

infectious or malignant aetiology, although the histological findings are typically non-specific for a diagnosis of lupus-related pericarditis. Pericardectomy is likely to be required for definitive treatment.

PS10:185 **NODULAR LOCALISED CUTANEOUS AMYLOIDOSIS IN A PATIENT WITH SYSTEMIC LUPUS ERYTHEMATOSUS**

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Introduction Nodular localised amyloidosis is a rare subtype of cutaneous amyloidosis, associated with various connective tissue diseases, mostly Sjogren's syndrome. Progression to systemic amyloidosis was described in 7%–50% cases. Amyloid deposition was also noted in hypertrophic lupus lesions.

Purpose To report a case of systemic lupus erythematosus (SLE) presenting with nodular localised cutaneous amyloidosis, followed up for 17 years.

Methods A 55 year patient was addressed to our tertiary unit with pain and swollen in both hands and multiple soft nodular lesions pink to brown on the chest and back.



Abstract PS10:185 Figure 1

Results Clinical examination and further investigations revealed inflammatory hand arthritis and polyserositis including

pericarditis and pleural effusion. Laboratory showed antinuclear antibodies with low anti-dsDNA titer, positive anti-Ro antibodies, positive rheumatoid factor, C3 and C4 consumption. She had negative anti-cyclic citrullinated peptide antibodies and anti-LA antibodies, no sicca symptoms and no ultrasound modification of the salivary glands. The skin histopathology with Congo red staining revealed amyloid deposition in the dermis. A screening for multiple myeloma, including bone marrow biopsy, was negative. She was treated with hydroxychloroquine, and over the time with methotrexate, azathioprine (with loss of tolerance), acitretin (with no significant skin improvement), and topical glucocorticoids. New lesions appeared mostly upon cessation of SLE therapy, on traumatised areas and sun exposure, but were quite stable during sustained systemic therapy, suggesting some relation to disease activity. She developed new-onset cryoglobulinemia with increasing anti-Ro titers and rheumatoid factor, but has still normal immunoglobulins, complement fractions and LDH and no light chains on immunoelectrophoresis.

Conclusions Nodular localised amyloidosis is rare in SLE. The lesions evolve slowly, are minimally influenced by systemic therapy, but a close monitoring for systemic amyloidosis or plasma cell dyscrasia is required even in longstanding cases.

PS10:187 **CAUSES OF DEATH IN CHILDHOOD-ONSET SYSTEMIC LUPUS ERYTHEMATOSUS IN A TERTIARY CARE CENTRE, SOUTHERN THAILAND**

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Introduction The mortality rate of childhood-onset systemic lupus erythematosus (cSLE) remains high due to the severity of the disease and its complications. The cause of death varies widely depending on the major organs involved and therapy received.

Objective To evaluate the causes of death of cSLE.

Methods The medical records of children aged <18 years who had been diagnosed with SLE following American Rheumatism Association criteria from 1985 – 2016 in the Division of Nephrology, Department of Paediatrics, Prince of Songkla University, Thailand, were reviewed.

Results There were 331 patients, 272 girls and 59 boys, of whom 77 (23.3%) died, 28.6% within the first year after diagnosis. Only 29 medical records were available for evaluation of cause of death. Of these, there were 7 boys and 22 girls with a mean age at presentation of 11.0 ± 3.0 years. The mean follow-up duration was 4.6 ± 3.7 (range 0.2–12.6) years. The major cause of death was sepsis (13) followed by acute respiratory distress syndrome (ARDS) (6), severe heart condition (3), acute kidney injury (AKI) (2), chronic kidney disease (CKD) (2) and intracranial haemorrhage (1). Conditions at the time of death were sepsis (25), pneumonia (16), acute kidney injury (15), bleeding disorders (11), neurological complications (10), ARDS (10), CKD (4), AKI on top of CKD (3).

Conclusion The cause of death in cSLE is usually multi-factorial and it is difficult to assign a single dominant cause. Sepsis remains the most common cause of death. In the long-term, end-stage renal disease emerges as an important cause of death in RRT limited institutions.