73 patients), damage and its components one year following diagnosis and at death, disease activity (ECLAM) at diagnosis, components of the metabolic syndrome, smoking and immunosuppressive treatment. Frequencies were compared using the chi-square and Fisher’s exact test, and continuous variables using the t-test and Mann-Whitney U-test. Variables associated with ND were included in a multivariate logistic regression model.

Results We identified 49/90 ND + patients: 17/44 with CIMP, 6/44 with seizures, 21/44 with CA, 20/44 with neuropathy, none with TM. ND + patients had a higher cumulative count of ACR criteria compared to their ND- counterparts (6.02 ± 1.23 vs 5.39 ± 1.26). They had a higher proportion of neurologic disorder (NRL-D) (6/37 vs 0/36) and a lower proportion of serositis (4/37 vs 11/36) at diagnosis, as well as higher cumulative proportions of NRL-D (9/44 vs 2/46), hematologic disorder (41/44 vs 34/46) and lymphopenia (34/44 vs 24/46) (p<0.05). ND + patients also had higher cumulative damage (6.43 ± 3.13 vs 3.43 ± 2.54), higher cumulative proportions of pulmonary (14/44 vs 6/46) and musculoskeletal damage (MSKD) (32/44 vs 21/46), and higher proportions of arterial hypertension (40/44 vs 34/46), secondary sicca (17/44 vs 9/46) (p<0.05). ND + patients also had higher cumulative damage (6.43 ± 3.13 vs 3.43 ± 2.54), higher cumulative proportions of pulmonary (14/44 vs 6/46) and musculoskeletal damage (MSKD) (32/44 vs 21/46), and higher proportions of arterial hypertension (40/44 vs 34/46), secondary sicca (17/44 vs 9/46) (p<0.05). ND + patients also had higher cumulative damage (6.43 ± 3.13 vs 3.43 ± 2.54), higher cumulative proportions of pulmonary (14/44 vs 6/46) and musculoskeletal damage (MSKD) (32/44 vs 21/46), and higher proportions of arterial hypertension (40/44 vs 34/46), secondary sicca (17/44 vs 9/46) (p<0.05). ND + patients also had higher cumulative damage (6.43 ± 3.13 vs 3.43 ± 2.54), higher cumulative proportions of pulmonary (14/44 vs 6/46) and musculoskeletal damage (MSKD) (32/44 vs 21/46), and higher proportions of arterial hypertension (40/44 vs 34/46), secondary sicca (17/44 vs 9/46) (p<0.05). ND + patients also had higher cumulative damage (6.43 ± 3.13 vs 3.43 ± 2.54), higher cumulative proportions of pulmonary (14/44 vs 6/46) and musculoskeletal damage (MSKD) (32/44 vs 21/46), and higher proportions of arterial hypertension (40/44 vs 34/46), secondary sicca (17/44 vs 9/46) (p<0.05). ND + patients also had higher cumulative damage (6.43 ± 3.13 vs 3.43 ± 2.54), higher cumulative proportions of pulmonary (14/44 vs 6/46) and musculoskeletal damage (MSKD) (32/44 vs 21/46), and higher proportions of arterial hypertension (40/44 vs 34/46), secondary sicca (17/44 vs 9/46) (p<0.05). ND + patients also had higher cumulative damage (6.43 ± 3.13 vs 3.43 ± 2.54), higher cumulative proportions of pulmonary (14/44 vs 6/46) and musculoskeletal damage (MSKD) (32/44 vs 21/46), and higher proportions of arterial hypertension (40/44 vs 34/46), secondary sicca (17/44 vs 9/46) (p<0.05). ND + patients also had higher cumulative damage (6.43 ± 3.13 vs 3.43 ± 2.54), higher cumulative proportions of pulmonary (14/44 vs 6/46) and musculoskeletal damage (MSKD) (32/44 vs 21/46), and higher proportions of arterial hypertension (40/44 vs 34/46), secondary sicca (17/44 vs 9/46) (p<0.05).

Conclusions Serositis may be associated with a lower likelihood of ND, while NRL-D was present at diagnosis only in patients that accrued ND. The association between MSKD and ND requires further elucidation.

Abstract PS8:165 Figure 1

### PS8:167 THERAPEUTIC EFFICACY OF BELIMUMAB IN ADDITION TO STANDARD THERAPY FOR LUPUS NEPHRITIS AND NEUROPSYCHIATRIC LUPUS – CASE SERIES OF ROUTINELY COLLECTED DATA AT A SINGLE CENTRE

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Objective Belimumab (BEL) is approved for Systemic Lupus erythematosus in addition to standard immunosuppressive therapies. Clinical studies have excluded patients with particular organ manifestations from participation in most clinical trials. Most importantly, Lupus nephritis (LN) and neuropsychiatric Systemic Lupus erythematosus (NPSLE) were exclusion criteria in the relevant clinical studies. We aim to report our experience of BEL’s effect on SLE manifestations which have not been formally addressed in clinical trials.

Methods We performed an observational study of routinely collected clinical data of all patients receiving BEL with or without other immunosuppressive therapy at our institution.

Abstract PS8:166

**COMPARISON OF CLINICAL AND SEROLOGICAL CHARACTERISTICS BETWEEN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS WITH AND WITHOUT ASSOCIATED JACCOUD’S ARTHROPATHY**

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Abstract PS8:166 Figure 1