**Results**

Of 418 eligible patients, 209 (50%) achieved remission within the first year, 102 (24.4%) within the 2nd/3rd years, 70 (16.7%) after 3 years and 37 (8.9%) never achieved remission. Regarding flares, 82 patients (19.6%) never flared, 75 (18%) had one flare and 261 (62.4%) had ≥2 flares. The total number of flares was 1159; 203 (17.5%) were characterized by an eGFR decrease of ≥10 ml/min/1.73 m². The trajectory and annual slope of eGFR according to time to remission and number of flares is shown in the Figure.

**Conclusions**

Complete remission after 3 years or no remission is associated with a significant eGFR decrease, while remission during the 2nd/3rd year from LN diagnosis is not associated with any significant eGFR decrease over time. Patients with one flare did not have any significant impact on their renal function over time. Patients with ≥2 flares had a significant eGFR decrease over 20 years, after adjustment for other covariates. Time on immunosuppressives after complete remission is protective against eGFR decline.

**Abstract LP-208 Table 1**

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>Patients who developed CKD stage IV or worse (n=10)</th>
<th>Patients who did not progress (n=81)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDI (SDI)</td>
<td>1.3 ± 1.9</td>
<td>0.3 ± 0.7</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>SCR (μmol/l)</td>
<td>209.2 ± 127.2</td>
<td>92 ± 32</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>eGFR (ml/min/1.73 m²)</td>
<td>45.2 ± 43.1</td>
<td>76.7 ± 23.7</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Abnormal SCR</td>
<td>8 (80.0%)</td>
<td>13 (16%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Elevated d:sDNA</td>
<td>2 (20.0%)</td>
<td>48 (59.3%)</td>
<td>0.019</td>
</tr>
<tr>
<td>Chronicity Index</td>
<td>2.2 ± 2.6</td>
<td>0.9 ± 1.6</td>
<td>0.028</td>
</tr>
<tr>
<td>Interstitial fibrosis (moderate-to-severe)</td>
<td>3 (30.0%)</td>
<td>3 (3.7%)</td>
<td>0.009</td>
</tr>
<tr>
<td>Tubular atrophy (moderate-to-severe)</td>
<td>3 (30.0%)</td>
<td>4 (4.9%)</td>
<td>0.014</td>
</tr>
</tbody>
</table>

**Abstract LP-208 Figure 1**

Trajectory and annual slope of eGFR according to time to remission and number of flares.
high neutrophil activity (n=6). Patients with ESRD at baseline were excluded. Individuals were followed over time for the development of advanced CKD.

**Results**

Of 91 eligible patients, 10 developed advanced CKD during follow-up, 7 CKD stage IV and 3 ESRD. Baseline characteristics in Table 1.

In 81/91 patients, there was no significant deterioration of the renal function after 16.8 years. Proteinuria was mild (1.17 ± 0.89g). Fifteen patients had a repeat biopsy; histologic transformation was demonstrated in 10 (7 proliferative nephritis, 2 membranous, 1 advanced glomerulosclerosis). Sixty-three patients (67.7%) had normal renal function while 19.4% had CKD stage III (eGFR=30–59ml/min/1.73m2) at last visit.

Seven patients developed CKD IV (4 had impaired kidney function at baseline). Proteinuria was mild (<1g/day). Four had a repeat biopsy; 2 developed membranous nephropathy. Renal function remained stable (eGFR=24.2±4.3ml/min/1.73m2) after a mean of 18.5 years.

Three patients developed ESRD after 8.6, 10.3 and 16.8 years respectively. Two had a repeat biopsy demonstrating histologic transformation (proliferative nephritis, advanced glomerulosclerosis).

**Conclusions**

Advanced CKD developed in 11% of LN II patients but the progression was slow. In most cases, kidney function was impaired at diagnosis while proteinuria was mild. These findings imply that mesangial disease can occasionally lead to CKD and underlines the need for close monitoring. Treatment should not be based on the level of proteinuria alone.

## 10. SLE outcomes and prognosis

### **LP-135**

**HIGH NEUTROPHIL-TO-LYMPHOCYTE RATIO IS A RISK FACTOR FOR CHRONIC KIDNEY DISEASE IN PATIENTS WITH LUPUS NEPHRITIS**

Dong-Jin Park*, Hyemin Jeong, Sung-Eun Choi, Ji-Hyoun Kang, Shin-Seok Lee. Department of Rheumatology, Chonnam National University Hospital, Republic of Korea

10.1136/lupus-2023-KCR.226

**Background**

The neutrophil-to-lymphocyte ratio (NLR) is known to be associated with a poor outcome in patients with chronic kidney disease (CKD). Several studies have reported that NLR is closely related to the presence and activity of systemic lupus erythematosus (SLE). However, little is known about the prognostic role of NLR in patients with lupus nephritis (LN). Thus, the aim of this study was to determine whether NLR can predict progression to CKD in LN patients.

**Methods**

We enrolled 175 LN patients with available clinical data at the time of renal biopsy from the longitudinal SLE cohort. We divided LN patients into three groups based on NLR levels (T1, < 2.43; T2, 2.43–4.75; T3, > 4.75), and compared their demographic, clinical, histological and laboratory findings, and long-term prognosis among the groups. Univariate and multivariable Cox proportional hazard regression models were used to identify independent risk factors for CKD in LN patients.

**Results**

Patients in the highest NLR tertile were older and had a higher SLEDAl score, lower eGFR, and higher white blood cell and platelet counts than those in the lowest tertile. During a mean follow-up of 100.8 ± 65.6 months, development of CKD and end-stage renal disease (ESRD) was more frequent in patients in the highest tertile (p < 0.001, p = 0.026). Finally, the highest NLR tertile was associated with an increased risk of development of CKD (adjusted hazard ratio (HR) = 2.972, 95% CI (1.429–6.182)).

**Conclusions**

Our results demonstrated that a higher NLR in LN patients had higher disease activity and showed more rapid decline of kidney function from the onset of LN. Therefore, NLR can be used as a prognostic marker for predicting CKD and ESRD in LN patients.

### **LP-136**

**A 52 YEAR OLD FEMALE WITH ABDOMINAL PAIN AND DIAGNOSED WITH CHRONIC INFLAMMATORY DEMYELINATING POLYRADICULONEUROPATHY AND PROBABLE SYSTEMIC LUPUS ERYTHEMATOSUS: A CASE REPORT**

Kimberly Yu*, Rosario Baes. Internal Medicine, Far Eastern University – Nicanor Reyes Medical Foundation Medical Center, Philippines

10.1136/lupus-2023-KCR.227

**Background**

Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP) is a rare immune-mediated neurologic disorder that targets the peripheral nerves and nerve roots which can cause progressive weakness and sensory loss, described as gradual to chronic progression of symmetric, proximal and distal weakness. It is often misdiagnosed due to its presentation as it can mimic different kinds of peripheral neuropathies. CIDP can also be associated with systemic lupus erythematosus (SLE), Human Immunodeficiency Virus (HIV), diabetes mellitus or thyroid disorders. CIDP is said to be an uncommon manifestation of SLE and Diabetes Mellitus.

**Methods**

CIPD patients usually respond to a loading dose of IVlg 2 g/kg/day infusion for 5 days and often repeat infusions of either 0.5 g/kg/day 2 to 5 days every 2 weeks; 1 g/kg/day for 2 to 5 days every 3 weeks or 2 g/kg/day for 5 days every month, for a total of 2 or 3 months. IVlg must then be tapered down or discontinued and must be determined if continuous use is still needed.

**Results**

IVlg has proven to be a safe and more effective treatment compared to steroids in a short-term prospective randomized controlled trials for CIDP; especially for those with pure motor CIDP.

**Conclusions**

In conclusion, there is a need for diagnostic vigilance as there is no proven diagnostic test to highly prove the diagnosis of CIDP, it is highly dependent on physical examination, neurologic evaluation, Electromyography – Nerve Conduction Velocity (EMG-NCV) test, lumbar puncture and lastly nerve biopsy. Early diagnosis and treatment of CIDP and its underlying cause is beneficial to patients. For cases of CIDP, it is treatable and responds to IVlg and steroids as well as compared to those suffering from diabetic polyneuropathy. Identification and reporting of this case can benefit physicians to establish a diagnosis and treatment in order to prevent progression of the disease.