entered into a specially designed excel database, which was later transferred into the SPSS version 22 for Windows for analysis. Frequent edit checks were done.

Abstract CE-34 Table 1 Demographic data among patients with SLE in South and Central Trinidad

Demographics		P value
Mean (SD) age/years [n = 91]	39.47 (15.22)	0.000[1]
Gender [n = 91]		
Male, n (%)	3 (3.30%)	
Female, n (%)	88 (96.70%)	
Ethnicity [n = 91]		
Indo Trinidadian, n (%)	46 (50.50%)	
Afro Trinidadian, n (%)	24 (26.40%)	
Mixed- Other, n (%)	15 (16.50%)	
Mixed- African and East Indian, n (%)	6 (6.60%)	
Chinese, n (%)		
Caucasian, n (%)		
Syrian/Lebanese, n (%)		
Portuguese, n (%)		
Indigenous, n (%)		
Other, n (%)		
Religion [n = 89]		
Hinduism	19 (20.90%)	
Pentecostal/Evangelical/Full Gospel	18 (19.80%)	
Roman Catholic	14 (15.40%)	
Baptist- Spiritual Shouter	8 (8.80%)	
Islam	8 (8.80%)	
Anglican	4 (4.40&)	
Seven Day Adventist	3 (3.30%)	
Presbyterian/Congregational	3 (3.30%)	
Jehovah's Witness	2 (2.20%)	
Orisha		
Methodist		
Atheists		
Other	10 (11.00%)	

Statistical Tests
t-test

Results Of the 169 patients on the database, to date, 91 were confirmed with SLE. Demographic variables are shown in Table 1. Among the patients with confirmed SLE 50.50% were Indo-Trinidadian, 26.40% were Afro-Trinidadian and 23.10% were of Mixed Ethnicity. Females accounted for 96.70% of the 91 patients. Mean (SD) age was 39.47 (15.22) years, the youngest was 5 years old and the eldest 74 years old. The most common religious affiliation was Hinduism (20.90%), closely followed by Pentecostal/Evangelical/Full Gospel (19.80%) and then Roman Catholic (15.40%).

Conclusion An unexpectedly high percentage of our patients were of East Indian origin. It is not clear whether this is a reflection of the ethnic background of the regional population being evaluated, or if this is a previously unidentified occurrence. Detailed epidemiologic studies would be necessary to address this question. Understanding this disease in our population has implications for resource allocation and access to subspecialty care.

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CE-35 LOW PREVALENCE OF PCP IN HOSPITALISED PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS: REVIEW OF A CLINICAL DATA WAREHOUSE

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Background In the era of powerful immunosuppression, opportunistic infections are an increasing concern in Systemic Lupus Erythematosus (SLE) patients. One of the best-studied opportunistic infections is Pneumocystis pneumonia (PCP); however, the prevalence of PCP in SLE is not clearly defined, and the low tolerance to trimethoprim-sulfamethoxazole in SLE presents a challenge for PCP prophylaxis in SLE patients. The objective of this study was to evaluate the prevalence of PCP in hospitalised SLE patients at a single medical centre, with a focus on validating PCP and SLE diagnoses with clinical information obtained from corresponding medical records, in order to better define the risk of PCP in SLE.

Materials and methods This is a retrospective cohort study evaluating the prevalence of PCP in all patients with SLE treated at Columbia University Medical Centre-New York Presbyterian Hospital between January 2000 and September 2014, using electronic medical record (EMR) data from the Clinical Data Warehouse. Patients with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and patients with renal transplants represented immunocompromised control groups. Patients with SLE, PCP, HIV/AIDS, or renal transplant were identified using diagnostic codes from the International Classification of Diseases, Ninth Revision (ICD-9).

Results Out of 2,013 hospitalised SLE patients, nine were identified with presumed PCP, yielding a prevalence of 0.45%. Three of the nine PCP cases were patients with concomitant SLE and HIV/AIDS. Only one of these nine cases was histologically confirmed as PCP, this too in a concomitant SLE and HIV/AIDS patient with a CD4 count of 13 cells/mm^3. The prevalence of PCP in renal transplant patients and HIV/AIDS patients was 0.61% and 5.98% respectively.

Conclusions Given the reported high rate of adverse effects of trimethoprim-sulfamethoxazole in SLE patients and our finding of low prevalence of PCP infections in hospitalised SLE patients, our data do not substantiate the need for initiating PCP prophylaxis in SLE patients except in those with concurrent HIV/AIDS.

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