192 PROTECTIVE EFFECT OF ANTIMALARIALS ON THE RISK OF DAMAGE ACCRUAL IN SYSTEMIC LUPUS ERYTHEMATOSUS


Institut Clinic de Medicina i Dermatologia- Barcelona-Spain, of Autoimmune Diseases, Barcelona, Spain; 2Universidad Nacional de Rosario, Estadística, Rosario, Argentina; 3Hospital Guillermo Almenara Ingeyos, ESalud, Rheumatology, Lima, Peru; 4Hospital Privado- Córdoba, Servicio de Reumatología, Córdoba, Argentina; 5Hospital Italiano de Buenos Aires, Sección de Reumatología, Buenos Aires, Argentina; 6Hospital Interal Hospital General de Aguados General San Martin, Reumatología, La Plata, Argentina; 7Emory School of Medicine, Division of Rheumatology, Atlanta, USA; 8Hospital Escuela Eva Perín, Reumatología, Granadero Baigorria, Argentina; 9Hospital las Clínicas da Faculdade de Medicina da Universidade de São Paulo, Rheumatology, São Paulo, Brazil; 10Universidad de Antioquia- Hospital Universitario- Fundación San Vicente Medellín, Reumatología, Medellín, Colombia; 11School of Medicine- Pontificia Universidad Católica de Chile, of Clinical Immunology and Rheumatology, Santiago, Chile; 12Centro de Investigaciones Médico Químicas CIMED, Servicio Nacional de Reumatología, La Habana, Cuba; 13Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán, Immunology and Rheumatology, México city, Mexico; 14Hospital de Especialidades- Centro Médico Nacional Siglo XXI- Instituto Mexicano del Seguro Social, Clínico de Reumatología, Ciudad de México, Mexico; 15Hospital General de Occidente and Universidad de Guadalajara, Department of Immunology and Rheumatology, Guadalajara, Mexico; 16Universidad Nacional Mayor de San Marcos- Lima- Perú Servicio de Reumatología- Hospital Nacional Edgardo Rebagliati Martins- ESalud- Lima- Peru, Reumatología, Lima, Peru; 17University of Antioquia- Medellín, Rheumatology, Medellín, Colombia; 18The University of Alabama at Birmingham, of Medicine- Division of Clinical Immunology and Rheumatology, Birmingham, USA; 19Hospital Provincial de Rosario, Rheumatology, Rosario, Argentina

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Background and aims Antimalarials (AMs) have been shown to exert a reduced risk of damage accrual in North American and European SLE patients. We are presenting data from Latin American patients.

Methods Patients with a recent SLE diagnosis (£2 years) from the GLADEL cohort were studied. End-point: Increase in damage (SLICC Damage Index, SDI) since cohort entry.

Results Of the 1466 patients included in this analysis 1049 (72%) received AMs during follow-up (as defined); median exposure time: 30 months (Q1-Q3: 11–57 months). Damage accrual occurred in 665 (45%) patients during a median follow up time of 24 months (Q1-Q3: 8–55 months). After adjusting for potential confounders (SDI at cohort entry, socioeconomic status, disease duration at cohort entry, malar rash, photosensitivity, serositis, oral glucocorticoids, pulse glucocorticoids and SLEDAI at cohort entry) at any time during follow up, a patient on AMs had a 25% lower risk of damage accrual than a patient not on AMs (adjusted HR 0.75, 95% CI 0.62–0.90).

Conclusions After adjustment for possible confounding factors related to AMs use and damage accrual, AMs were independently associated with a reduced risk of damage accrual in this cohort.

193 MASSIVE PERICARDIAL EFFUSION IN YOUNG FEMALE OF SYSTEMIC LUPUS ERYTHEMATOSUS

D.M. Rangkuti. Medan, Indonesia

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Background and aims Systemic lupus erythematosus (SLE) is an autoimmune disease that has a variety of complications in all organs of the body. Pericardial effusion in the one manifestation SLE of the heart and an emergency nature. Massive pericardial effusion may result failure in cardiac pumping that is often referred to cardiac tamponade. Searching for the causes of pericardial effusion is required for diagnosis and therapy.

Methods A woman, 19 years old with complaints of chest pain and shortness of breath. Pale, joint pain, fever and weight loss.

On examination found tachycardia, pallor, muffled heart sounds, bilateral pleural effusions, and pretilial oedema.

Laboratories: Hb 8.6 g/dl, leukocytes 5900/mm 3, Ht 27.7%, PLT 192,000/mm 3, urea 97.9 mg/dl, creatinine 1,51 mg/dl, ferritin >2000 ng/ml, FE 17 mg/dl, TIBC 103 ug/dl, albumin 2.1 g/dl, 68.9 ANA test positive, Anti ds-DNA in 2754, CRP positive. Echocardiography showed massive pericardial effusion Φ 30.2 mm. Fluid analysis : reddish colour, pH 7.9, 0.178 × 103 WBC/uL, 0.005 × 106 RBC/uL, MN cells 36%, and 64% PMN cells.

Diagnosed was done SLE with massive pericardial effusion.

Therapy: pulse steroids and mmf. Antibiotic, diuretic, ACEi, deferoxamine and antipyretic. Patients do pericardiasisnthesis.

Results After all therapy for 5 days of treatment, the patients showed clinical improvement where the shortness and chest pain were reduced, clinical symptoms improved, and pulse 90x/min. The patient is discharged with a follow-up plan every one moth.

Conclusions We reported a case of massive pericardial effusion young SLE patient. Patients receive immunosuppressive and also do pericardiasisnthesis.

194 RISK FACTORS FOR BACTEREMIA IN THAI PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

B Siripaitoon, P Intapiboon. Prince of Songkla University, Department of Internal Medicine, Songkhla, Thailand

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Background and aims Bacteremia significantly affects mortality rate in SLE. It characterises differently across diverse geographic area. This study aimed to identify risk factors for bacteremia in Thai SLE patients.

Methods A retrospective case-control study recruited SLE patients who admitted between 2004 and 2014. Cases with significant bacteremia from microbiology database were matched with SLE diagnosis. Controls were SLE patients selected from the year of the matched case’s hospital admission with a ratio of 1:4. The admissions for elective procedure or patients having prior bacteremia were excluded.

Demography, clinical features, organ involvement, SLE disease activity score, and treatments in the 3 months prior to admission were reviewed.

Results Among 87 episodes of bacteremia occurred in 68 SLE patients, gram negative bacteremia was commonly found in 62 episodes (69.7%). The most common organism was non-typhoidal Salmonella sp. (22 episodes, 25.3%). Common sites
of infection were unknown focus, urinary tract, abdomen, and lower respiratory tract respectively. The mortality rate was 25%. Compared with 272 SLE controls, the bacteremia group had a longer SLE duration and a larger number of active major organ involvement. Active lupus nephritis, renal failure, lymphopenia, prior use of prednisolone 15 mg or more and pulse methylprednisolone increased risk for bacteremia significantly (table 1). The overall 30 day survival was 77.9% after bacteremia and the survival probability was poorer than controls (figure 1).

Conclusions Risk for bacteremia in SLE patients comprises both SLE disease factors and treatment factors. To improve survival, early recognition and prevention strategies in the high-risk patients is crucial.

Abstract 194 Table 1  Multivariate analyses of factors associated with an occurrence of bacteremia in thai SLE patients.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Odds ratio</th>
<th>95%-CI</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active lupus nephritis</td>
<td>2.38</td>
<td>1.22-4.66</td>
<td>0.01*</td>
</tr>
<tr>
<td>Lymphopenia (ALC &lt; 1000/mm³)</td>
<td>2.62</td>
<td>1.14-6.01</td>
<td>0.007*</td>
</tr>
<tr>
<td>Renal failure (GFR &lt; 30 ml/min)</td>
<td>3.51</td>
<td>1.66-7.40</td>
<td>0.002*</td>
</tr>
<tr>
<td>Use of prednisolone ≥ 15 mg/day</td>
<td>3.20</td>
<td>1.16-8.81</td>
<td>0.013*</td>
</tr>
<tr>
<td>Use of pulse methylprednisolone</td>
<td>3.85</td>
<td>1.51-9.81</td>
<td>&lt;0.001*</td>
</tr>
</tbody>
</table>

* Statistical significance; p < 0.05.

Abstract 194 Figure 1  Survival probability in SLE patients having bacteremia and controls.