Background and aims Disease activity increases risk of irreversible organ damage in SLE.

To understand the impact of disease activity (SELENA-SLE-DAI) and proportion of time with a certain level of disease activity on risk of developing new organ damage (SLICC/SCR Damage Index (SDI) score).

Methods Cox Proportional hazard models were used to estimate the impact of disease activity as time-dependent variables on the risk of developing any new organ damage over time.

Results Patients (n=2199) were followed for an average of 6.2 years (mean age at cohort entry, 38.0 years; mean disease duration, 5.1 years). The most frequent types of organ damage occurring over time were ocular (cataract) and musculoskeletal (osteoporotic fractures). In Model 1, excluding the variable "proportion of clinic visits with SLEDAI score >6," age, and SDI score at cohort entry, SLEDAI score during follow-up and corticosteroid use during follow-up were significant predictors of risk of developing any new organ damage. When including the "proportion of clinic visits with SLEDAI score >6" (Model 2), SLEDAI score during follow-up was no longer significant. in Model 3, excluding the time-dependent variable "SLEDAI score during follow-up" from the model, the effect of "proportion of clinic visits with SLEDAI score >5 was slightly reduced but remained significant.

Conclusions Higher organ damage risk was observed in patients with high levels of disease activity for a greater time compared to those with high levels of disease activity for a lesser time. These findings call for active measures to control disease activity over time in SLE.

| 190 | CASE REPORT: ELECTROLYTE ABNORMALITY CAUSED BY SUSPECTED ACQUIRED GITELMAN SYNDROME IN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENT |

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Background and aims Gitelman syndrome is a hereditary autosomal recessive abnormality of the kidney, that had presentation as hypokalemia, metabolic alkalosis, hypomagnesemia, and hypocalciuria. It is caused by mutation of SLC 12A3 gene encoding thiazide sensitive sodium-chloride co transporter. However, acquired Gitelman Syndrome can be found in SLE

Methods A 37 years old woman was admitted to hospital because of 7 days fever. She also had butterfly rash, hemolytic anaemia, and leucopenia. She was diagnosed as having SLE with hematologic and skin manifestation. Her sodium and potassium level were low. Her electrolyte imbalances were response well with supportive treatment. Ten days later, she had recurrent hypokalemia. Her haemoglobin level was decreased, and she was given packed red cell transfusion in her second admission.

Results One month later, she had neurologic manifestation, hemolytic anaemia, discoid rash, and low complement level.

Her sodium, potassium, calcium, and magnesium levels were still low. High dose steroid and chloroquin were given. She was discharged from the hospital well, but had recurrent admission five days later due to spasm of the face and extremities, can't open mouth, dyspnea, recurrent hyponatremia, hypokalemia, hypomagnesemia, and hypocalcemia. Her blood gas analysis showed metabolic alkalosis. She was diagnosed as having electrolity abnormality due to suspected acquired Gitelman syndrome.

Conclusions She was given pulse dose steroid, mycophenolate mofetil, and parenteral correction of electrolyte abnormality. She responsed well, and discharged from the hospital.

| 191 | REASONS FOR HOSPITALISATIONHOSPITALIZATION AMONG FILIPINO PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS |

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Background and aims To describe reasons and outcomes of hospitalisation among Filipino patients with systemic lupus erythematosus (SLE).

Methods Retrospective hospital chart review of Filipino SLE patients confined at University of Santo Tomas (UST) Hospital in Manila, Philippines from January 2011 to December 2015. Excluded were admissions for routine infusions. Final diagnoses were categorised as SLE-related or non-SLE related. Effect on SLE-relatedness of disease duration, age at SLE diagnosis and length of hospitalisation were analysed using Chi-square and Pearson's correlation coefficient.

Results There were 430 patients (95.58% female, 78% adults>18 years old) with 596 hospitalizations, Median number of hospitalisation per year per patient was one (range 1–3). Average age at hospitalisation was 28.98+12.95 SD years (range 5–71), average disease duration 6.51+6.30 SD years (range <1–16). Mean length of hospitalisation was 4.22+4.61 SD days (range 1–38). 479 (80%) hospitalizations for SLE-related reasons included lupus flare (357), lupus flare with concomitant infection (68), kidney biopsy (28) and renal failure requiring dialysis (26). Of 117 non-SLE related hospitalizations, infection with inactive SLE was recorded in 40 (29%). Among 16 deaths, 9 were infection-related and 7 were SLE-related. There was no significant association of age at SLE diagnosis, disease duration nor length of hospitalisation with SLE-relatedness.

Conclusions In this cohort of Filipino SLE patients, majority of hospitalizations were due to active SLE and/or infection, with infection having high risk for poorer outcomes. These findings strongly reinforce need to effectively control disease while minimising infection risk usually due to immunosuppressives.