



Abstract LP-125 Figure 1

history, high blood pressure, leukocytoclastic vasculitis, edema in the lower limbs, anemia, thrombocytopenia, active sediment, 0.6 g/24 hrs. proteinuria, ANA, lupus anticoagulant, and SSA +. Case 4, a 39-year-old woman with no medical history, non-scarring alopecia, malar erythema, emergency hemodialysis criteria, lymphopenia, anemia, hypocomplementemia, 4.1 g/24 hrs. proteinuria, ANA, and anti-DNA +. The clinical manifestations are summarized in (table 1) according to the SLE EULAR/ACR 2019 classification criteria. Renal biopsy was performed in 4 cases (table 1), the first being associated with the long-standing use of Interferon β 1, the second with star fruit consumption, the third with antiphospholipid syndrome, and the fourth ANCA-Associated Vasculitis (figure 1). The treatment and evolution of the patients 8 weeks after identification are shown in (table 1).

Conclusions Glomerulopathy in SLE is a frequent and severe manifestation, so timely treatment is necessary. However, the role of renal biopsy becomes important despite the clinical characteristics, where its performance shows us that in the clinical spectrum of glomerulopathies not everything is Lupus.

LP-126 **THE INFECTIOUS COMPLICATION IN MULTITARGET THERAPY OF CLASS V LUPUS NEPHRITIS: A CASE REPORT**

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Description Agents such as cyclosporine A(CSA) and tacrolimus(TAC) have long been used in SLEpatients. A new therapeutic approach of lupus nephritis(LN) is a multitarget therapy: calcineurin inhibitors with mycophenolate mofetil (MMF).

Here is a case report of lupus nephritis (class V) and infectious complication in a SLE patient treated with low-dose combination of CSA and MMF.

A 40-year-old woman(caucasoid), the disease debut at the age of 25, duration 16 years(since 2006), the diagnosis of SLE was established in 10.2011(full picture after childbirth). History: LN (class IV, with nephrotic syndrome, azotemia – 2011), nervous system (migraine with aura, sensorimotor polyneuropathy of the lower extremities, dysuria – 2011), arthritis and Raynaud's phenomenon (2006, 2010), thrombocytopenia (2011), positive anti-ds-DNA, anti-Sm, ANA, hypocomplementemia (2011). In 2011, therapy was carried out with high doses of prednisolone(max 40mg/day), cyclophosphamide (total 5000mg, 2011–2012years), rituximab (1000 mg No. 2, 2012–2013years), MMF 2.5–1 g/day (2012 -2017years), hydroxychloroquine(HCQ). Low disease activity was achieved in 2016–12.2020years: therapy with prednisolone 5mg/day and HCQ 200mg/day.

In 12.2020 there was a disease relapse – isolated persistent proteinuria 1.3g/day. Repeated nephrobiopsy was performed: membranous glomerulonephritis(class V) was revealed. The dose of prednisolone was increased from 5 to 30mg/day, MMF 2 g/day was added, HCQ. After 5 months of this therapy, proteinuria did not decrease – 1.2g/day. A decision was made to switch to multitarget therapy: a combination of MMF 1g/day and CSA 150mg/day (2 mg/kg/day) from 06/14/2021, but on 07/16/2021 panaritium of the 2nd toe of the foot developed. Resumption of multitarget therapy 08/12/2021. By September 2021 proteinuria decreased to 0.6g/day, but on 09/28/2021, purulent bursitis of the right elbow joint developed. The patient was transferred to monotherapy of MMF 1–2 g/day, prednisone10–7.5mg/day, HCQ 200mg/day, proteinuria 0.18 g/day from 03.2022

Conclusions Multitarget therapy with CSAandMMF is effective in treating LN(classV), but can lead to purulent infectious complications.