



**Abstract 227 Figure 1** Percentage of patients reporting problem in each

**Abstract 227 Table 2** Prevalence of Neuropsychiatric manifestations

		No. of patients	Percentage of total patients	Percentage of SLE patients
Central Nervous system	Headache	10	9.9	
	Seizure	4	3.9	
	Acute confusional state	2	2.0	
	Anxiety disorder	5	4.9	
	Cognitive dysfunction	4	3.9	
	Movement disorder	1	1	
	Psychosis	0	0	
	Depression	4	3.9	
	Peripheral Nervous System	Autonomic disorder	2	1.9
	Cranial neuropathy	0	0	
	Mononeuritis multiplex	1	1	
	Polyneuropathy	9	8.9	

abnormal). Screening for neuropathy was done in only ¼ patients by NCS. Quality of life was assessed by EURO QOL 5D questionnaire

**Results** This study included 101 patients of SLE. Among these, 33 patients had neuropsychiatric manifestations with a total of 42 events. The most common manifestation was headache (10) followed by anxiety disorder (5) and peripheral neuropathy (9). Other NPSLE syndromes observed in the study are seizure (4), cognitive dysfunction (4), depression (4), acute confusional state (2), autonomic disorder (2), movement disorder (1) and multiple mononeuropathy (1). Mann-whitney U test showed that there was statistically significant differences in self-care score ( $p=0.002$ ), limitation of mobility score ( $p=0.001$ ), pain score ( $p=0.005$ ) between NPSLE vs no NPSLE.

**Conclusions** NP manifestations are common and lead to significant reduction in qol in North Indian SLE patients.

## 228 MASSIVE PAINLESS ASCITES A RARE FORM OF ONSET OF SYSTEMIC LUPUS ERYTHEMATOSUS : A CASE REPORT

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10.1136/lupus-2017-000215.228

**Background and aims** Systemic lupus erythematosus (SLE) is an autoimmune disease characterised by involvement of various organs. Serositis is commonly seen in SLE, approximately 16% of patients with SLE have pleural or pericardial involvement. However, peritoneal involvement is extremely rare, and SLE with ascites as the first manifestation is an even rarer condition.

**Methods** A 36 – year old woman, a housewife was admitted with progressive painless abdominal distention for a month followed by early satiety and post prandial abdominal discomfort. There was no history of medication use, abdominal surgery, trauma or infection. The physical examination finding massive ascites without evidence of organomegaly or clinical stigmata of liver disease. Laboratory data were as follows : Haemoglobin 6,8 g/dl, BUN was normal and serum albumin 2,5 g/dl. Urinalysis evidenced erythrocytes 25/ul and proteinuria ++. Puncture of ascitic fluid showed SAAG 1,1, total leukocyte count of 370 (PMN 10%,MN 90%), There is no bacterial growth and negative smear for malignancy. CT Abdomen revealed massive pelviabdominal free ascites

**Results** Patient diagnosed as lupus peritonitis treated with methylprednisolone and cyclosporin with substantial improvement of her condition.

**Conclusions** Lupus peritonitis as the initial SLE manifestation is rare, we described a case of SLE who presented with persistent massive unexplained ascites with good response to immunosuppressive therapy.

## 229 MYCOPHENOLATE MOFETIL FOR INDUCTION OF REMISSION IN LUPUS ENTERITIS

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10.1136/lupus-2017-000215.229

**Background and aims** Lupus enteritis (LE) is a distinct gastrointestinal manifestation of systemic lupus erythematosus, and is a major cause of acute abdominal pain in these patients. Once recognised, management of this condition consists of immunosuppressive therapy with corticosteroids and other medications which includes cyclophosphamide, azathioprine and mycophenolate mofetil. Mycophenolate mofetil (MMF) is an immunosuppressive agent that inhibits both B and T lymphocyte proliferation. MMF reduces antibody production, and can affect glycosylation of adhesion molecules, and their *in vitro* expression. The aim of study was to determine the efficacy of Mycophenolate mofetil in the induction of remission in patients with lupus enteritis.

**Methods** We describe a case series of five patients with lupus enteritis. Laboratory features included low complement levels, anaemia, leukocytopenia or leukocytosis and thrombocytopenia. Median CRP level was 2.0 mg/dL (range 0–8.2 mg/dL) Acute kidney injury was present in 60% of the cases. Ct abdomen revealed bowel wall oedema (95%), ascites (92%), the characteristic "target sign" (98%), mesenteric abnormalities (88%)