infection occurred in a 2-months-old infant with calico-pyelic and ureteral dilatation at birth. One newborn presented with interatrial defect and situs inversus (paternal 10 chromosome inversion).

Conclusions Despite our data do not allow definitive conclusions, the live birth rate and the exclusion of drug-related congenital defects are encouraging. SLE flares occurred more frequently after Belimumab discontinuation at positive pregnancy test. We suggest that women on good disease control while on belimumab could be offered to continue it and to discuss discontinuation timing according to their specific risk/benefit ratio.

Acknowledgements 'Gender Medicine' Study Group of the Italian Society for Rheumatology

P139 THE FAMALE STUDY: INVESTIGATING FAILING MATERNAL-FETAL TOLERANCE IN PREGNANT WOMEN WITH SLE

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Objective Pregnant women with systemic lupus erythematosus (SLE) have an increased risk of maternal complications and adverse fetal outcomes, like preeclampsia, preterm birth and fetal growth restriction. Interestingly, this increased risk persists in subsequent pregnancies, whereas it decreases in healthy women due to the development of maternal-fetal tolerance. Since maternal-fetal tolerance is crucial for a healthy pregnancy, we hypothesize that its failure contributes to the increased risk of pregnancy complications in women with SLE. Therefore, we initiated the FaMaLE study to investigate failing maternal-fetal tolerance in pregnant women with SLE.

Methods In the FaMaLE study, healthy women and women with SLE are included in their first trimester of pregnancy (<14 weeks gestational age (GA)) at Amsterdam UMC. Peripheral blood is collected once every trimester, within 48 hours before delivery and 5–12 weeks after delivery. Furthermore, the placenta is collected after delivery. Whole blood, peripheral blood mononuclear cells (PBMC) and placenta are freshly analyzed by flow cytometry.

Results First we set up a protocol for obtaining single-cell suspensions containing both immune cells and stromal cells from the placental basal plate and chorioamniotic membranes. Furthermore, we designed 5 flow cytometry panels to freshly analyze composition of placental cells, PBMC and whole blood. Currently 19 SLE patients are included in the study, of whom 15 have delivered (6 with complications) and 11 completed the study. Preliminary analysis of these 11 patients revealed a decreased CD4/CD8 ratio in the blood throughout and after pregnancy in women who experienced pregnancy complications. Furthermore, we found a decreased trophoblast/stromal cell ratio in the placenta of these patients.

Conclusions In conclusion, we designed a workflow to study blood and placenta in SLE patients with and without pregnancy complications. In preliminary analysis we found significant differences in blood and placenta, which require validation in the rest of the cohort (total 18 healthy controls and 60 SLE patients). These data will provide novel insights into the development and failure of maternal-fetal tolerance, and thereby into pregnancy complications in women with SLE.

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P140 PREGNANCY AND SYSTEMIC LUPUS ERYTHEMATOSUS: EXPERIENCE IN A PREGNANCY CLINIC

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Objective Adverse events during pregnancy are common in systemic lupus erythematosus (SLE). For this reason, EULAR

Abstract P140 Table 1 Demographic and clinical characteristics

Cases, n (%)	56 (100)
Age at 1st visit, mean (SD), years	35.6 (4.5)
BMI, mean (SD)	23.1 (4.1)
Smoke, n (%)	
never	39 (69.7)
active	6 (10.7)
previous smoker	11 (19.6)
Hypertension, n (%)	3 (5.4)
Diabetes, n (%)	0 (0)
Dyslipidemia, n (%)	1 (1.8)
Previous nephritis, n (%)	9 (16.1)
Disease duration, days, median (IQR)	2845 (998.0–5325.0)
ART, n (%)	13 (23.2)
anti-Ro positive, n (%)	12 (21.4)
APL positive, n (%)	25 (46.3)
APS associated, n (%)	6 (10.7)
Never pregnant, n (%)	23 (41.1)
Previous newborn, n (%)	33 (59)
Previous abortion, n (%)	23 (41.1)
High pregnancy risk, n (%)	54 (96.4)
Preconceptional counselling	
Pregnant at 1st visit, n (%)	24 (29.3)
Treatment adjustment, n (%)	15 (26.8)
Contraindicated pregnancy, n (%)	2 (3.6)
Not adjustment needed, n (%)	15 (40.3)
Corticosteroid use at 1st visit, n (%)	15 (26.8)
Corticosteroid daily at 1st visit, mg/day, median (IQR)	5 (2.5–15.0)
cDMARDS at 1st visit, n (%)	11 (19.6)
bDMARDs at 1st visit, n (%)	2 (3.6)
Hydroxychloroquine at 1st visit, n (%)	29 (51.8)
Aspirin at 1st visit, n (%)	16 (28.6)
Anticoagulation at 1st visit, n(%)	4 (7.1)
Pregnancy, n (%)	45 (80.4)

ART (additional reproductive therapies), APL (antiphospholipid antibodies), APS (antiphospholipid syndrome), bDMARDS (biological disease-modifying antirheumatic drugs), BMI (Body Mass Index), RA (rheumatoid arthritis), cDMARDS (conventional disease-modifying antirheumatic drugs).

recommends its management in specialized pregnancy clinics. Our aim is to report the 10-year experience of a pregnancy clinic in a tertiary center in Spain.

Methods Retrospective study of patients with SLE followed up in a specialized pregnancy clinic at a tertiary center in Madrid, Spain, who attended the clinic from December 2012 to January 2023. Categorical variables were described as proportions and/or percentages, while continuous variables were shown as mean and standard deviation (SD) or median and interquartile range (IQR) when appropriate.

Results 56 cases of pregnancy counselling's in 38 patients with SLE were included. The main characteristics are reported in table 1. Preconception consultation was performed in 57.1% (32/56) of the cases since 42.9% (24/56) were already pregnant in the 1st visit; 58.3% (14/24) of pregnant patients were referred from services other than Rheumatology. Before 1st visit, only 48.2% (27/56) of SLE patients had been treated with hydroxychloroquine (HCQ) and 33.3% (5/15) of patients treated with corticosteroids had doses $\geq$ 10 mg/day. At the first visit, treatment adjustment was recommended to 46.9% (15/32) of patients being the introduction of HCQ was the most frequent. The pregnancy rate was 80.4% (45/56) and 6 (13.3%) ended in spontaneous abortion. 80% (36/45) pregnancies ended with a live birth, 6/36 (16.7%) flared. During pregnancy the use of corticosteroids continued to be around 33.3% (n=12/36), median dose 6.9 mg/day (IQR 3.1–10.0). The most frequent delivery was eutocic 27/36 (75%) at a median of 39.2 GW (IQR 37.6–40.1). An adverse pregnancy outcome occurred in 44.4% (n=16/36) of the pregnancies, being gestational diabetes and premature rupture of membranes the most frequent ones. Preeclampsia was found in 5.6% (n=2/36) of the pregnancies and 12.1% (n=4/36) of the neonates had low birth weight.

Conclusions Besides high rates of pregnancy at 1st visit there was a low rate of flares and adverse outcomes. Pregnancy planning should be carried out to minimize the risk of adverse events during pregnancy. It is advisable to closely monitor pregnancies in patients with SLE in specialized clinics.

P141 EFFECT OF REMISSION, CLINICAL REMISSION WITH ACTIVE SEROLOGY, AND GLUCOCORTICOID DOSAGE ON THE PREGNANCY OUTCOME OF PREGNANT PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Background Remission is a key treatment target in systemic lupus erythematosus (SLE) management. Given the direct correlation between lupus flares and elevated risks of adverse pregnancy outcomes (APOs), securing remission before conception becomes crucial. However, the association between clinical remission with active serology, and the risk of APOs is not thoroughly understood. Additionally, determining the optimal glucocorticoid dosage during pregnancy to mitigate APO risks remains under-researched. This study investigated the risk of APOs in relation to remission/serological activity status in patients in clinical remission/glucocorticoid dosage.

Methods Pregnant patients with SLE, who were followed up at two Japanese tertiary referral centers, and had their remission status assessed at conception, were included in this study. We categorized the patients into two groups based on whether they achieved Zen/Doria remission at conception and analyzed

Abstract P141 Table 1 Adverse pregnancy outcome ratio according to the achievement of remission at conception

	Zen/Doria remission			Logistic regression model (univariate analysis)			Logistic regression model (multivariate analysis)		
Factor	no remission	remission	p-value	OR	95%CI	P value	aOR	95% CI	P value
N	37	59							
Overall APO (%)	**26 (70.3)**	**23 (39.0)**	**<0.01**	**0.27**	**0.11–0.65**	**<0.01**	**0.28**	**0.11–0.70**	**<0.01**
Maternal APO (%)	**15 (40.5)**	**11 (18.6)**	**0.032**	**0.34**	**0.13–0.85**	**0.021**	**0.33**	**0.12–090**	**0.030**
Neonatal APO (%)	**23 (62.2)**	**23 (39.0)**	**0.036**	**0.39**	**0.17–0.90**	**0.028**	**0.37**	**0.15–0.90**	**0.029**
PROMISSE APO (%)	10 (27.0)	12 (20.3)	0.47	0.69	0.26–1.81	0.45	0.64	0.23–1.76	0.38
Flare during pregnancy (%)	**8 (21.6)**	**2 (3.4)**	**0.012**	**0.13**	**0.03–0.64**	**0.012**			
Flare after delivery (%)	2 (6.7)	1 (1.9)	0.29	0.26	0.23–3.04	0.29			
Gestational DM (%)	6 (16.2)	4 (6.8)	0.18	0.38	0.10–1.43	0.15			
Preeclampsia (%)	3 (8.1)	3 (5.1)	0.67	0.61	0.12–3.18	0.56			
Hypertensive disorders in pregnancy (%)	7 (18.9)	6 (10.2)	0.24	0.49	0.15–1.58	0.23			
HELLP syndrome (%)	1 (2.7)	1 (1.7)	1.0	0.62	0.04–10.2	0.74			
Oligohydramnios (%)	**6 (16.2)**	**2 (3.4)**	**0.053**	**0.19**	**0.04–0.97**	**0.046**			
Maternal death (%)	0 (0.0)	0 (0.0)	NA	NA	NA	NA			
Live birth (%)※	29 (78.4)	54 (91.5)	0.12	2.98	0.89–9.94	0.76			
Total duration of gestation (days)	**262.0 [242.0, 271.0]**	**268.0 [262.0, 276.0]**	**0.019**	NA	NA	NA			
Preterm birth (%)	6 (18.2)	8 (14.8)	0.77	0.78	0.25–2.5	0.67			
Spontaneous abortion (%)	1 (2.8)	2 (3.4)	1.0	1.25	0.11–14.3	0.86			
Missed abortion (%)	3 (8.1)	1 (1.8)	0.30	0.20	0.02–2.02	0.17			
Iatrogenic abortion (%)	**5 (13.5)**	**2 (3.4)**	**0.10**	**0.23**	**0.04–1.22**	**0.084**			
Still birth (%)	0 (0.0)	0 (0.0)	NA	NA	NA	NA			