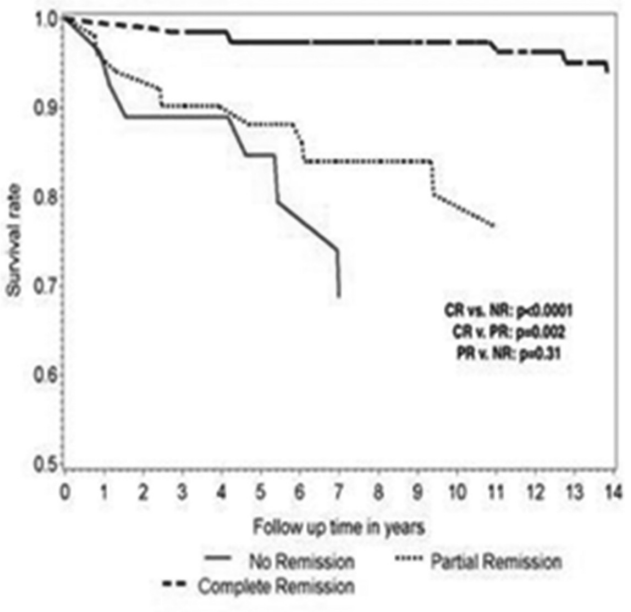

Abstract 219 Figure 1 Kaplan Meier analysis of long term outcome of low eGFR (<15 mL/min) among patients who acheived CR, PR or NR at 2 years of LN diagnosis

from 81 patients with SLE.We examined anti-dsDNA level, clinical features and kidney laboratory profile in all patient. The obtained data were statistically analysed.

Results 81 SLE patients with mean level of anti-dsDNA 294 IU/ml (6.1–1317). There is no significant relationship between increased level of Anti-dsDNA with other clinical manifestations (p>0.05). There are significant relationships between increased level of Anti-dsDNA with ureum level (p=0.016), thrombocytopenia (p=0.001), leucopenia (p=0.006), kidney disorder (p=0.049) and urine protein (p=0.028).Arthritis is the most frequent clinical manifestation (96.3%) from this study followed by malar rash (77.8%) and photo sensitivity (40.7%).

Conclusions Elevated anti-ds DNA level was not correlated with clinical symptoms but there is significant correlation with haematology disorder and kidney laboratory profiles of SLE patients.

221 SELECTED NAILFOLD CAPILLAROSCOPY PARAMETERS ARE PREDICTIVE OF SLE ONSET IN CONNECTIVE TISSUE DISEASES SUBGROUP

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Background and aims Nailfold capillaroscopy (NVC) is an useful, non-invasive, reproducible and cost-effective favourable diagnostic tool able to assess the shape of capillaries in the periungal region and the presence of their peculiar abnormalities, essential in the differential diagnosis of connective tissue diseases (CTD).

Methods The aim of the study was to evaluate if selected NVC pictures are linked to SLE onset in a cohort of 42 CTD-affected women presenting Raynaud's phenomenon, observed over 36 months. All of them were examined by this method every 6 months. We considered the following NVC parameters: presence of ectasic capillary loops (diameter ≥20 µm); megacapillaries (≥50 µm); hemosiderin deposits; capillary number reduction; neo-angiogenesis phenomena; micro-vascular array disorganisation. CTD and SLE diagnoses were posed according to the 2015 ACR/SLICC criteria. Qualitative variables were expressed in frequencies; their association, by non-parametric tests. Quantitative variables were assessed by analysis of co-variance.

Results The presence of hemosiderin deposits, ectasic loops and neo-angiogenic phenomena was strongly associated to the clinical subgroup of patients that later developed SLE (12/42 subjects; OR=13.5). The variable meandering deposits was the more strongly associated to SLE onset (OR=8.32; p<0.0101). The independent variables ectasic loops (OR=12.16) and neo-angiogenic phenomena (OR=6.60) were predictive for the persistence of CTD diagnosis.

Conclusions Nailfold capillaroscopy, summarising, can help in CTD management, since the presence of typical capillaroscopic abnormalities seems to be related to the development of SLE.

222 ASSESSMENT OF THE RISK OF FLARES IN SYSTEMIC LUPUS ERYTHEMATOSUS

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Background and aims To evaluate the risc of flares in SLE patients

Methods A prospective analytic study of SLE patients (SLICC, 2012 criteria) with a fallowed–up in 5 visits: baseline visit, month 3, month 5, month 9 and month 12 visit. At visits disease activity (SLEDAI, SLAM), SELENA/SLEDAI flare index and laboratory tests were assessed.

Results The study included 102 patients, 94,1% females, age ±SD 42.4±13.3 (range 20–73) years, disease duration±SD 93.9±77.1 (range 0,1–228) months. During fallow–up, 55 flares were enregistered, including 11 severe, with a SLEDAI increase with 3–17 points. The incidence of flares was 0,53 patient/year, the for severe flares - 0,10 patient/year. To assess the risk of flares, potential risk factors were studied (table 1).

The main risk factors were laboratory findings, while only active pulmonary involvement derived from SLAM and antiphospholipid syndrome, as clinical and laboratory variables, associated with the flares in SLE patients.

Conclusions In our study, the incidence of flare in a 12 moths period was 53,9%, including 10,8% of severe flares. We have determined that patients with high ERS, low Hb and lymphocytopenia are at risk for flares and antiphospholipid syndrome and pulmonary involvement were the main clinical risk factors in our cohort.