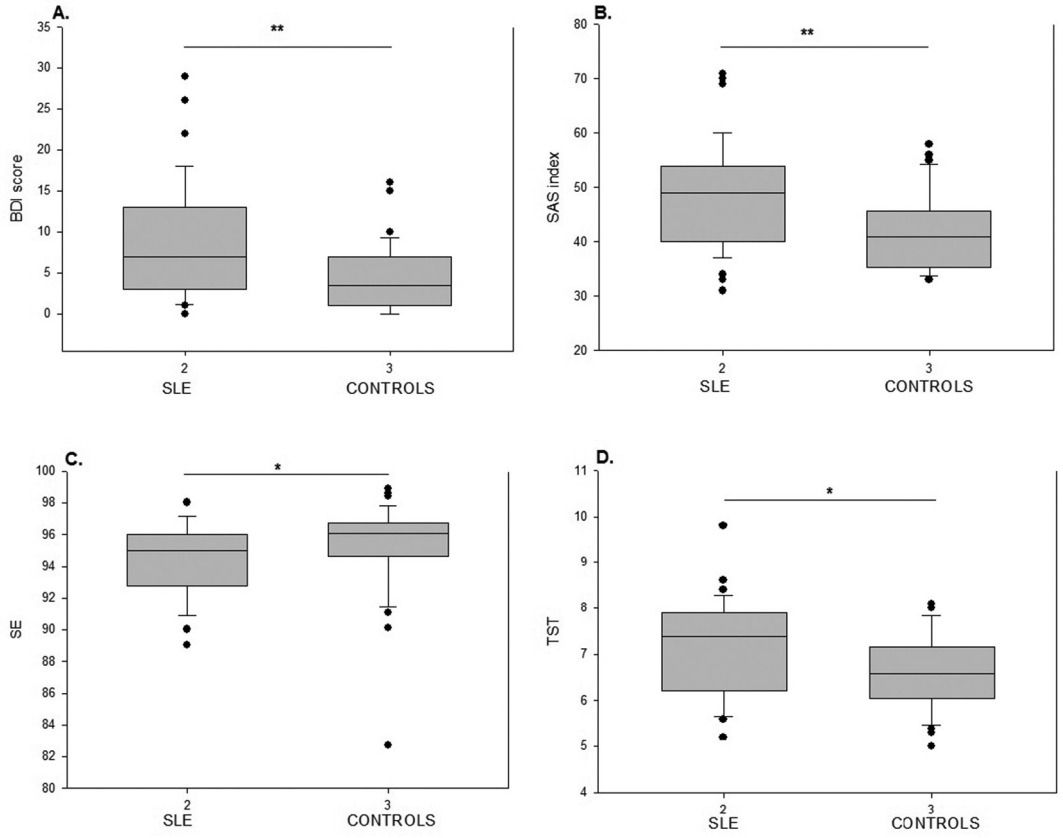

Abstract PS6:118 Figure 1 Comparison of beck depression inventory score (A), self rating anxiety scale index (B), sleep efficiency (C), total sleep time (D) between systemic lupus erythematosus group and controls. All these factors were significantly different between the two groups. Mann-Whitney rank sum test *=p<0.05; **=p<0.01

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 INFLAMMATORY ARTHRITIS ASSOCIATED WITH SYSTEMIC LUPUS ERYTHEMATOSUS AND SJÖGREN'S SYNDROME

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Background Musculoskeletal Ultrasound (US) is increasingly used as a valid and reliable tool for diagnosis and management of inflammatory arthritis. However, its use in Systemic Lupus Erythematosus (SLE) and Sjogren's syndrome (SS) patients in clinical practice remains less established.

Objectives To analyse a real life cohort of SLE and SS patients referred for US assessment of their hand joints in the context of clinical symptoms of arthralgia/arthritis, to review their characteristics and correlate US findings with clinical and laboratory markers, and disease activity scores (musculoskeletal ESSDAI and BILAG).

Methods We performed a cross-sectional study of patients with SLE and SS referred to our US clinic in the last year. The OMERACT US scoring system was used to assess patients' wrists, metacarpophalangeal and proximal interphalangeal joints bilaterally.

Results Patient characteristics and differences between ultrasound findings in SLE (n=18) and SS (n=23) patients are shown in Figure 1. There was no correlation between the total PD score and musculoskeletal BILAG and ESSDAI scores (R=0.36, p=0.12, and R=0.32, p=0.13, respectively). Similarly, there was no correlation between the total Grey Scale score (assessing the degree of synovial hypertrophy) with either BILAG or ESSDAI scores (R=0.41, p=0.09, and R=0.084, p=0.7, respectively). Interestingly, more than one in two SLE patients had erosions, while more than one in three had erosions in the SS group (Table 1). In addition, the US assessment prompted treatment changes (including both optimisation of immunosuppressive therapy or analgesia based on the results of the scan) in up to 61% of SLE patients and in 35% of SS patients, who would have otherwise not had their treatment changed based on BILAG/ESSDAI scores alone.

Conclusion US examination was proven superior to clinical examination and blood test results for optimising the management of hand arthralgia/arthritis associated with SLE and SS. Our study showed that active joint inflammation was found in 27.8% of SLE patients while twice as many already had erosions. Future research is needed to establish if the development of erosions could be prevented by early diagnosis and prompt treatment of inflammatory arthritis associated with SLE and SS.

Abstract PS6:120 Table 1

	SLE (n=18)	SS (n=23)	
Age (mean +/- SD)	45.7+/- 12	51.4 +/- 14	p=0.18
Gender (% females)	94.4	100	p=0.25
Disease duration (years, mean +/- SD)	14.04+/-14.8	8.9+/-9.8	p=0.21
% of patients on steroids	44.4	4.3	p=0.002
% of patients on cDMARDs	88.9	52.2	p=0.012
% of patients on Rituximab	11.1	8.7	p=0.79
% ANA	77.8	34.8	p=0.006
%dsDNA	27.8	13	p= 0.23
% ENA	55.6	56.5	p = 0.95
CRP(mean +/- SD)	4.98 +/- 4.17	4.69 +/- 6.04	p= 0.87
ESR (mean +/- SD)	31.41 +/- 26.11	23.35 +/- 19.78	p= 0.27
SJC (mean +/- SD)	3.29 +/- 4.29	2.24 +/- 6.11	p= 0.58
TJC (mean +/- SD)	7.69 +/- 7.96	6.20 +/-7.68	p= 0.59
Power Doppler (PD) score (mean +/- SD)	1.35+/-2.7	0.52+/-1.68	p=0.24
Percentage of patients with PD signal	27.8	21.7	p= 0.65
Erosions score (mean +/- SD)	2.71+/- 3.62	2+/- 5.01	p=0.6249
Percentage of patients with erosions	55.6	34.8	p = 0.18