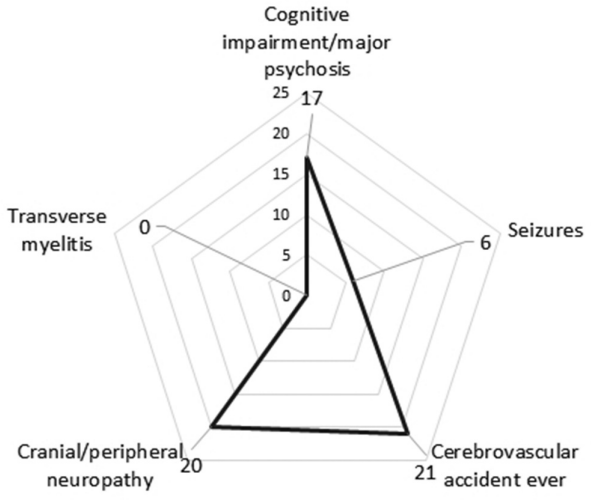
73 patients), damage and its components one year following diagnosis and at death, disease activity (ECLAM) at diagnosis, components of the metabolic syndrome, smoking and immunosuppressive treatment. Frequencies were compared using the chi-square and Fisher´s exact test, and continuous variables using the t-test and Mann-Whitney U-test. Variables associated with ND were included in a multivariate logistic regression model.

Results We identified 44/90 ND +patients: 17/44 with CIMP, 6/44 with seizures, 21/44 with CA, 20/44 with neuropathy, none with TM. ND +patients had a higher cumulative count of ACR criteria compared to their ND- counterparts (6.02 ±1.23 vs 5.39±1.26). They had a higher proportion of neurologic disorder (NRL-D) (6/37 vs 0/36) and a lower proportion of serositis (4/37 vs 11/36) at diagnosis, as well as higher cumulative proportions of NRL-D (9/44 vs 2/46), hematologic disorder (41/44 vs 34/46) and lymphopenia (34/44 vs 24/46) ($p<0.05$). ND +patients also had higher cumulative damage (6.43±3.13 vs 3.43±2.54), higher cumulative proportions of pulmonary (14/44 vs 6/46) and musculoskeletal damage (MSKD) (32/44 vs 21/46), and higher proportions of arterial hypertension (40/44 vs 34/46), secondary sicca (17/44 vs 9/46) and Hughes syndrome (11/44 vs 4/46) ($p<0.05$). Serositis at diagnosis and cumulative MSKD were associated with ND in the multivariate model (OR 0.17 (95% CI: 0.03 to 0.89) and 6.00 (95% CI: 1.64 to 21.91), respectively).

Conclusions Serositis may be associated with a lower likelihood of ND, while NRL-D was present at diagnosis only in patients that accrued ND. The association between MSKD and ND requires further elucidation.



Abstract PS8:165 Figure 1

PS8:166 COMPARISON OF CLINICAL AND SEROLOGICAL CHARACTERISTICS BETWEEN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS WITH AND WITHOUT ASSOCIATED JACCOUD'S ARTHROPATHY

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Objectives To compare the profile of clinical and serological manifestations of patients with SLE with and without JA followed in a tertiary care hospital of Madrid.

Methods We performed a retrospective observational study of a cohort of patients diagnosed with SLE (4 or more ACR criteria) between June 1977 and December 2015. The variables evaluated included demographics, clinical, analytical and radiological manifestations. The definition of JA was based on the presence of clinical criteria (reversible joint deformities) and absence of radiographic erosions typical of rheumatoid arthritis.

Results We included 108 patients representing a sample of 24% of the total number of patients with SLE treated at our centre during that period. The majority of patients were women (89.8%), mean age at diagnosis was 30±12.29 years (range: 7–75) and duration of disease was 127 months (range: 2–411). Thirteen patients (12.03%) had findings compatible with JA. There were no significant differences in age, sex or race, but the duration of disease was higher in JA patients (190 vs 118.2 months, $p=0.0299$). There were significant differences in the presence of malar rash ($p=0.0009$), photosensitivity ($p=0.0050$), oral ulcers ($p=0.0032$) and pericarditis ($p=0.000001$), which were more frequent in patients without JA, but arthritis, nephritis, pleuritis, seizures, psychosis, Raynaud's phenomenon and antiphospholipid syndrome had a similar distribution between both groups. Among the immunological features, no significant difference was found in relation to hemolytic anaemia, lymphopenia, thrombocytopenia, ANA, anti-ENA, anti-DNA, anticardiolipin, anti-β2 glycoprotein I and lupus anticoagulant, but leukopenia was also more frequent in patients without JA ($p=0.0041$).

Conclusions In the analysed sample of patients in our centre JA was a relatively frequent finding and was associated with a longer duration of the disease. It was not possible to corroborate other JA associations suggested in previous studies such as a lower frequency of lupus nephritis or major secondary antiphospholipid syndrome, probably due to limited sample size, but there are also other studies that do not demonstrate significant differences in relation to clinical and serological findings in patients with SLE with JA with respect to those who do not present it.

PS8:167 THERAPEUTIC EFFICACY OF BELIMUMAB IN ADDITION TO STANDARD THERAPY FOR LUPUS NEPHRITIS AND NEUROPSYCHIATRIC LUPUS – CASE SERIES OF ROUTINELY COLLECTED DATA AT A SINGLE CENTRE

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10.1136/lupus-2018-abstract.210

Purpose Belimumab (BEL) is approved for Systemic Lupus erythematosus in addition to standard immunosuppressive therapies. Clinical studies have excluded patients with particular organ manifestations from participation in most clinical trials. Most importantly, Lupus nephritis (LN) and neuropsychiatric Systemic Lupus erythematosus (NPSLE) were exclusion criteria in the relevant clinical studies. We aim to report our experience of BEL's effect on SLE manifestations which have not been formally addressed in clinical trials.

Methods We performed an observational study of routinely collected clinical data of all patients receiving BEL with or without other immunosuppressive therapy at our institution.

Results We identified 15 patients currently receiving BEL therapy. Of these, 9 were not analysed further because they had no history of LN or NPSLE.

One 48-y/o female patient after renal transplantation with background therapy consisting of prednisone (GC), hydroxychloroquine (HCQ), leflunomide (LEF) and tacrolimus (TAC) had a stable disease but no additional benefit (BEL stopped after 5 months). Three female patients with GC, HCQ and mycophenolate mofetil (MMF) had an improvement of proteinuria, steroid dosage and overall quality of life. One female patient is receiving BEL or placebo (PBO) during a clinical trial (BLISS-LN), she has markedly improved proteinuria with GC, HCQ, MMF and BEL/PBO. One 73-y/o male patient with NPSLE who failed or could not tolerate various standard and additional therapies (including Rituximab and Cyclophosphamide) had a persistent clinical improvement of cutaneous lupus and neuropsychiatric symptoms (dysarthria, concentration, ataxia) after the second BEL infusion. Overall, there was one upper respiratory tract infection but no other adverse events.

Conclusions In the six patients analysed, 3 had improved proteinuria, 1 had stable disease after renal transplantation, 1 improved regarding NPSLE symptoms and 1 had improved proteinuria, but in the last case, it is not yet clear whether the effect is due to BEL. Overall, while the results of the BLISS-LN trial are awaited, we experienced improved Lupus nephritis with BEL in addition to standard therapy and observed one case of improved NPSLE. While BEL has not been approved for these severe organ manifestations, it still might be effective in well-selected patients.

PS8:168 PROTEINURIA IN RELATION TO CLASS OF LUPUS NEPHRITIS – A RETROSPECTIVE SINGLE-CENTRE STUDY

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10.1136/lupus-2018-abstract.211

Purpose Lupus nephritis (LN) is one of the most severe organ complications of Systemic lupus erythematosus (SLE) affecting up to 60% throughout the course of their disease. Currently, LN is classified according to the ISN/RPS classification. Classes III/IV require aggressive immunosuppressive treatment to avoid end-stage renal disease. However, there are no clinical or serological parameters to predict the type of renal disease and overall renal prognosis.

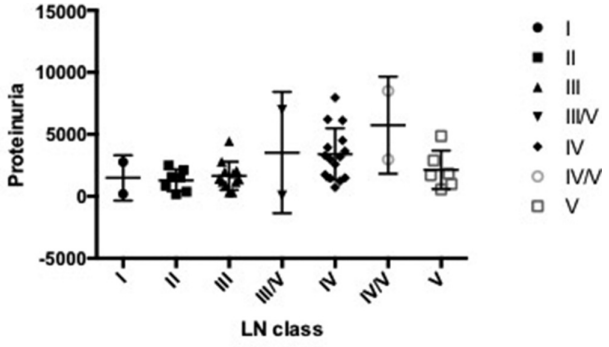
Methods We performed a single-centre study at our institution of all patients who underwent a renal biopsy between 2001 and 2017. Proteinuria, creatinine and other clinical/serological data were collected. Median values were analysed with ANOVA and Bonferroni's correction for multiple comparisons.

Results 49 patients were analysed in our study. 3 patients were excluded because of incomplete data. The remaining 46 patients were stratified according to the histopathological class of Lupus nephritis. 2 patients had class I, 7 patients had class II, 12 patients had class III, 2 patients had class III/V, 15 patients had class IV, 2 patients had class IV/V and 6 patients had pure class V.

Median proteinuria at or around the nearest time point to renal biopsy were 1487 mg/g creatinine (Cr) (class I), 1515 mg/g Cr (class II), 1373 mg/g Cr (class III), 3528 mg/g Cr (class III/V), 3190 mg/g Cr (class IV), 5741 mg/g Cr (class IV/V) and 1773 mg/g Cr (class V).

While LN classes III/V, IV and IV/V showed the highest median proteinuria, there was no statistical difference between groups.

Conclusions Although often presumed, proteinuria is not a reliable marker for the various types of Lupus nephritis. There was a higher median proteinuria with class V (pure or combined) membranous nephropathy, however, even proteinuria in this group was not significantly different compared with the other groups. Lack of reliable clinical markers challenges the current lupus nephritis classification system, a combination of clinical, serological and histopathological findings might more appropriately predict the overall prognosis in LN.



Abstract PS8:168 Figure 1

PS8:169 PREVALENCE AND IMPACT OF DYSLIPIDEMIA IN LUPUS NEPHRITIS PATIENTS

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10.1136/lupus-2018-abstract.212

Dyslipidemia is a well-established atherosclerotic risk factor. It is also believed to affect the outcome of SLE, especially in lupus nephritis patients (LN). The aim of this study was to assess the prevalence and impact of dyslipidemia in our LN patients.

Methods We performed a retrospective clinical study, 140 patients with biopsy-proven LN from were analysed. The renal activity and classification were evaluated according to renal pathology. SLE disease activity was scored using the SLE Disease Activity Index (SLEDAI). Adverse outcome was defined by the occurrence of ESRD or death. The correlations between dyslipidemia and both ESRD and mortality were assessed.

Results Mean age of our patients was 34.63±12,7 years old, 83% were females. Class III, IV and V lupus nephritis accounted for 21%, 58.7% and 11.2% The prevalence of dyslipidemia with elevations in total cholesterol (TC), low-density lipoprotein (LDL), triglyceride (TG) were noted in in our LN patients, ranging from 41% at diagnosis to 59.7% or even higher after 24 months, and statitns were administered in 23% of the patients

After a mean follow-up of 22 months, ESRD occured in 24%, and death in 13% of cases. Moreover, dyslipidemia was significantly associated to both ESRD ($p<0.02$) and death ($p<0.003$).