up take pattern was significantly lower in HAVS than in primary RP.

Conclusions There were significant differences in hand perfusion scintigraphic features between primary RP and HAVS. These results suggest that the underlying pathophysiology of the two diseases differs; thus, different criteria should be applied for their evaluation.

### Abstract 372

**CLINICAL FEATURES, OUTCOMES AND RISK FACTORS FOR THE DEVELOPMENT OF POSTERIOR REVERSIBLE ENCEPHALOPATHY SYNDROME (PRES) IN THAI PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)**

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Background and aims PRES in SLE is increasingly recognised. This study aimed at determining the prevalence, clinical features, brain imaging findings, risk factors, and outcomes of PRES in Thai SLE patients.

Methods SLE patients with PRES seen between 1 January 1986 and 31 August 2013 were identified. Controls were matched with hospital number and disease duration to cases (ratio, 1:4). Clinical features, brain imaging patterns, risk factors, treatment and outcome of PRES were determined.

Results Of 1141 SLE patients, 26 PRES episodes occurred 20 in females (prevalence 1.8%). Mean±SD age at diagnosis and disease duration was 29.3±13.1 and 2.8±3.4 years, respectively. Among the 26 episodes, 24 (92.3%) had seizure, 14 (53.8%) headache, 9 (34.6%) fever and vomiting and 8 (30.8%) visual disturbance. All of them had acutely elevated blood pressure. 20 and 23 patients had active lupus nephritis (LN) within 3 months prior to and at PRES onset, respectively. Dominant parietal-occipital pattern was the most common brain imaging abnormality. 22 episodes improved with blood pressure control. Immunosuppressive therapy was given for active disease in 8 episodes. Anti-convulsant therapy could be discontinued in 21 of 22 episodes (median duration 3 months). Auto-immune hemolytic anaemia (AIHA) and LN were PRES risk factors (OR 6.55, 95% CI 1.09–39.39, p=0.04 and OR 3.06, 95% CI 1.12–8.39, p=0.03, respectively). 6 patients (23.1%) died during PRES episodes. The mortality rate in SLE patients with PRES was significantly higher than those without (30% vs. 10%, p<0.001).

Conclusions The mortality rate was high in Thai SLE with PRES. AIHA and LN were risk factors for PRES.

### Abstract 374

**ANA NEGATIVE RENAL LIMITED LUPUS NEPHRITIS – A RARE ENTITY**


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Background and aims Antinuclear antibodies (ANA) in serum is considered a decisive diagnostic test for SLE. ANA negative SLE is a subgroup of SLE that is infrequently recognised. We report an unusual case of seronegative SLE which presented
as rapidly progressive renal failure with no other systemic manifestations.

Methods 34 year old female presented with fever, nephrotic range proteinuria and rapidly progressive renal failure. She did not have any other systemic features of SLE. Her clinical, biochemical and serological findings are as shown in table 1. She had low complementemia, but her ANA, ANA profile including anti double stranded DNA (anti-dsDNA) antibodies and anti cardiolipin antibody was negative. Renal biopsy on light microscopy showed diffuse proliferative glomerulonephritis with a full house on immunofluorescence including C1q consistent with class 4 lupus nephritis (Figure 1). A diagnosis of ANA negative renal limited lupus nephritis was made.

Results She was treated with pulse methyl prednisolone followed by oral steroids 1mg/kg/day and pulse cyclophosphamide 500–750 mg/m² body surface area as per NIH protocol. She recovered completely and is on follow-up for two years. She has remained persistently negative for all ANA antibodies including anti-dsDNA antibodies.

Conclusions Ours is an unusual case of ANA negative renal limited lupus nephritis. The low complement levels, full house nephropathy in immunofluorescence and response to therapy were important clues in diagnosing the case. We report this patient to highlight the possibility of SLE in seronegative patients as well in order to avoid delay in the management.