prognosis is different according to ethnicity. There are no controlled trials in African populations.

**Objectives** Evaluate the efficiency of two regimens of cyclophosphamide in the treatment of LN.

**Patients and methods** 48 patients with histological proven LN and treated with cyclophosphamide were included. Patients were divided in 2 groups: Group 1 (6 monthly high-dose intravenous cyclophosphamide) and Group 2 (Eurolupus protocol). We evaluate complete remission rate (absence of proteinuria and renal failure), partial remission (decrease of proteinuria more than 50% without renal failure) and renal relapses into the 2 groups.

**Results**

There were 32 patients in group 1 and 16 patients in group 2. Mean age at time of LN diagnosis was 30 years in group 1 and 28.3 years in group 2. Mean level of proteinuria was 3 g/day (group 1) and 3.73 g/day (group 2). Hematuria was found in 16 and 4 patients respectively. Five patients in group 1 and three in group 2 were in renal failure at time of LN flare. Lupus nephritis was class III in 10 (group 1) and 4 cases (group 2), class IV (group 1: n=14, group 2: n=9), class III/V (group 1: n=5, group 2: n=2) and class IV/V (3 in group 1). Complete remission was achieved in 62.5% of case in group 1 and 56.3% patients in group 2 (p=0.6). Partial remission was obtained in 25% of cases in both groups. Renal relapses occurred in 12.5% (group 1) and 18.8% (group 2) of patients (p=0.56). None had end stage renal failure. The average duration of follow up was of 5.32 years in the group 1 and 5.49 years in group 2.

**Conclusion** Monthly cyclophosphamide pulses regimen was similar to Eurolupus protocol in our group. These results encourage us to use biweekly cyclophosphamide pulses which are safer in SLE patients. More studies are needed to confirm these results.

**PS6:118** **OBJECTIVE MEASUREMENTS OF SLEEP DISORDERS AND PSYCHIATRIC COMORBIDITIES IN A COHORT OF PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS**

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**Background** Depression is one of the most frequent disorders in SLE, from 17% to 75% of prevalence, although subtle neuropsychiatric syndromes like symptoms of depressive and anxiety axes are often considered as ‘non-neuropsychiatric SLE’. Recent data suggest SLE patients also suffer from sleep disturbances like frequent awakenings and unrestrictive sleep, and worse sleep quality has been found to be a fellow traveller with this disease.

Aims to objectively evaluate sleep in SLE patients in comparison with a cohort of age and sex-matched controls and to find possible relationships with disease manifestations and to find the factors that have greater impact on mood disorders in SLE group.

Methods sleep was evaluated in 41 SLE patients and 36 controls using actigraphy. The presence of mood disorders, temperament, health-related quality of life and perception of sleep were evaluated with specific questionnaires: Beck Depression Inventory (BDI), Self Rating Anxiety Scale (SAS), Brief COPE, Pittsburgh Sleep Quality Index (PSQI), Insomnia Severity Index (ISI), Perceived Stress Scale (PSS), Resilience Scale for adult, Functional Assessment of Chronic Illness Therapy (FACTIT) Fatigue Scale, Brief TEMPS-M, Lupus QoL and Short Form Health survey 36 (in SLE patients and controls respectively).

**Results**

The strongest predictors of the SLE group were higher scores in BDI and SAS index, lower Sleep Efficiency and greater Total Sleep Time.

Statistically significant differences were found between depressed SLE patients and non-depressed SLE patients in several parameters. Lower scores in FACTIT fatigue scale, burden to others, pain and body image domains and higher PSS score were found in depressed SLE patients. In SLE group, FACTIT score was strongly negative correlated with BDI score and positively correlated with physical domain.

Fibromyalgic SLE patients had lower scores in pain domain when compared with non-fibromyalgic SLE patients. Instead, no difference in pain domain was found between patients with joint involvement and patients without joint involvement, addressing fibromyalgia as the factor with greater impact over pain.

**Conclusion** SLE is a chronic disease that has great impact on mood and sleep quality and identification of this problems and consequent therapeutic interventions may improve the quality of life of these patients.
PS6:119  CLASS III-IV LUPUS NEPHRITIS MANAGEMENT IN EVERYDAY PRACTICE

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Purpose To study the use in real life clinical practise of glucocorticoids (GCs), immunosuppressive and adjuvant therapy in Class III-IV Lupus Nephritis (LN).

Methods A multiple choice electronic questionnaire was sent to Latin American rheumatologists. Ten questions addressing the following topics: use of methylprednisolone pulses at the beginning of treatment and additionally during induction, use of oral GCs (maximum dose, tapering schedules, time on prednisone doses >30 mg/day, time until a prednisone dose of 5 mg/day is reached); use of immunosuppressants during induction and maintenance therapies; and use of adjuvant therapies.

Results Were assessed 153 surveys (67 were from Argentina, 26 from Brazil, 12 from Venezuela, and 48 from Chile, Colombia, Cuba, Ecuador, Peru, Mexico and Costa Rica). As of GCs, 63.40% (97/153) give three intravenous pulses of methylprednisolone of 1 gr, and then switch to 0.5–1 mg/kg/day of oral prednisone. With the lack of a definite tapering scheme, 88.24% (135/153) taper prednisone based on disease activity; 81.04% (124/153) maintain doses of oral prednisone >30 mg/day for 4 or more weeks and 40.42% (62/153) for 6 or more weeks; 43.79% (67/153) reach an oral prednisone dose of 5 mg/day in 4 to 6 months, and 39.87% (61/153) in >6 months; 79.08% (121/153) do not use additional intravenous pulses of methylprednisolone during induction.

Intravenous cyclophosphamide (IVCYC), 1 gr/4 weeks, (60.13%, 92/153) and mycophenolate mofetil (MFM) (68.63%, 105/153) are the most used drugs for induction and maintenance treatment, respectively.

Regarding adjuvant therapy, 81.05% (124/153) prescribe hydroxychloroquine in order to improve the prognosis of patients, and only 36.6% (56/153) consider it relevant to keep an adequate intake of calcium and vitamin D.

Conclusions In the real world therapy of LN, high doses of oral GCs are used during prolonged periods of time, with tapering schemes based on clinical response. Pulses of methylprednisolone are frequently given, but only at the beginning of the induction phase. IVCYC and MFM are the immunosuppressive drugs of choice for induction and maintenance therapy, respectively. Hydroxychloroquine frequently (but not universally) considered to improve the prognosis of these patients. Little attention is paid to calcium and vitamin D supplements.

PS6:120  HAND ULTRASOUND GUIDED THERAPEUTIC DECISIONS IN INFAMMATORY ARTHRITIS ASSOCIATED WITH SYSTEMIC LUPUS ERYTHEMATOSUS AND SJÖGREN’S SYNDROME

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