systemic lupus erythematosus (SLE) largely depends on migration of pulmonary artery smooth muscle cells (PASMCs). In this study, we tested whether IgG from SLE with PAH have stimulatory effects on PASMC migration.

**Methods** Sera from 6 SLE patients, including 1 with PAH, and 7 healthy subjects were collected, and IgG was purified using protein A or protein G. PASMC migration was examined by a Boyden chamber method. Lamellipodia formation and antibody binding sites in the cells were examined by immunocytochemistry. Identification of anti-enolase1 antibodies was performed by immunoprecipitation, western blotting, mass spectrometry, and ELISA.

**Results** IgG from SLE with PAH significantly increased migration of PASMCs than those without PAH in a concentration dependent manner (p<0.001). After incubation with IgG, the number of cells with lamellipodia, which was subsequently identified as enolase1 reported to be involved in cell migration. Furthermore, the titer of IgG anti-enolase1 antibodies was 1.5-fold higher in SLE patients with PAH than those without PAH.

**Conclusions** IgG from a patient with SLE accompanied by PAH promoted a migration of PASMCs, which is possibly ascribed to autoantibodies to enolase1.

**A CHALLENGE IN THE MANAGEMENT OF LUPUS NEPHRITIS WITH ACUTE KIDNEY INJURY, HEART FAILURE ON HEMODIALYSIS AND ORAL WARFARIN THERAPY: A CASE REPORT**

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Background and aims Systemic lupus represents a major autoimmune disorder that leads to different major injuries to different organs of the body. Lupus nephritis can present with different disorders like nephrotic syndrome, acute kidney injury and rapidly progressive glomerulonephritis. Wise and tailored management of these cases is a must for nephrologists in order to gain the complete remission with the least side effects. If lupus nephritis is associated with other organs problems like heart failure, prosthetic valves and oral warfarin therapy, it needs more wise management. We clarify the tailored management of lupus nephritis induced nephrotic syndrome and acute kidney injury meanwhile the patient on oral warfarin therapy for prosthetic valve replacement and subsequent heart failure.

Methods We report a case of heart failure with mitral and aortic valves replacement on oral warfarin therapy. She had nephrotic syndrome, AKI due to lupus nephritis. The patient received high dose of oral steroid and maintained on hemodialysis for 2 months with full recovery of the AKI and partial recovery of the nephrotic syndrome.

Results The patient received oral high dose steroid only. Partial remission of the nephrotic syndrome occurred with full recovery of the acute kidney injury and she was maintained on once per week ultrafiltration session with improvement of the ejection fraction of the heart.

**Conclusions** Lupus nephritis can present with complex situations. Individualization and tailoring the management for every patient in order to gain complete remission represents a challenge for nephrologists.
Methods The UK Clinical Practice Research Data-link (CPRD) was used to identify 1605 incident cases of SLE from 1997 to 2005 and matched 1:4 to 6284 controls by birth year, gender, general practice and year of first continuous registration. Odds ratios (ORs) of comorbidities at diagnosis and hazards ratios (HRs) after diagnosis of SLEs were estimated adjusting for age, sex, diagnosis year, body mass index, smoking and alcohol consumption. Results SLE was associated with a higher risk for pre-existing comorbidities, with adjusted ORs (95% confidence interval [CI]) of 2.25 (1.97–2.56), 3.37 (2.49–4.57) and 3.54 (1.89–6.63) for the Charlson index of 1–2, 3–4 and ≥5, respectively. SLE was associated with an adjusted HR (95% CI) of 1.30 (95% CI, 1.13–1.49) for developing new comorbidity after the SLE diagnosis. SLE was associated with a greater risk for cancer, cardiovascular, renal, liver, rheumatological and neurological diseases as well as hypothyroidism, psychosis and anaemia. The development of comorbidities was most frequent in the first two years of SLE diagnosis. Patients with SLE also had high risk of death compared with the control group, with a HR of 1.91 (95% CI, 1.62–2.26).

Conclusions SLE patients had a burden of pre-existing comorbidities at diagnosis and the risk of development of multiple comorbidities were higher after the diagnosis compared to matched controls.

Conclusions Decrease in the cost of antibiotics and alimentary system drugs could significantly reduce the patient's hospitalisation expenses. To save the disease burden, the cost of drugs for the prevention of GC adverse reactions also should be properly managed.