Background
Past studies suggest that males with lupus nephritis (LN) may have increased rates of end-stage renal disease (ESRD) and mortality compared to females. However, studies included few males and were focused on biological differences, not healthcare use. In a nationwide cohort of SLE patients with incident LN, we investigated LN-related outcomes and utilisation by sex.

Materials and methods
We used the Medicaid Analytic eXtract (MAX) with nationwide claims data to identify individuals 3–65 years with LN (2000–2004) using a validated algorithm (PPV 80%) and required 12 months without any LN codes to define incident cases. MAX data were linked to the U.S. Renal Data System (USRDS) 2000–2006 to identify ESRD onset. Mortality was determined using National and Social Security Death Index Files (2000–2006). We assessed sex-specific incidence rates and adjusted incidence rate ratios (IRRs) for healthcare utilisation, medications, preventive care and renal biopsies using Poisson regression. We used Fine and Grey proportional hazard models to compare the distribution hazard ratios (HRsd) of ESRD by sex accounting for the competing risk of death, and Cox models to compare hazard ratios (HR) of death, adjusted for age and race/ethnicity.

Results
Of 2576 patients with incident LN, 230 (9%) were male. Mean follow-up was 2.8 (SD 1.5) years for both sexes. Mean age was 30 (SD 16) years among males and 34 (SD 14) years among females (p < 0.001). 31% of males and 36% of females underwent renal biopsy (p = 0.06). Other than azathioprine use, which was more frequent among females (p = 0.02), there were differences in medications or preventive care. Adjusted rates of outpatient and emergency department (ED) visits were lower for males compared to females (IRR 0.81, 95% CI: 0.68–0.98 and 0.88, 95% CI: 0.79–0.99, respectively); hospitalizations were comparable. The five-year cumulative incidence of ESRD was 13% and the HRsd of ESRD for males compared to females was 0.86 (95% CI: 0.53–1.38) in the first two years and 2.21 (95% CI: 1.2–4.1) in the subsequent two years. The five-year cumulative incidence of death was 15% with no difference in HR by sex.

Conclusions
In this incident LN Medicaid cohort, we found high rates of ESRD and mortality overall, with no differences in ESRD by sex in the first two years but more than twice the risk among males thereafter. Males had lower rates of outpatient and ED visits compared to females. Further studies are needed to understand the relationship between utilisation and long-term outcomes.

Acknowledgements
Drs. Feldman and Broder contributed equally.
Results Ninety-three SLE patients were recruited (88% female) with median age of 33.6 ± 12.4 years and median disease duration of 11.5 ± 14.8 years. Mestizo (75%) and Afro-Latin American (22%) were majority. One quarter of patients had an early SLE (< 2 years of duration) and 64 were admitted at the time of urine collection. Hematologic disease (89%), arthritis (83%), cutaneous involvement (82%), and renal disease (66%) were among most common manifestations. 63% of patients were positive for anti-C1q. We found a significant positive correlation between uNGAL levels and SLEDAI (r = 0.331, p = 0.02) and between uMCP-1 with SLEDAI (r = 0.428, p < 0.02) and with uNGAL (r = 0.467, p < 0.0001). uNGAL and uMCP-1 were significantly higher in patients with LN than in patients without LN (53.0 ± 56.3 vs 16.0 ± 16.6 pg/ml, p = 0.001 and 2340.4 ± 4521.4 vs 472.4 ± 596.5, p = 0.015, respectively). uNGAL levels were also significantly higher in patients with active LN (>500 mg proteinuria/24 hrs) than in inactive LN (66.1 ± 61.9 vs 9.0 ± 8.6, p < 0.001). A ROC curve constructed for uNGAL, uMCP-1, and anti-C1q for LN in all SLE patients showed a good level of sensitivity and specificity (Figure 1).

Conclusions Colombian LN patients had 4 times and 5 times higher levels of uNGAL and uMCP-1, respectively than patients without LN. Additionally, uNGAL was significantly higher in patients with active LN. Both markers were correlated with disease activity. A multinational prospective study is ongoing under GLADEL cohort, in order to evaluate those biomarkers in 14 Latin American countries.

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Background The Indian Health Service Lupus Registry previously reported a high prevalence of systemic lupus erythematosus (SLE) among American Indian/Alaska Native populations. SLE was defined based on having documentation in the medical record of the American College of Rheumatology (ACR) classification criteria. The SLICC criteria have recently been developed for SLE. The Boston weighted criteria were previously developed for epidemiologic studies. The primary aim of this analysis is to compare the sensitivity of the ACR, SLICC, and Boston weighted criteria for specialist-diagnosed SLE in this population-based registry.

Materials and methods We included all individuals in the IHS Lupus Registry with a documented specialist diagnosis of SLE in