Results Patient 1 was an 11-year-old girl who presented with fever, rash and generalized body swelling for 3 months. Physical examinations revealed heart rate 148/min, respiratory rate 30/min, and blood pressure (BP) 100/80 mmHg. She had pallor, malar rash, hepatomegaly and gallop rhythm. Investigations are detailed in the table. She received intravenous immunoglobulin and initiated on pulse methylprednisolone and followed by pulse intravenous cyclophosphamide. She was discharged on oral prednisolone and subsequently tapered. Patient 2 was a 9-year-old girl presented with fever and rash for 3 months with lethargy for 1 day. She had pallor, malar rash, hepatomegaly. Physical examinations revealed heart rate 132/min, respiratory rate 32/min, feeble peripheral pulses and BP 100/80 mmHg. She received intravenous cyclophosphamide monthly for 6 months along with oral prednisolone in tapering dose. Patient 3 was a 12-year-old girl, who was known to have SLE for 2 months, presented with fever, malar rash, and photosensitivity. She had stopped taking steroids for 2 weeks. On examination, she had heart rate 122/min, respiratory rate 28/min and BP 100/72 mmHg. She had pallor, alopecia, oral ulcers, malar rash, gallop rhythm and tender hepatomegaly. She was given pulse methylprednisolone and furosemide therapy followed by oral prednisolone in gradually tapering dose. Patient 4 was an 11 year-old-girl who was known to have SLE for 6 months, presented with pain in the small joints, low grade fever, and cough for 1 month. She had stopped steroids on her own. On examination, she was found to have anasarca, malar rash and oral ulcers. She had heart rate 128/min, respiratory rate 32/min, BP 108/

74 mmHg, soft systolic murmur at the apex with normal heart sounds and hepatosplenomegaly. She was given pulse methylprednisolone along with cyclophosphamide in view of severity of symptoms. She developed multiorgan dysfunction and died after 8 days in hospital.

Conclusions Myocarditis in lupus is uncommon but carries a significant morbidities. The presence of global hypokinesia with a low ejection fraction on two dimensional echocardiography (2DE) is a strong pointer towards the diagnosis. Immunosuppressant drugs with supportive therapy remain the preferred treatment. Early diagnosis and prompt treatment may be very rewarding.

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RENAL OUTCOMES IN LUPUS NEPHRITIS RANDOMIZED CONTROLLED TRIALS: A SYSTEMATIC REVIEW AND A POOLED ANALYSIS ON 3922 PATIENTS

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Background Systemic lupus erythematosus (SLE) is a complex and potentially life-threatening autoimmune disease characterized by a wide range of manifestations. Renal involvement represents a major cause of morbidity and mortality and lupus nephritis (LN) remains a major therapeutic challenge.¹ Therefore, selecting appropriate outcome measures for clinical trials

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represent a crucial step in order to identify appropriate drug regimens for LN treatment. The aim of this study was to systematically review the available literature to compare renal primary outcome measures used in randomized controlled trials (RCTs) for both the induction and the maintenance therapy in biopsy proven LN setting.

Methods A detailed literature search was applied a priori to Ovid-MEDLINE (2000–2018), clinicaltrials.gov and to abstracts from the EULAR and ACR/ARHP Annual Meetings (table 1).

Results A total of 3922 patients with LN were identified from 28 RCTs. Mean follow-up period was 17.3 ± 15.9 months. Patients were distributed, based on the presence of active biopsy-proven LN, as follow: 717 (23.6%) patients presented class III LN, 1681 (55.3%) class IV, 448 (14.7%) class V, and 195 (6.4%) class IV+V. Twenty-three RCTs (92%) were designed to investigate induction therapy for active LN, while 5 (8%) for maintenance. Twenty-five out of 28 (89.3%) trials considered 'complete remission' (CR) as the primary outcome, and 3 (10.7%) studies used 'time to renal flare/time to treatment failure' as primary endpoint. When analyzing the definition of CR based on the inclusion of urine protein excretion, renal function (including serum creatinine, serum albumine, glomerular filtration rate, and/or estimated glomerular filtration rate), urinary sediment, and the SELENA-SLEDAI, we found that only 1 (4%) trial considered all these variables, 13 (52%) comprehended 3 items, 9 (36%) 2 items, and 2 (8%) included only one variable. In detail, protein excretion was included as a variable computed to define CR in 23 (92%) studies (with range of UPCR ranging from 3.2 to 0.3), renal function in 22 (88%), urinary sediment in 13 (52%), and SELENA-SLEDAI in 2 (8%) of the analyzed trials.

Conclusions We report an overall heterogeneity of the primary endpoints used in RTC in LN patients. With the armamentarium of treatments for LN potentially expanding, a better homogeneity in the choice of clinical outcomes is warranted to improve the comparability of the results, potentially leading to a more personalized approach to LN management.

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TREATMENT COMPLIANCE IN SYSTEMIC LUPUS ERYTHEMATOSUS: COMPARISON OF TWO QUESTIONNAIRES

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Background Lack of compliance to prescribed treatment is an ongoing problem in healthcare, leading to therapeutic failure and increased costs. Treatment compliance is defined by two related concepts: adherence and persistence during time. WHO estimates show that one every two patients with a chronic disease is not adherent. Studies on compliance in patients with Systemic Lupus Erythematosus (SLE) are scarce, especially in third world countries. Low treatment compliance can be presumed.

Different tools had been developed to assess compliance, been the Compliance Questionnaire on Rheumatology (CQR)

and the Morisky and Green questionnaire (MG) the most widely used.

The aim of this study is to evaluate the correlation between both questionnaires in SLE patients and to evaluate the relation between this instruments and SLE disease activity.

Methods Consecutive patients from our SLE unit were recruited in July and August 2018. The following variables were assessed: age, gender, ethnics, disease duration, occupation, monetary income, educational level, health insurance, place of residence, marital status, disease activity by SELENA-SLEDAI, accrual damage by SLICC-DI, current treatment and number of follow-up visits during the prior 12 months.

Compliance was assessed by CQR19 (compliant if 80%) and by MG (compliant if=0). Continual variables are expressed as mean and DS or median and interquartile range according to distribution. Categorical variables are presented as n(%). Association was assessed by chi2 or logistic regression as appropriate. Statistical analysis was performed using SPSS v21.

Results 70 consecutive patients were included. Baseline characteristics are shown in table 1.

Sensitivity and specificity for MG to detect lack of compliance was 90% and 42% respectively.

In our study, correlation between MG and CQR19 was found (RS=0.406, 0.01 bilateral; p=0.0005). However, none correlated with SELENA-SLEDAI, SLICC-DI. Both CQR19

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Age (mean±SD)	40.8±15.5
Women (n (%))	66 (94.3)
Half blood (n (%))	69 (98.6)
Place of residence (n (%))	CABA 22 (31.4)
	GBA 34(48)
	Country side 14(20)
Civil Status (n (%))	Single 39 (55.7)
	Married 22 (31.4)
	Divorced 8 (11.4)
	Widow 1 (1.41)
Education (n (%))	Primary School 16 (22.9)
	High School 28(40)
	Tertiary education 14(20)
	Collage education 12 (17.1)
Occupation (n (%))	Employed 24 (34.3)
	Unemployed 14(20)
	Student 4 (5.7)
	Housewife 12 (17.1)
	Retired 7 (10)
Health Insurance (n (%))	49(70)
Satisfaction with prescription (n (%))	Satisfied 60 (85.7)
	Half satisfied 1 (1.4)
	Unsatisfied 9 (12.9)
Trust in medical group (YES=n (%))	70(100)
Last year controls (media±SD)	2.96±1.39
SLEDAI (mean±SD)	2.07±3.047
SLICC (mean±SD)	039±0.839
CQR (n (%))	Adherent 40 (57.1)
	Non adherent 30 (32.9)
MORISKY GREEN (n(%))	Adherent 20 (28.6)
	Non adherent 50 (71.4)