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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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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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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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

form is associated with an underlying condition such as connective tissue disease, monoclonal gammopathy, cryoglobulinemia, or chronic myelomonocytic leukaemia. It is often associated with other forms of cutaneous lupus, and about 20% of patients develop systemic lupus erythematosus(SLE). The patient usually comes with symptoms of purple plaques or nodules and oedematous skin, mainly around the acral regions of the body. Histologic features are identical to those of discoid lupus erythematosus. The damaged skin gives a Positive fluorescent band test picture. CHLE is defined by the Mayo Clinic criteria, which include two major and four minor. Diagnosing a patient requires two major and at least one minor criterion. Patients with chilblain lupus erythematosus may also display hypergammaglobulinaemia, positive rheumatoid factor, antinuclear antibody, antiphospholipid or anti-Ro antibodies. They are usually negative for anti-double-stranded DNA antibodies. The first-line treatment for mild and localised symptoms is topical corticosteroids. Second-line systemic treatments consist mainly of immunomodulators and immunosuppressants. Studies have shown benefits from the use of topical tacrolimus and pimecrolimus. We want to report a case of a young lady that presented to our centre with CHLE.

Conclusions Chilblain lupus erythematosus is a rare and chronic disease mainly affecting women. Although it is not as severe as Systemic Lupus Erythematosus(SLE), it may be the sentinel sign of a range of underlying auto-immune diseases. Physicians should be vigilant in dealing with CHLE as their symptoms may be subtle and mimic other similar pathologies.

LP-206 ANA-NEGATIVE LUPUS PRESENTING WITH SEGMENTAL HYALINIZING VASCULITIS AND VALVULAR HEART DISEASE – A RARE CASE REPORT

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Description The presence of antinuclear antibody (ANA) is usually considered a hallmark of Systemic Lupus Erythematosus (SLE). However, a small group of SLE patients had the typical clinical manifestation of SLE with negative ANA tests. Segmental hyalinizing vasculitis is an orphan disease associated with various diseases including SLE. We report a case of a 29-year-old female presented with a painful skin ulcer on both her upper and lower extremities for 2 weeks. She also noted joint pain, fever, and shortness of breath. The symptoms were accompanied by multiple redness and pus-filled skin ulcer on both arms, thighs, and legs. The remainder examination revealed hair loss, pale conjunctiva, crackles in chest examination, ascites, and edema in both feet. There were also redness and tenderness on both hand at Distal Interphalangeal(DIP), Proximal Interphalangeal(PIP), and Metacarpophalangeal(MCP). Laboratory studies showed anemia, elevated erythrocyte sedimentation rate, and positive LE cell. The antinuclear antibody immunofluorescence (ANA IF) test was negative. A skin biopsy revealed segmented hyalinizing vasculitis suitable for Lupus. A transthoracic echocardiogram showed mildly abnormal left ventricular systolic function with an ejection fraction 45%, moderate mitral regurgitation, and mild aortic regurgitation. Chest X-ray showed signs of pulmonary edema and right pleural effusion. The conditions fulfilled the clinical criteria of SLE, and the patient was diagnosed with ANA-negative SLE. The patient underwent treatment with hydroxychloroquine 200 mg twice daily, methylprednisolone 16 mg twice daily, and desoximethasone cream. The patient showed significant clinical improvement and her ulcer completely resolved after 6 months of treatment, and there is no recurrent ulcer.

Conclusions Case report of a 29-year-old woman diagnosed with ANA-negative SLE with segmental hyalinizing vasculitis and valvular heart disease as the main manifestation of SLE. Early recognition and aggressive SLE therapy of this rare subset of SLE disease showed clinical improvement and completely resolved skin ulcers.

5. SLE epidemiology and public health

LP-068 THE CHALLENGES IN THE MANAGEMENT OF SYSTEMIC LUPUS ERYTHEMATOSUS DURING THE 3RD WAVE OF COVID19 PANDEMIC IN SRI LANKA: A SINGLE-CENTRE EXPERIENCE

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Background COVID19 pandemic likely has had significant influence on the presentation, management and outcome of Systemic Lupus Erythematosus (SLE). A single-centre experience of managing SLE during the 3rd wave of COVID19 pandemic in Sri Lanka is presented.

Methods New and follow up patients with SLE seen at Peradeniya University Teaching Hospital from the 1st of July to the 31st of August 2021 were audited. Those with moderate to severe disease (assessed by British Isles Lupus Assessment Groups 2004/BILAG score[1]) requiring intensification of immunosuppression, were identified. Possible effects of the pandemic on the clinical presentation, and treatment outcome were assessed.

Results Of 45 patients with SLE seen during this period, eleven had moderate to severe flares (female:male 10:1). Four were new diagnoses during the study period. Of the seven follow-up patients, six had well-controlled disease over the preceding 24 months, while one had intermittent flares.

9 out of 11 patients were BILAG-A in at least one domain and two were BILAG-B. All needed aggressive immunosuppression. Remission was induced in ten patients while one succumbed to severe disease and sepsis.

In 72.7% of patients (n=8), effects of COVID19 were evident. These were possible causal association (n=1), disease flare concomitant with COVID19 infection (n=2), COVID19 complicating immunosuppression (n=1) and delayed presentation leading to requirement of aggressive immunosuppression (n=4).

Conclusions Diagnosing and managing SLE is challenging due to variable clinical presentation, multi-system involvement and complex treatment decisions.[2] The on-going pandemic has increased these challenges several-fold. COVID19 probably has a causative relationship with autoimmune disease.[3] Delayed presentation can cause unfavourable outcomes during the pandemic.