steroid regimens. Those with class IV nephritis (35.3% vs 73%, p = 0.015) and hematuria (36% vs 74% p < 0.001) were more likely to be treated with IV CTX. Physicians more often reported compliance concerns as a reason for selecting treatment for the CTX group compared to MMF (22% vs 0%, p = 0.04). Overall, physicians reported "this is what I or my group always does" as the most common reason for choice of induction agent and steroid regimen. Induction agent use did not differ significantly according to study site. Steroid regimen differed significantly by study site and induction agent. CRR at 6 months was achieved for 56% with MMF and 64% with IV CTX (p = 0.6); the study was not powered to evaluate treatment efficacy.

Conclusions Class IV nephritis, hematuria and patient adherence influenced selection of induction agent. Steroid regimens differed by study site and induction regimen. To evaluate comparative effectiveness, future larger studies will be needed.

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CE-32 THE EPIDEMIOLOGY OF INDIVIDUALS NOT FULLY MEETING CLASSIFICATION CRITERIA FOR SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): THE GEORGIA LUPUS REGISTRY

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Background Identifying individuals as early as possible in the development of an autoimmune disease may lead to important opportunities. This study utilises an established population-based registry to evaluate the burden of individuals who do not meet criteria for SLE but may be at higher risk of being diagnosed later.

Materials and methods The Georgia Lupus Registry (GLR) is designed to more accurately estimate the incidence and prevalence of SLE in Atlanta, Georgia. The state allowed investigators and trained abstractors to access protected health information without patient consent. Sources of potential cases included hospitals (20), rheumatologists (35), nephrology groups (10), dermatology groups (20), commercial labs, and population databases. Databases were queried for the International Classification of Diseases, Ninth Revision, (ICD-9) code 710.0 (SLE), as well as 695.4 (discoid lupus), 710.8 (other specified connective tissue disease), and 710.9 (unspecified connective tissue disease), as well as serologies and pathology results suggestive of SLE. Antiphospholipid antibody syndrome was searched for if a consistent code was used at a particular facility. Those with less than 4 American College of Rheumatology (ACR) criteria for SLE and without a final physician diagnosis of a specific connective tissue disease were analysed. Rates were determined for incidence (2002–2004) and prevalence (2002) and age adjusted using the 2000 US population. Age adjusted estimates and 95% confidence intervals were calculated by the direct method using R (routine ageadjust.direct).

Results 220 individuals were prevalent in 2004 with an overall age-adjusted rate of 14.2 per 100,000 person-years. 99 individuals were incident in 2002–04 with a rate of 2.1. Similar to SLE, the highest rates were in women and blacks. The rate ratio of prevalent women to men was 4.9 and was 2.2 in blacks to whites, lower than seen in SLE. (Table 1) The most frequent ACR criteria manifestations were ANA (56.4% and 57.6% in prevalent and incident individuals, respectively), hematologic disorder (39.1%, 35.4%), and arthritis (30%, 32.3%). There were no statistically significant differences between blacks and whites.

Abstract CE-32 Table 1 Rates of individuals not fully meeting classification criteria for systemic lupus erythematosus in Atlanta, Georgia, categorised by race/sex* (prevalence in 2004, incidence in 2002–04)

Race/Ethnicity, sex	Catchment population (person-years)	No. of cases	Crude rate (95% CI):	Age-adjusted rate (95% CI):
PREVALENCE				
Overall	1610314	220	13.7 (12,15.6)	14.2 (12.5, 16.1)
Women	822408	185	22.5 (19.5,26)	22.5 (19.5, 26)
Men	787906	35	4.4 (3.2,6.2)	4.6 (3.3, 6.3)
Black	783405	131	16.7 (14.1,19.8)	18.2 (15.5,21.5)
Women	418297	114	27.3 (22.7,32.7)	28.4 (23.8, 34)
Men	365108	17	4.7 (2.9,7.5)	5.1 (3.3, 8.1)
White	753526	65	8.6 (6.8,11)	8.3 (6.5, 10.7)
Women	368338	52	14.1 (10.8,18.5)	12.8 (9.6, 17)
Men	385188	13	3.4 (2,5.8)	3.4 (2, 5.9)
INCIDENCE				
Overall	4742264	99	2.1 (1.7,2.5)	2.1 (1.7, 2.6)
Women	2424592	78	3.2 (2.6,4)	3.2 (2.5, 4)
Men	2317672	21	0.9 (0.6,1.4)	1.0 (0.7, 1.5)
Black	2321302	58	2.5 (1.9,3.2)	2.8 (2.2, 3.5)
Women	1239819	47	3.8 (2.9,5)	3.9 (3, 5.2)
Men	1081483	11	1.0 (0.6,1.8)	1.4 (0.9, 2.3)
White	2210389	27	1.2 (0.8,1.8)	1.1 (0.8, 1.7)
Women	1082131	20	1.8 (1.2,2.9)	1.6 (1, 2.6)
Men	1128258	7	0.6 (0.3,1.3)	0.6 (0.3, 1.3)

* Rates are per 100,000 person-years (95% confidence intervals [95% CIs]).
* Age-adjusted rates used the 2000 US population.

Conclusions This is the first population-based evaluation of those not fully meeting ACR criteria for SLE in the US. The prevalence and incidence rates were 15% and 30%, respectively, of that which were seen in those validated as having SLE from the same general population. This suggests a significant population at higher risk of being diagnosed with SLE in the future can be identified. Studies are ongoing to determine the outcomes of these patients.

CE-33 CARDIOVASCULAR EVENTS AMONG US MEDICAID RECIPIENTS (2000–2010) WITH SYSTEMIC LUPUS ERYTHEMATOSUS, BY RACE AND ETHNICITY

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Background Cardiovascular disease (CVD) is the leading cause of death among SLE patients, with significantly elevated risks of

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Abstract CE-33 Table 1 Rates and Adjusted Subdistribution Hazard Ratios for Stroke, MI, or Stroke/MI Hospitalisation among Medicaid patients with SLE in the US, from 2000-2010, by Race and Ethnicity

Race/Ethnicity	Total individuals	Number of events	Person-years (mean, [SD])	Rate* [95% CI]:	Multivariable-Adjusted Subdistribution Hazard Ratio (HRsd)[95% CI]:
Stroke					
White	17113	273	3.36 [2.82]	4.75 [4.22–5.35]	1.0 (ref)
Black	17813	413	3.46 [2.83]	6.70 [6.08–7.38]	**1.36 [1.15–1.60]**
Asian	1296	26	3.97 [3.01]	5.05 [3.44–7.42]	1.05 [0.70–1.59]
Hispanic	6732	107	3.44 [2.86]	4.62 [3.82–5.58]	1.02 [0.81–1.29]
Native American	494	12	3.65 [2.96]	6.66 [3.78–11.73]	1.43 [0.80–2.57]
MI					
White	17113	218	3.37 [2.82]	3.78 [3.31–4.32]	1.0 (ref)
Black	17813	235	3.49 [2.84]	3.78 [3.33–4.30]	1.08 [0.89–1.30]
Asian	1296	14	4.00 [3.03]	2.70 [1.60–4.56]	0.93 [0.53–1.61]
Hispanic	6732	42	3.46 [2.86]	1.80 [1.33–2.44]	**0.59 [0.42–0.84]**
Native American	494	**	**	3.78 [3.31–4.32]	1.12 [0.53–2.36]
Stroke or MI (combined)					
White	17113	477	3.32 [2.81]	8.38 [7.66–9.17]	1.0 (ref)
Black	17813	625	3.43 [2.82]	10.22 [9.45–11.05]	**1.22 [1.07–1.38]**
Asian	1296	37	3.96 [3.01]	7.22 [5.23–9.96]	0.93 [0.66–1.31]
Hispanic	6732	142	3.43 [2.85]	6.16 [5.23–7.26]	**0.82 [0.67–0.99]**
Native American	494	19	3.62 [2.95]	10.62 [6.77–16.65]	1.33 [0.84–2.09]

* Rate per 1,000 person-years, ¥ HRsd= Sub-distribution hazard ratio from Fine and Grey proportional hazards competing risks model. Multivariable models adjusted for age, sex, U.S. region of residence, calendar year, area-based SES, and baseline comorbidities (including history of angina, coronary artery bypass graft, coronary atherosclerosis, percutaneous coronary intervention, hypertension, smoking, obesity) and SLE-specific risk adjustment index. **Cell sizes under 11 are suppressed in accordance with Federal data reporting requirements.

myocardial infarction (MI) and stroke among SLE patients compared to age-matched controls. The objective of our study was to examine the rates of non-fatal MI, stroke, and the combined endpoint of non-fatal MI or stroke, overall and by race/ethnicity, among SLE patients enrolled in Medicaid.

Materials and methods Within Medicaid Analytic eXtract (MAX), containing billing claims from 2000–10 for Medicaid patients from the 29 most populated US states, we identified patients aged 18–65 with prevalent SLE ($\geq$ 3 ICD-9 codes 710.0, $\geq$30 days apart) with >12 months of continuous enrollment prior to 3rd code (index date). Baseline data from 12 months prior to index date included age, sex, race/ethnicity, zip code, year, SLE-related and other comorbidities, including CVD risk factors (based on ICD-9 and DRG codes). Those missing race/ethnicity were excluded. Subjects were followed from index date to first MI or stroke event, death, Medicaid disenrollment, or end of follow-up. MI, stroke, and combined outcome per 1000 person-years with 95% CIs were calculated overall and by race/ethnicity. Subdistribution proportional hazards regression models, accounting for the competing risk of death, were used to calculate multivariable-adjusted hazard ratios (HRsd) for MI, stroke, and combined outcome.

Results Among 43,448 cases with prevalent SLE, 93.6% were female. Racial/ethnic breakdown was: 41% Black, 39% White, 15% Hispanic, 3% Asian, 1% Native American. Mean follow-up was 3.48 ± 2.86 years for all SLE patients. Overall crude rates were highest among Native Americans for MI, Blacks for stroke, and Native Americans for MI or stroke. Hispanics had the lowest overall crude rates for MI, stroke, and the combined outcome. After multivariable adjustment and accounting for the competing risk of death, Hispanics had lower MI risk (HRsd] 0.59 [95% CI: 0.42–0.84]) and Blacks had elevated risk of stroke (HRsd 1.36 [95% CI: 1.15–1.60]) as compared with Whites. For the outcome of MI or stroke, Blacks had an elevated risk (HRsd 1.22 [95% CI: 1.07–1.38], whereas Hispanics had a lower risk (HR 0.82 [95% CI: 0.67 to 0.99] compared to Whites.

Conclusions Marked race/ethnicity-specific variation exists in MI and stroke risks among Medicaid patients with SLE. Elevated CVD risks among Blacks and lower risks among Hispanics may account for some of the excess all-cause mortality observed among Black patients and lower overall mortality among Hispanics with SLE as previously described.

CE-34 AN ANALYSIS OF THE DEMOGRAPHIC DATA IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS IN SOUTH AND CENTRAL TRINIDAD

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Background Very limited data is available on the epidemiology of systemic Lupus erythematosus (SLE) in the Caribbean. This study was aimed at analysing the demographic data among patients diagnosed with SLE in the South and Central regions of Trinidad.

Materials and method This was a retrospective analysis of patients attending the Rheumatology Clinic at the South-West Regional Health Authority. After written consent was obtained, a data capture sheet (DCS) was completed; collecting information from patients with suspected SLE. Each patient was given a unique identification number. From this DCS, patients with a confirmed diagnosis of SLE (defined by at least 4 criteria of the Systemic Lupus International Collaborating Clinics (SLICC) Classification Criteria for SLE, of which at least 1 clinical and 1 laboratory criteria OR biopsy-proven lupus nephritis with positive ANA or Anti- dsDNA) were identified. The information was

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