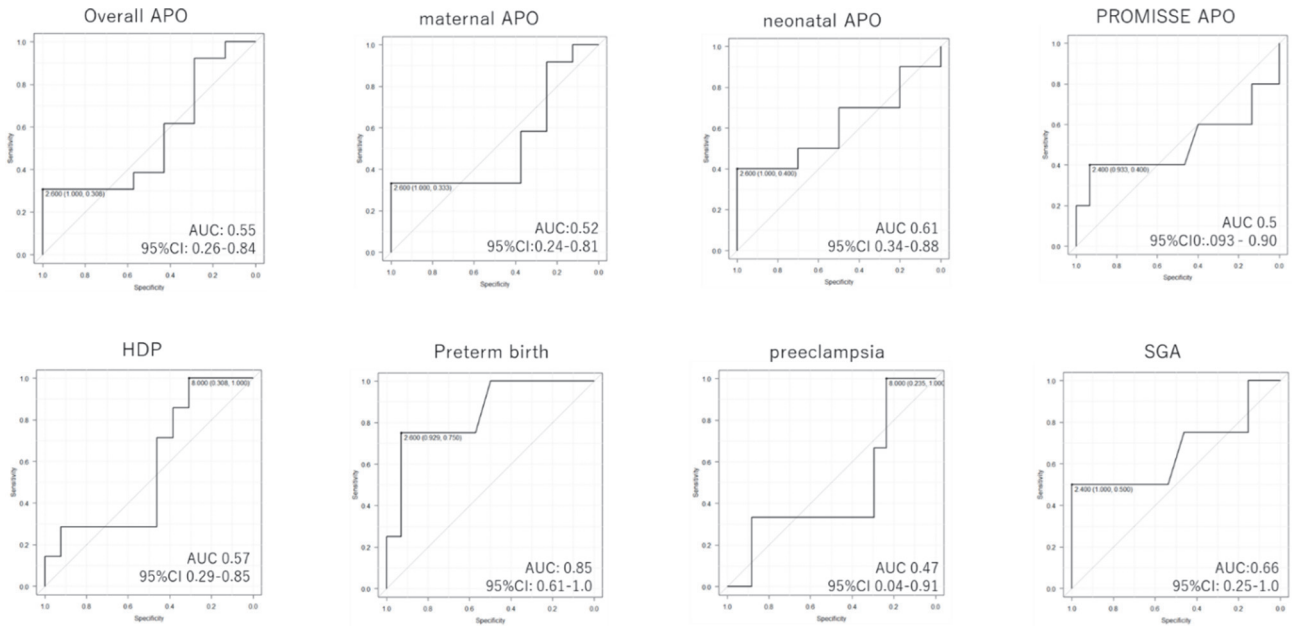

Abstract P142 Figure 1 ROC curve for the maximum tacrolimus trough concentration during pregnancy and each adverse pregnancy outcome. APO: adverse pregnancy outcome, AUC: are under the curve. CI: confidence interval HDP: hypertensive disorders during pregnancy. ROC: receiver operating characteristic, SGA: small for gestational age

lupus nephritis, and the impact of combined tacrolimus-aspirin therapy on the APO ratio relative to patients exclusively administered tacrolimus.

Results Of the 124 pregnancies, 29 were exposed to tacrolimus. Multivariate analysis showed no statistical difference in APO ratio. (overall APO: adjusted odds ratio [aOR], 0.69; 95% confidence interval [CI], 0.23–2.03; p=0.50; maternal APO: aOR, 1.17; 95% CI, 0.36–3.83; p=0.80; neonatal APO: aOR, 1.10; 95% CI, 0.38–3.21; p=0.86; PROISSE APO: aOR, 0.50; 95% CI, 0.14–1.74; p=0.27) (table 1).

Blood pressure and estimated glomerular filtration rate (eGFR) during pregnancy and after delivery did not differ between the two groups. Receiver operating characteristic (ROC) curve showed that tacrolimus concentration>2.6ng/ml was related to reduced preterm birth rate. (AUC=0.85, 95% CI: 0.61–1.00, sensitivity: 93% and specificity: 75%) (figure 1).

Regarding tacrolimus effect on lupus nephritis pregnancy, tacrolimus showed no increased risk of APO, blood pressure or eGFR during pregnancy and after delivery. (overall APO: OR, 1.00; 95% CI, 0.25–4.08; p=0.98; maternal APO: OR 1.60, 95% CI, 0.39–6.64; p=0.51; neonatal APO: OR, 0.71; 95% CI, 0.17–3.03; p=0.65, PROMISSE APO: OR, 0.50; 95% CI, 0.08–3.22; p=0.47). (table 2).

Tacrolimus-aspirin combination therapy showed protective tendency against hypertensive disorders during pregnancy, preeclampsia and low birth weight.

Conclusions Tacrolimus use during lupus pregnancy showed no significant influence on APO, blood pressure, or renal function, suggesting that tacrolimus might be a suitable option for controlling lupus activity during pregnancy. In addition, when using tacrolimus during pregnancy, we should aim its trough concentration ≥2.6 ng/ml while paying careful attention to possible maternal side effects of tacrolimus.

P143 EFFICACY OF CONSULTATION BEFORE AND DURING PREGNANCY ON THERAPEUTIC ADHERENCE SURVEYED IN A SINGLE-CENTER COHORT OF PATIENTS WITH RHEUMATIC DISEASE

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Objective To define efficacy of consultation before and during pregnancy on therapeutic adherence in a single-center cohort of patients with rheumatic diseases.

Methods A web-based survey was administered to a cohort of patients with a rheumatic disease having had at least one pregnancy. Items investigated included therapy during pregnancy, reduction or discontinuation of therapy without medical consultation and patients' perceptions about counselling before and during pregnancy. Clinical data were collected for further analysis.

Result 71 patients diagnosed with rheumatic disease having had a pregnancy between 1996 and 2023 participated. Mean age at conception of the last pregnancy was 34±1.0 years, mean disease duration at conception was 11.2±6.4 years. Participants' rheumatic diseases included SLE (n=43;60.5%), Sjogren's syndrome (n=6;8,5%), UCTD (n=8;5%), psoriatic arthritis (n=3;4.2%), juvenile arthritis (n=3;4.2%), rheumatoid arthritis (n=3;4,2%), vasculitis (n=3;4,2%), spondylarthritis (n=1;1.4%) and myositis (n=1;1.4%).

Therapies taken at the time of conception included prednisone (n=20;28.2%), hydroxychloroquine (n=48;67.6%) and immunosuppressant (n=25;35.2%) of which mostly

biologic drugs (n=16.9%) and azathioprine (n=11;15.5%). Therapies taken during pregnancy included hydroxychloroquine (n=50;70.4%), prednisone (n=20;28.2%), azathioprine (n=12;16.9%) and biologic drugs (n=6;8.4%). 68 patients (95.8%) declared full adherence to the prescribed therapy; 3 (4.2%) reported lowering the dosage of therapy during pregnancy without medical consultation; 1 (1.4%) reported discontinuing the medication. The given reasons were the feeling of wellness regarding their rheumatic disease and the fear of side effects for themselves and the fetus. 69 patients (97.2%) reported receiving adequate preconception counselling. All patients reported satisfaction with the counselling received during pregnancy. The children of the patients examined by the cohort were all healthy at the time of birth.

Conclusions Almost the whole cohort, the majority of whom were patients diagnosed with SLE, reported receiving an adequate counselling, in both the preconception and pregnancy phases, and declared complete adherence to therapy. The very few cases of poor adherence were related to a perception of inadequate preconception counselling (less than 3% of the entire cohort) and fear of side effects of drugs on maternal and foetal health. The effectiveness of appropriate counselling before and during pregnancy can be demonstrated by the high level of therapeutic adherence, which is essential in avoiding disease-related maternal-foetal complications, as shown by our cohort. A limitation of this study was the impossibility of having a control group, i.e. patients not receiving counselling in the preconception phase and during pregnancy, also due to ethical reasons.

P144 PREGNANCY IN CONNECTIVE TISSUE DISEASES: A 30 YEAR FOLLOW-UP STUDY OF 465 PREGNANCIES FROM A SPANISH MONOCENTRIC REGISTRY

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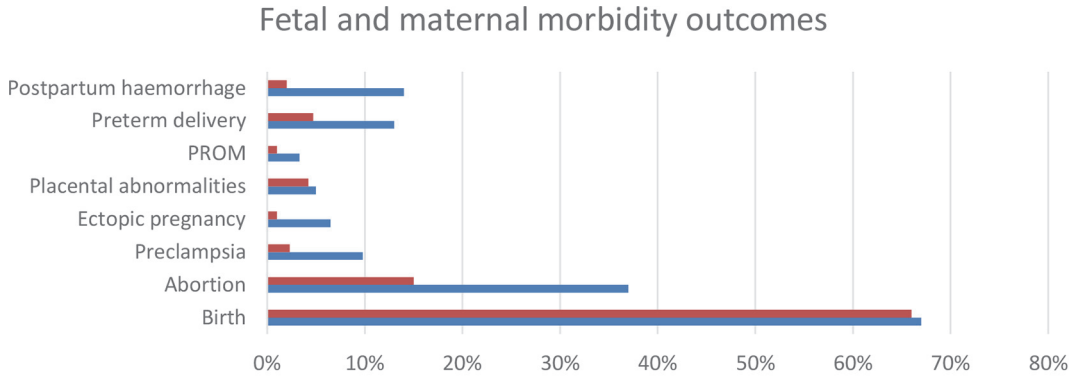
Objective To evaluate the pregnancy outcomes in patients with systemic autoimmune diseases, including systemic lupus erythematosus (SLE), systemic sclerosis (SSc), primary Sjögren's syndrome (pSS) and undifferentiated connective tissue disease (UCTD).

Methods A retrospective and descriptive study was conducted from 1990 to 2020. All data were collected from the medical records of childbearing age women with SLE, SSc, SS and UTCD enrolled in our clinic at the time of their pregnancy and childbirth. The obstetric, maternal and fetal outcomes were collected and compared regarding diagnosis and adverse outcomes.



	Birth	Abortion	Preclampsia	Ectopic pregnancy	Placental abnormalities	PROM	Preterm delivery	Postpartum haemorrhage
non-SLE	0.66	0.15	0.023	0.01	0.042	0.01	0.047	0.02
SLE	0.67	0.37	0.098	0.065	0.05	0.033	0.13	0.14

Abstract P144 Figure 1 Fetal and maternal morbidity outcomes in SLE and non-SLE patients