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 44/90 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) and Hughes syndrome (11/44 vs 4/46) (p<0.05). Serositis at diagnosis and cumulative MSKD were associated with ND in the multivariate model (OR 0.17 (95% CI: 0.03 to 0.89) and 6.00 (95% CI: 1.64 to 21.91), respectively).

**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.

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**Abstract PS8:165 Figure 1**

**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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**Objectives** To compare the profile of clinical and serological manifestations of patients with SLE with and without JA followed in a tertiary care hospital of Madrid.

**Methods** We performed a retrospective observational study of a cohort of patients diagnosed with SLE (4 or more ACR criteria) between June 1977 and December 2015. The variables evaluated included demographics, clinical, analytical and radiological manifestations. The definition of JA was based on the presence of clinical criteria (reversible joint deformities) and absence of radiographic erosions typical of rheumatoid arthritis.

**Results** We included 108 patients representing a sample of 24% of the total number of patients with SLE treated at our centre during that period. The majority of patients were women (89.8%), mean age at diagnosis was 30±12.29 years (range: 7–75) and duration of disease was 127 months (range: 2–411). Thirteen patients (12.03%) had findings compatible with JA. There were no significant differences in age, sex or race, but the duration of disease was higher in JA patients (190 vs 118.2 months, p=0.0299). There were significant differences in the presence of malar rash (p=0.0009), photosensitivity (p=0.0050), oral ulcers (p=0.0032) and pericarditis (p=0.00001), which were more frequent in patients without JA, but arthritis, nephritis, pleuritis, seizures, psychosis, Raynaud’s phenomenon and antiphospholipid syndrome had a similar distribution between both groups. Among the immunological features, no significant difference was found in relation to hemolytic anaemia, lymphopenia, thrombocytopenia, ANA, anti-ENA, anti-DNA, anticardiolipin, anti-β2 glycoprotein I and lupus anticoagulant, but leukopenia was also more frequent in patients without JA (p=0.0041).

**Conclusions** In the analysed sample of patients in our centre JA was a relatively frequent finding and was associated with a longer duration of the disease. It was not possible to corroborate other JA associations suggested in previous studies such as a lower frequency of lupus nephritis or major secondary antiphospholipid syndrome, probably due to limited sample size, but there are also other studies that do not demonstrate significant differences in relation to clinical and serological findings in patients with SLE with JA with respect to those who do not present it.

**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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**Purpose** 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.
Results We identified 15 patients currently receiving BEL therapy. Of these, 9 were not analysed further because they had no history of LN or NPSLE.

One 48-y/o female patient after renal transplantation with background therapy consisting of prednisone (GC), hydroxychloroquine (HCQ), leflunomide (LEF) and tacrolimus (TAC) had a stable disease but no additional benefit (BEL stopped after 5 months). Three female patients with GC, HCQ and mycophenolate mofetil (MMF) had an improvement of proteinuria, steroid dosage and overall quality of life. One female patient is receiving BEL or placebo (PBO) during a clinical trial (BLISS-LN), she has markedly improved proteinuria with GC, HCQ, MMF and BEL/PBO. One 73-y/o male patient with NPSLE who failed or could not tolerate various standard and additional therapies (including Rituximab and Cyclophosphamide) had a persistent clinical improvement of cutaneous lupus and neuropsychiatric symptoms (dysarthria, concentration, ataxia) after the second BEL infusion. Overall, there was one upper respiratory tract infection but no other adverse events.

Conclusions In the six patients analysed, 3 had improved proteinuria, 1 had stable disease after renal transplantation, 1 improved regarding NPSLE symptoms and 1 had improved proteinuria, but in the last case, it is not yet clear whether the effect is due to BEL. Overall, while the results of the BLISS-LN trial are awaited, we experienced improved Lupus nephritis with BEL in addition to standard therapy and observed one case of improved NPSLE. While BEL has not been approved for these severe organ manifestations, it still might be effective in well-selected patients.

Dyslipidemia is a well-established atherosclerotic risk factor. It is also believed to affect the outcome of SLE, especially in lupus nephritis patients (LN). The aim of this study was to assess the prevalence and impact of dyslipidemia in our LN patients.

Methods We performed a retrospective clinical study, 140 patients with biopsy-proven LN were analysed. The renal activity and classification were evaluated according to renal pathology. SLE disease activity was scored using the SLE Disease Activity Index (SLEDAI). Adverse outcome was defined by the occurrence of ESRD or death. The correlations between dyslipidemia and both ESRD and mortality were assessed.

Results Mean age of our patients was 34.63±12.7 years old, 83% were females. Class III, IV and V lupus nephritis accounted for 21%, 58.7% and 11.2%. The prevalence of dyslipidemia with elevations in total cholesterol (TC), low-density lipoprotein (LDL), triglyceride (TG) were noted in our LN patients, ranging from 41% at diagnosis to 59.7% or even higher after 24 months, and statins were administered in 23% of the patients.

After a mean follow-up of 22 months, ESRD occurred in 24%, and death in 13% of cases. Moreover, dyslipidemia was significantly associated to both ESRD (p<0.02) and death (p<0.003).