Background and aims To study the association between serum 25-Hydroxyvitamin D3 levels and clinical manifestation, disease activity, and disease damage of systemic lupus erythematosus (SLE).

Methods This was a retrospective cross sectional study of SLE patients seen between 1996 until 2015. Patients were grouped according to the Vitamin D3 levels: group 1 (<25 nmol/L : deficiency), group 2 (25–75 nmol/L : insufficiency) and group 3 (>75 nmol/L : adequate). Assessment of disease activity was done using Systemic Lupus Erythematosus Disease Activity Index Selena Modification (SLEDAI) while Systemic Lupus International Collaborating Clinics (SLICC) was use for disease damage.

Results A total of 42 patients had their serum 25-Hydroxyvitamin D3 levels taken at one point of their visit. Majority were females (n=41). Mean age was 37.2 years (SD ±13.13) and mean duration of illness 9.5 years (SD ±5.7). The proportion of patients with 25-Hydroxyvitamin D3 level group 1 was 31%, group 2 was 61.9% and group 3 was 7.1% respectively. Main clinical manifestations were haematological 71.1%, arthritis 68.9%, malar rash 53.3%. SLEDAI mild activity (0-3) 90.5%, moderate activity (4-8) was 4.8% and severe activity (>8) was 4.8%. SLICC showed 78.6% had no damage and 21.4% with damage. Test of association using ANOVA, did not show any significant difference between Vitamin D3 level and SLEDAI, SLICC and clinical manifestations were observed among the group.

Conclusions Vitamin D insufficiency and deficiency was common in our SLE cohort. However, we did not find significant association between vitamin D deficiency and disease activity, damage or clinical manifestations. The study limitation includes small number of patients and retrospective design.
hypocomplementemia (60%), alopecia (50%), and hemolytic anemia (40%). All patients showed significant initial response to high dose corticosteroid. Three patients eventually required surgery including ileal resection, abdomino-perineal resection and appendectomy; post-op histopath findings confirmed vasculitis in all 3 patients. One patient with ileal ischemia and perforation requiring resection also received belimumab infusions which enabled successful tapering and discontinuation of steroid. Another patient with refractory protein losing enteropathy and ischaemic colitis underwent abdomino-perineal with ileal resection, but succumbed to anastomotic failure with fulminant bacterial peritonitis.

Conclusions Though rare, gastrointestinal flare in SLE can be potentially catastrophic. Because of nonspecific manifestations, diagnosis strongly relies on clinical assumption and response to steroids. In some cases, surgery can be life-saving and belimumab offers another effective therapeutic option.

Background and aims The aim of this study was to review renal flare frequency, to identify potential risk factors for relapses, to assess the value of serological tests during flares and to analyse their impact of global outcome in lupus nephritis (LN) patients.

Methods Patients with biopsy proven LN were identified from our database. LN classes were defined according to the ISN/RPS classification. According to the response to treatment, LN patients were divided into 3 groups of complete remission (CR), partial remission (PR) and no response (NR). Those in remission were divided into 2 groups of relapsing and non-relapsing during maintenance period.

Results 218 (70.64%) of 276 SLE patients with biopsy proven LN (class I-18 patients, class II-45, class III-56, class IV-75, class V-54, class VI-2, mixed forms - 26) achieved either CR (55.8%) or PR (23.2%). 47 patients had one flare, 36 - two, 27 - three, 17/21 4 flares. The maintenance immunomodulating drugs at the time of flare was low dose corticosteroids and/or azathioprine. Non-adherence to treatment at time of relapse was documented in 26 patients.

Conclusions Renal flares in patients with LN are common, have a negative impact on outcome, but cannot be readily predicted. Our study shows that 58.83% of LN patients develop at least one relapse after reaching remission, usually within 2 years. The length of time to flare tends to be shorter in cases of preceding PR than in CR. Lack of adherence to long term immunosuppression was identified as a significant factor in LN flare (20.47%).