Odds ratio 95% CI	Secondary multivariate model Odds ratio 95% CI
Demographics							
Age at diagnosis, yr	34.7*	40.9*	35.8	39.9*	1.03 (1.01, 1.04)*	1.02 (1.00, 1.03)*	
Female	89.7	90.1	100	92.0	1.33 (0.60, 2.95)		
Post-secondary educ.	66.7*	76.1†	31.3†*	67.5	1.04 (0.64, 1.67)		
Ethnicity							
Asian	23.2*	4.2*	11.8	5.7*	0.20 (0.08, 0.50)*	0.29 (0.11, 0.74)*	0.34 (0.13, 0.86)*
Black	16.2*	7.0*	5.9	6.8*	0.38 (0.16, 0.88)*		
Hispanic	3.4	2.8	0	2.3	0.67 (0.16, 2.83)		
White	52.4†*	84.5*	76.5†	83.0*	4.42 (2.50, 7.81)*		
Other[1]	4.8*	1.4*	5.9	2.3	0.46 (0.11, 1.93)		
Country of Residence							
Canada	29.3*	42.3*	47.1	43.2*	1.83 (1.18, 2.85)*		2.07 (1.28, 3.36)*
USA	26.7	28.2	23.5	27.3	1.03 (0.63, 1.68)		
Europe	28.3	25.4	23.5	25.0	0.84 (0.51, 1.39)		
Asia	15.7*	4.2*	5.9	4.5*	0.26 (0.09, 0.71)*		
Smoking							
Current smoker	15.1	21.9	18.8	21.3	1.52 (0.86, 2.66)		
Former smoker	21.1	26.6	25.0	26.3	1.33 (0.79, 2.24)		
Alcohol use, F: >10/wk; M: >15/wk	1.5	1.5	0	1.2	0.84 (0.11, 6.40)		
Hypertension, on meds or SBP > 140 or DBP >90	32.6*	29.6†	58.8†*	35.2	1.12 (0.71, 1.77)		
Nephritis[2] at enrollment	28.7	26.6	50.0	31.3	1.13 (0.69, 1.85)		
# ACR criteria	4.8	4.7	4.7	4.7	0.89 (0.71, 1.12)		
SLEDAI-2Kscore	5.4*	4.1*	5.4	4.3	0.96 (0.91, 1.00)		
Neurological	0.3	0.3	0.0	0.3	1.01 (0.88, 1.16)		
Mucocutaneous	1.1	1.0	1.3	1.1	0.99 (0.88, 1.11)		
Musculoskeletal	0.8	0.7	1.3	0.8	1.01 (0.89, 1.16)		
Renal	1.4	0.7	1.8	0.9	0.94 (0.86, 1.03)		
Serositis	0.1	0.1	0.0	0.1	1.03 (0.66, 1.61)		
Constitutional	0.0	0.0	0.0	0.0	0.30 (0.04, 2.17)		
Immunological	1.6*	1.1*	1.1	1.1*	0.82 (0.71, 0.95)*		
Hematological	0.1	0.0	0.0	0.0*	0.33 (0.11, 1.03)		
Medications, % ever using							
Steroids	80.6	74.6	82.4	76.1	0.77 (0.46, 1.28)		
Antimalarials	74.3	69.0	52.9	65.9	0.67 (0.42, 1.06)		
Immunosuppressants	43.6*	23.9†*	58.8†	30.7*	0.57 (0.36, 0.92)*		
Biologics	0.48	2.8	5.9	3.4	7.32 (1.72, 31.15)*	7.29 (1.57, 33.7)*	12.63 (2.12, 75.26)*

†, *, or in combination: values with the same superscript are significantly different from each other, i.e. †* is different from† and *, but † and *are not.
Abbreviations: ACR, American College of Rheumatology; ANA, anti-nuclear antibody; IIF, indirect immunofluorescence; SLE, systemic lupus erythematosus; SLEDAI, SLE disease activity index; wk, weeks; yr, years.
[1]Native North American, Native Hawaiian or other Pacific Islanders, others
[2]Lupus nephritis was diagnosed by renal biopsy or fulfilling the ACR criteria for lupus nephritis
[3]The SLEDAI-2K organ system scores were calculated by grouping the following items: Neurological: seizures, psychosis, organic brain syndrome, visual disturbance, cranial nerve disorder, lupus headache, CVA; Mucocutaneous: vasculitis, rash, alopecia, mucosal ulcers; Musculoskeletal: arthritis, myositis; Renal: urinary casts, hematuria, proteinuria, pyuria; Serositis: pleurisy, pericarditis; Constitutional: fever; Immunological: low complement, increased DNA binding; Hematological: thrombocytopenia, leukopenia

erythematosus (SLE) (2152, 14%). There were a total 38 738 patient encounters including 34 267 outpatient clinic visits and 4471 hospitalizations. Of these, SLE consistently had highest frequency outpatient encounters (9534, 28%) averaging 1192/yr (range 1–16, median 7), and hospitalizations (1956, 43%) averaging 245/yr (range 1 to 9; median 4). Polyarthritides (4726, 14%) and OA (4346, 13%) had next most frequent outpatient visits; other connective tissue diseases (641, 14.37%) and gout/pseudogout (612, 13.72%) ranked next to SLE in hospitalisation frequency (Figure 1). Mean age of OA patients (2258, 79.84% female) was 62.49+12.37 (20–101) years, gout/pseudogout (487, 20% female) 55.08+15.24 (18-94) years, and SLE (2004, 93% female) 30.7+14.3 SD (range 2–84) years.

Conclusions This 8 year patient census in a tertiary care Rheumatology training centre illustrates the burden of illness in SLE, with consistently the highest frequency of clinic visits and hospitalizations, affecting relatively young individuals.