the initial 52 subjects enrolled. Participants were assessed once over 24 hours by ambulatory blood pressure monitoring, using routine equipment and SpaceLabs software. Diurnal and nocturnal averages for both systolic and diastolic blood pressure were assessed, and nocturnal blood pressure dipping was calculated as difference between median awake and sleep measurements. In addition, blood pressure loads were calculated as percentages of measurements that exceeded validated, age-specific thresholds for normal blood pressure. Nocturnal hypertension was defined as systolic or diastolic load during sleep of >25%. Enrollment in the BPpSLE study is open to all interested CARRA investigators.

Results The cohort is 79% female, 29% Hispanic and 27% black. Median age was 16.3 years (IQR 13–17) at time of testing. Median SLEDAI was 4 (IQR 2–11), renal SLEDAI was 0 (IQR 0–4), and median glomerular filtration rate was 104 mL/1.73 m²/min (IQR 91–114). Nocturnal hypertension was seen in 47% and attenuated dipping was seen in 71% of children with SLE, compared to 39% and 26% of historical controls. Loads were 14% and 13% while sleeping versus 5% systolic and 6% diastolic while awake. This corresponded with median nocturnal dipping of 6% in systolic and 13% in diastolic blood pressures (normal >10%).

Conclusions There is a high prevalence of both nocturnal hypertension and attenuated nocturnal blood pressure dipping in out SLE cohort, compared to an age-matched adolescent population with borderline high blood pressure. These patterns are not due to renal failure or active nephritis. Although most SLE patients in the cohort do not meet criteria for diagnosis of hypertension, the degree of dysregulation could potentially contribute to the cardiovascular risk noted in SLE.

Acknowledgements This abstract is being presented on behalf of the Midwest Pediatric Nephrology Consortium (MWPNC).

CS-35

DAMAGE ACCRUAL AND HEALTH-RELATED QUALITY OF LIFE IN A COLOMBIAN COHORT OF PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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10.1136/lupus-2018-lsm.70

Background Systemic Lupus Erythematosus (SLE) is a chronic multisystemic autoimmune pathology of unknown etiology with a variable course and a predilection for women of reproductive age. Chronic activity and flares of disease activity are correlated with greater damage accrual and mortality. Mortality and health-related quality of life (HR-QoL) are higher in SLE patients when compared to general population. Damage accrual, duration of the disease, disease activity and involvement of specific organ systems, might relate to worse HR-QoL in SLE. A worse perception of health is associated with a higher damage accrual over time.

Methods A retrospective cohort of SLE patients (ACR 1997 or SLICC 2012 classification criteria), followed for at least 1 year, between 2015 and 2017 in a specialized center was analyzed. Activity evaluated by Systemic Lupus Erythematosus Disease Activity Index (SLEDAI), damage accrual by SLICC/

Abstract CS-35 Table 1

	SDI [‡] 0			SDI [‡] 1			SLEDAI [§] 0–4			SLEDAI [§] ≥5		
	Initial (%)	Final	p Value	Initial	Final	p Value	Initial	Final	p Value	Initial	Final	p Value
Mobility												
1	119	99	0,01	100	120	0,01	209	205	0,21	1	6	0,21
2	99	77	0,01	76	98	0,01	160	154	0,11	1	7	0,11
3	1	1	0,5	2	2	0,5	3	3	NS	0	3	NS
Personal Care												
1	166	134	0,01	129	161	0,01	278	270	0,1	2	10	0,1
2	53	43	0,01	46	56	0,02	91	88	0,2	0	3	0,2
3	1	1	0,5	3	3	1	4	4	0,5	0	4	0,5
Quotidian Activities												
1	137	114	0,01	99	122	0,01	224	217	0,26	0	7	0,26
2	80	61	0,01	73	153	0,01	139	136	0,03	2	5	0,03
3	2	2	1	7	9	1	9	8	0,5	0	1	0,5
Pain/Discomfort												
1	68	54	0,01	58	126	0,01	117	114	0,22	1	4	0,22
2	104	82	0,01	80	184	0,01	171	166	0,14	1	6	0,14
3	48	42	0,1	42	90	0,1	85	82	0,72	0	3	0,72
Anxiety/Depression												
1	115	95	0,01	99	119	0,01	199	197	0,4	2	4	0,04
2	73	61	0,01	53	126	0,01	117	113	0,26	0	4	0,4
3	29	19	0,012	26	55	0,012	53	48	0,45	0	5	0,4

[‡] Without damage
[‡] Any Damage
[§] Low activity (0 to 4)
[§] Moderate to severe activity (≥5)
[†] Mc. Nemar test.

ACR damage index (SDI) and HR-QoL by EQ-5D were measured. Bivariate analysis through chi squared and U Mann Whitney Multivariate analysis was performed by logistic regression to adjust for significant associations. Statistical analysis for related samples was evaluated with Mc. Nemar test.

Results We analyzed 400 Colombian patients. Baseline median age was 49 years (15 IQR) with median age at diagnosis and disease duration of 37 years (17 IQR) and 9 years (13 IQR) respectively. There were 94% female patients and 17.3% late onset SLE. Most frequent clinical manifestations were hematological (82.8%), mucocutaneous (75.3%) and nephritis (33.8%). Only 4.5% had neurological involvement. The mean SLEDAI were 1.18 and 0.65 at first and second measurement respectively, in the first measurement 97.1% of the patients had a SLEDAI ≤ 4 . The mean SDI was 0.7275 at first measurement and 0.985 at the second measurement. Although SDI was associated to various dimensions of HR-QoL measured by ED-5D, disease activity was not related (See table 1).

Conclusions In SLE Colombian patients with a established disease and an altered HR-QoL, low disease activity is not related with HR-QoL when measured by EQ-5d. In the present study, it is highlighted that while disease activity decreases, damage increases. Damage accrual has a relation with HR-QoL in the short term. The impact and correlation must be better defined in a long-term follow-up. The associated effect on HRQOL emphasizes the need for strategies to reduce the risk of cumulative organ damage.

CS-36 RECOMMENDATIONS FOR THE ASSESSMENT OF SYSTEMIC LUPUS ERYTHEMATOSUS IN CANADA

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10.1136/lupus-2018-lsm.71

Background To develop GRADE-based recommendations for the diagnosis and monitoring of systemic lupus erythematosus patients in Canada.

Methods Recommendations were developed using the GRADE (Grading of Recommendations, Assessment, Development and Evaluation) approach. The Canadian SLE Working Group (panel of Canadian rheumatologists and patient representative

Abstract CS-36 Table 1 Summary of recommendations with strength of evidence for the diagnosis and monitoring of SLE in Canada

Recommendation	Strength of Recommendation; Quality of Evidence
We recommend that all adult and pediatric patients suspected of SLE be referred to a lupus specialist, most often a rheumatologist, to confirm diagnosis and be involved in ongoing care	strong recommendation; moderate quality evidence
For adult and pediatric patients with SLE, we suggest assessing disease activity with a validated instrument of disease activity during baseline and follow up visits.	conditional recommendation, low quality evidence
For adult and pediatric patients with SLE, we suggest assessing disease activity with a validated instrument of disease activity during baseline and follow up visits	conditional recommendation, low quality evidence
For adult lupus patients, we recommend that indicators of obesity, smoking status, diabetes, blood pressure and a basic lipid profile be measured upon diagnosis of SLE and be reassessed periodically according to current recommendations in the general population and be used to inform the cardiovascular risk assessment.	strong recommendation, moderate quality evidence
For adult patients with SLE, we suggest assessing the risk of osteoporosis and fractures every 1 to 3 years using a detailed history and focused physical examination, and measuring bone mineral density in patients with other risk factors according to recommendations in the general population.	conditional recommendation, low quality evidence
For all adults with SLE, we suggest screening 25-hydroxyvitamin D as part of the assessment for risk of osteoporosis and fractures	strong recommendation, moderate quality evidence
For adults and paediatric patients with a diagnosis of SLE and high risk behaviours for HCV acquisition, we recommend screening for Hepatitis C and repeating according to recommendations in the general population.	conditional recommendation, low quality evidence
For adult patients with SLE who do not have clinical symptoms suggestive of osteonecrosis, we suggest not screening for or performing investigations for osteonecrosis. For patients who have suspected clinical symptoms of osteonecrosis, we suggest radiographs as the initial imaging modality rather than MRI or bone scan with SPECT according to recommendations in the general population.	conditional recommendation, low quality evidence
For women with SLE, we suggest that anti-Ro and anti-La antibodies be measured immediately prior to pregnancy or during the first trimester.	conditional recommendation, low quality evidence
For pregnant women with SLE, we suggest that uterine and umbilical Doppler studies be performed in the second or third trimester, or at the time of a suspected flare.	conditional recommendation; low quality evidence
For women with prior or active lupus nephritis who are pregnant, we suggest measuring serum creatinine and urine protein to creatinine ratio every 4–6 weeks, or more frequently if clinically indicated. We suggest blood pressure and urinalysis be measured prior to pregnancy and every 4–6 weeks until 28 weeks, every 1–2 weeks until 36 weeks and then weekly until delivery.	conditional recommendation; low quality evidence