lupus 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

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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 SLEDAI 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 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

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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 IVIg 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. IVIg must then be tapered down or discontinued and must be determined if continuous use is still needed.

Results IVIg 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 IVIg 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.