151 RETINAL TOXICITY DUE TO HYDROXYCHLOROQUINE IN A SINGLE CENTER SYSTEMIC LUPUS ERYTHEMATOSUS COHORT

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Background The use of Hydroxychloroquine (HCQ) in Systemic Lupus Erythematosus (SLE) has been shown to decrease disease activity and all cause mortality. Retinal toxicity (RT) may limit its use and the pathogenesis of RT has not been fully established.

The aim of this study is to evaluate retinal toxicity in our SLE cohort.

Methods Our electronic SLE database (Jan 2014–June 2018) was evaluated. Patients fulfilling ACR 1997 criteria, with at least 1 year follow-up, at leats 12 week of HCQ treatment and computerized visual field (CVF) study performed who suspended HCQ due to RT were included. Patients with other HCQ suspension causes (intolerance, hypersensibility, muscular toxicity, skin rash) were excluded.

RT was defined as diminution in visual acuity and/or worsening in CVF below reference levels that required HCQ suspension or dose adjustment.

Other possible causes of retinal alteration (diabetes, arterial hypertension), cumulative dose of HCQ at the time of suspension, time of HCQ exposure and accrual damage by SLICC-DI at the time of suspension and at the last recorded visit were assessed.

Results 231 patients evaluated. 33 included. 10 (30%) reinitiated treatment at a later time, 5 with dose adjustment. HCQ suspension was definite in 23 (69.7%, 9.9% of the global population).

Patients with RT had mean age 44.5 (DS ±12,6) years; Ethnicity: Amerindian 6,06%, Caucasian 6,06% and Mestizo 87,8%; 12 (36.3%) had arterial hypertension and 2 (6.06%) diabetes.

Median Cumulative dose of HCQ at suspension was 576 gr (IQR 144–1008). 9 (27.2%) patiens had cumulative dose >1000 gr and 13 (39.3%)>5 years of exposure.

Mean SLICC-DI at suspension was 0.8 (DS ±1,2) and mean SLICC-DI at last visit was 1,17 (DS ±1,7).

22 (70.9%) patients with CVF worsening were receiving HCQ>5 mg/kg (real weight) and 23 (74.1%) were receiving HCQ>6.5 mg/kg (ideal weight)

Conclusions We observed a similar frecuency of HCQ suspension due to RT as reported in other studies. In our patients, there was no difference in RT between patients receiving <5 mg/kg (real weight) vs <6.5 mg/kg (ideal weight).

We found a higher frecuency of RT in patients with cumulative dose of HCQ <1000 gr and <5 years of HCQ exposure. This might challenge the American Society of Ophthalmology recommendation of CVF after 5 years of exposure or >1000 gr of cumulative dose.

A raise in the SLICC-DI score was observed after HCQ discontinuation, reaffirming the role of HCQ therapy in SLE.

A limitation is that RT was defined by CVF and was not routinely assessed by higher complexity studies (OCT). As a strength, RT was studied in the Mestizo population of Argentina, the dominant ethnicity, which might not be fully represented in previous international studies.

Abstract 151 Table 1 Cumulative dose in years

Year Kg	<1000	>1000
<5	20/33 (60,6%)	0
>5	4/33 (12,1%)	9/33 (27,2%)

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152 MEN AND SEXUAL FUNCTION: AN OVERLOOKED ISSUE IN SYSTEMIC LUPUS ERYTHEMATOSUS

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Background Whereas SLE is uncommon in men, the disease is usually more severe and requires more aggressive immunosuppression in male patients. There are multiple studies regarding sexual aspects in women with SLE, but information about sexual function in male patients is quite scant.

Methods We performed a longitudinal study in a third-level referral center in Mexico City (January–November 2018). We included men aged 16 years who fulfilled ACR criteria for SLE and who were sexually active in the previous six months. All subjects answered the International Index of Erectile Function-15 (IIEF-15), the SF-36 (which determines generic health-related quality of life) and the HAQ in two visits. Other clinical, serological and demographic variables were measured. Oxidized LDL was quantified by ELISA.

Results We included 108 male SLE patients. Mean age was 37.2±1.1 years and most patients (87.9%) were taking immunosuppressive therapy. Comorbidities were present in 58.3% of subjects, with dyslipidemia and hypertension being the most prevalent (34.2% and 28.7%, respectively).

The prevalence of sexual dysfunction (SD) was 53.7%. In the basal visit, the only significant differences between the patients with SD and those without SD were a lower education degree (p=0.007) and persistent lymphopenia (p=0.01). There was a positive correlation between global IIEF-15 score (gsIIEF-15) and global SF-36 score (r=0.459, p=0.0001). The physical function domain had the highest correlation (r=0.509, p=0.0001). Likewise, there was a weak negative correlation between gsIIEF-15 and HAQ score (r=−0.252, p=0.012). Also, the gsIIEF-15 had a weak correlation with the absolute lymphocyte count (r=0.273, p=0.005) and oxidized LDL (r=0.310, p=0.04).

In the follow-up visit the only significant differences between the patients with SD when compared with subjects without SD was a low absolute lymphocyte count (1031 ±89 vs 1458±119, p=0.005); the correlations mentioned in the baseline visit remained significant. Regarding erectile