significantly higher in the osteoporosis than non-osteoporosis group ($p<0.001$). Cox regression showed that increasing age (HR1.08[1.03–1.12]), osteoporosis/fracture (HR3.47[1.59–7.59]) and a family history of fracture (HR4.31[1.41–13.2]) were independently associated with new fractures after adjustment for SLE duration, childhood onset disease, other osteoporosis risk factors, clinical manifestations, GCs and immunosuppressive medications. No relationship between the daily dosage of GCs and fractures was observed.

Conclusions In this longitudinal cohort of SLE, new fragility fracture developed in 8.9% of patients. Increasing age and severe osteoporosis at baseline was major risk factors.

LP-066 SEVERE SYSTEMIC LUPUS ERYTHEMATOSUS WITH MANIFESTATION OF LUPUS NEPHRITIS AND PERICARDIAL EFFUSION: A CASE REPORT

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10.1136/lupus-2023-KCR.175

Description Clinical manifestations of SLE in male patients tend to be more severe with a worse prognosis. Generally, SLE in male patients involves kidney and serological abnormalities such as hypocomplementemia and anti-dsDNA autoantibodies. In addition, cardiovascular complications are more common in men with SLE, which contributes to an overall increase in organ damage. Case illustration A 18-year-old male patient suffered from back pain 6 months ago. He complained of low urine output (urinating 3–4 times a day with a total output of approximately 400 mL), dyspnea, and swelling in both legs. Pericard effusion was discovered, and pericardiocentesis was performed. Physical examination showed the patient was hemodynamically stable. We found malar rash, rash in the plantar pedis and plantar manus also decreased vesicular sounds with rales in both lungs. Laboratory examination showed leukopenia, thrombocytopenia, hypoalbuminemia, hyperuricemia, and a glomerular filtration rate of 94 mL/min/1.73 m2. Urinalysis showed proteinuria, hematuria, and leukocyturia. Blood gas analysis found metabolic alkalosis. ANA IF test was positive for anti-Smith, anti-RNP-Smith, and anti-dsDNA antibodies. The patient was given methylprednisolone pulses dose (1000 mg/day) for 3 days, followed by methylprednisolone 125mg/12h for 3 days, 62.5mg/12h for the next 3 days and tapered-off to 8mg/day. The patient also received mycophenolic acid (500mg/8h), hydroxychloroquine (200mg/day) per oral, and Captopril 12.5mg/8h per oral during hospitalization. The patient showed clinical improvement and was discharged after 11 days. Subsequent follow-up at rheumatology policlinic showed the patient had improved both clinically and laboratory.

Conclusions The patient's condition in this case is consistent with the theory, where the patient is experiencing lupus nephritis and pericardial effusion. Establishing an accurate diagnosis of SLE in male patients is crucial. Early diagnosis leads to better outcomes.

LP-067 ANALYSIS OF HOSPITAL LENGTH OF STAY IN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS HOSPITALISED WITH INFECTION

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10.1136/lupus-2023-KCR.176

Background Serious infections contribute significantly to morbidity and mortality in systemic lupus erythematosus (SLE)

Methods We undertook a retrospective analysis of all SLE patients enrolled in the Australian Lupus Registry & Biobank admitted to hospital with infection between 2009–2020. Comparisons of length of stay (LOS) according to different patient and disease characteristics and clinical decisions regarding corticosteroids (CS), immunosuppression (IS) and anti-microbial therapy were performed using ANOVA (Kruskal Wallis test). Cox and related regression models were used to identify associations between hospital LOS and clinical variables.

Results 53 patients with 85 separate hospitalisations were identified. Patients had a mean (SD) age of 44.6 (14.8) years. Mean hospital LOS was 15.4 (19.7) days. Admission to the Intensive Care Unit (ICU) occurred in 11.8% of cases. IS was withheld during 29.4% of infections. There was considerable variation in whether CS were modified from a patient's baseline dose. Use of pulse CS and weaning baseline CS during infection were strongly associated with longer LOS. Unsurprisingly, ICU admission, intravenous anti-microbial use and nosocomial infections were also linked with increased LOS. Withholding immunosuppression during infection did not reduce LOS. Patient factors including age, Charlson Co-Morbidity Index (CCI), preceding disease activity and pre-admission immunosuppression did not influence LOS.

Conclusions From this single centre study hospital LOS was primarily influenced by factors relating to the severity of infection. Factors possibly relating to inadequately controlled SLE, such as attempted tapering of usual CS dose and administering pulse CS – commonly used to treat severe disease flares, also significantly prolonged infection admissions. Further research is required to identify the optimal approach towards modifying baseline CS and immunosuppression when managing infections in SLE patients.

LP-204 CHILBLAIN LUPUS ERYTHEMATOSUS-A RARE ENCOUNTER

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10.1136/lupus-2023-KCR.177

Description Chilblain lupus erythematosus(CHLE) or Perniosis is a rare and chronic form of lupus involving the toes, fingers, nose, and ears precipitated by cold exposure. The prevalence is 3–20%, affecting mostly women and can be divided into primary and secondary. The primary or idiopathic form is not associated with an underlying disease, while the secondary