Abstracts

score (RR: 2.1, 95% CI:1.1–4.0, $p=0.04$) and the Charlson index (RR: 2.5; 95% CI: 1.3 to 4.8, $p=0.009$). The accumulated damage (SDI>0) was closely associated with significance: RR: 2.0; 95% CI: 1.0 to 4.0, $p=0.07$. The use of immunosuppressants was associated with a significant increase in the risk of mycobacterial infection: RR: 4.3; 95% CI: 2.2 to 8.3, $p=0.31$.

Two patients (4.8%) died (1respiratory and 1extrapulmonary). The mean survival after diagnosis in these cases was 21 days.

Conclusion M.I. in RELESSER affects 1.15% of patients. Its incidence rate is 1 per 1000 patients/year (95% CI: 0.7 to 1.4). Extrapulmonary localization affects more than half of the patients and is associated with the use of immunosuppressants. Previous admission by SLE activity, renal involvement, severity of SLE, and increased number of associated comorbidities are factors associated with the existence of mycobacterial infection.

PS8:151 HEMOPHAGOCYTIC SYNDROME IN PATIENTS FROM SLE REGISTRY FROM THE SPANISH SOCIETY OF RHEUMATOLOGY (RELESSER)

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Background SLE in our area presents hematologic manifestations in approximately 70%of cases. Some of them are very rare, there are no large series whose analysis could provide relevant information.

Objectives To study the characteristics of patients with Hemophagocytic Syndrome (HS) in a large sample of SLE patients.

Methods SLE patients from RELESSER database were studied. We analysed the SLE manifestations present at 12domains (mucocutaneous, renal, musculoskeletal, constitutional, hematologic, vascular, cardiac, respiratory, neuropsychiatric, gastrointestinal, ophthalmic and serological) before, during and after HS diagnosis and until the last available assessment. We studied activity (SELENA- SLEDAI) and damage (SLICC/ACR DI) indices in each of those moments.We evaluated the treatment received, HS recurrences and the deaths by this entity.

Results 3656 patients from 45Rheumatology Units across Spain were studied.7patients with SLE and HS were identified. 71.4%were women, with a mean age ($\pm$ SD) at the diagnosis of SH of 35.1 ($\pm$ 17.1) years. In 5of the 7 cases the HS occurred 115.5($\pm$ 162.9 months after the diagnosis of SLE. In the remaining 2 cases the diagnosis of both entities was simultaneous. The main triggers of HS were infections, followed by SLE activity flares. At the time of HS diagnosis, they had high SLE activity with a mean SLEDAI score of 13.1 ($\pm$ 11.3) and 1.4 ($\pm$ 2.3) SDI scores. Clinically, 100% of the patients presented fever and alterations of the liver profile, 85.8%cytopenias and 71.5% dermatological manifestations. Respiratory manifestations and hemolytic anaemia were present in 57.2% of the cases. Lymph nodes and coagulopathy in 42.9%. Hepatomegaly was detected in 28.6%, as well as neuropsychiatric, digestive and renal manifestations. Splenomegaly was detected in 14.3%. The mean haemoglobin level was 8.6 ($\pm$ 1.1) g/dl, platelets 85 585 ($\pm$ 83,390), ferritin 7410 ($\pm$ 6,470) n/ml and triglycerides 404.7 ($\pm$ 235.6) mg/dl.All patients underwent a bone marrow study.All patients were admitted. They required an average of 2.2 ($\pm$ 1.5) treatment lines, using 2.8 ($\pm$ 1.7) drugs. One patient died during the HS episode and another 2 patients had 2 and 3 recurrences respectively.

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	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7
Number of organ systems affected by SLE before HS diagnosis	9	4	5	5	6	Simultaneous diagnosis of SLE and SH	Simultaneous diagnosis of SLE and SH
Number of organ systems affected by SLE at HS diagnosis	4	1	2	4	2	4	3
Number of organ systems affected by SLE until last assessment	Died	2	2	Follow-up lost	1	5	1
SLEDAI//SLICC-ACR DI at HS diagnosis	4//6	4//0	5//0	29//3	4//1	25//0	21//0
SLEDAI//SLICC-ACR DI 1 year after HS	*	0//0	0//0	*	2//1	0//0	2//13
SLEDAI//SLICC ACR DI at last assessment	*	0//0	0//0	*	0//1	2//0	2//13
Number of treatment lines	1	0	3	2	2	4	3
Number	2		5	3	2	4	4
Treatments administered	GC and CsA	0	GCs, etoposide, iv Ig, CsA, platelets, red cells	GC, CYP and iv Ig	Amphotericin B, miltefosine	GC, iv Ig, CsA, MM	GC, Cs A, anakinra and CYP
Relapses	0	2	0	3	0	0	0
Deaths	Yes	No	No	No	No	No	No
Follow-up time (months)	Died	45	80	Follow-up lost	Unknown	26	24

The following table shows the characteristics of each patient.

Conclusion HS is a rare life-threatening manifestation (<0.5%). It must be suspected in patients with persistent fever who do not respond to antibiotics, cytopenias and evidence of multiorgan involvement.

PS8:152 TRENDS AND OUTCOMES OF VENOUS THROMBOEMBOLISM IN HOSPITALISED PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS: RESULTS FROM NATIONWIDE INPATIENT SAMPLE DATABASE 2003–2011

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Background/purpose Venous thromboembolism (VTE) is a major cause of morbidity and mortality in hospitalised patients particularly patients with autoimmune disorders. Nationwide Inpatient Sample (NIS) database was analysed to determine trends in rate of hospitalisation and mortality from VTE in hospitalised systemic lupus erythematosus (SLE) patients to assess its impact.

Methods 2003–2011 NIS database of Healthcare Cost and Utilisation Project was queried to identify all adults (age >18 years) hospitalised with SLE and VTE. Demographic characteristics and in-hospital outcomes of this population were compared to SLE patients without a VTE diagnosis. Multivariate logistic regression analysis was used to obtain adjusted odds ratio (OR).

Results The total number of hospitalised patients with SLE was 2 99 595 of which 9175 (3.06%) had VTE. Mean age of the study population was 50 years and 89% were females. Mean age of SLE patients with VTE was lower than those without VTE (48 vs 51 years). Rate of VTE was higher in African Americans as compared to Caucasians (3.8% vs 2.8%) and in males when compared to females (4.3% vs 2.9%).

After adjusting for potential confounders, compared to those without VTE, SLE patients with VTE had higher inpatient mortality (5% vs 2.0%, OR 2.35 (CI: 2.10 to 2.62, $p<0.001$), greater disability at discharge (34% vs 26%, OR 1.53 (CI: 1.46 to 1.62),

$p<0.001$), longer length of stay by 3.57 days and higher cost of hospitalisation by \$24 500 (table 1).

The rate of VTE among SLE patients have increased since 2005 as shown in Graph 1.

Graph 1

Abstract PS8:152 Figure 1

Conclusion VTE in hospitalised patients with SLE is associated with significantly higher inpatient mortality, greater disability at discharge, increased length of stay and higher cost of hospitalisation. The rate of VTE in SLE patients is on rise likely due to awareness and higher reporting. In this database patients with SLE and VTE were younger. Male sex and African-American race may be associated with an increased risk of VTE in patients with SLE. This cross-sectional study would help in the development and implementation of appropriate prophylactic strategies in high risk SLE population.

PS8:153 SUBTYPES AND LOCATION OF MYOCARDIAL INFARCTIONS IN SYSTEMIC LUPUS ERYTHEMATOSUS

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Introduction Patients with systemic lupus erythematosus (SLE) are affected by morbidity and premature mortality from

Abstract PS8:152 Table 1 Outcomes

Variable	All Patients	VTE	No VTE	OR	p-Value
Inpatient Mortality	6132 (2%)	429 (5%)	5703 (2%)	2.35 (CI 2.10 – 2.62)	<0.001
Moderate to severe disability at discharge	77904 (26%)	3117 (34%)	74787 (26%)	1.53 (CI 1.46 – 1.62)	<0.001
Variable	All Patients	VTE	No VTE	Co-efficient	p-Value
LOS Median (IQR), Days	4	6	4	3.57 (CI 3.32 – 3.83)	<0.001
Total Charges (\$10,000) Median (IQR)	23100	36100	22800	2.54 (CI 2.30 – 2.79)	<0.001
Data are presented as Number of patients (%) or Median (± IQR).					
Abbreviations: OR = Odds Ratio (95% Confidence Intervals (CI)); LOS = Length of stay; VTE = Venous Thromboembolism; IQR = Interquartile range					