Methods A retrospective analysis of 29 SLE patients with PTE admitted to our hospital from January 2009 to August 2018 was conducted.

Results Among the 29 patients, 26 (89.66%) were female and 3 (10.34%) were male. The age ranged from 23 to 66 years. The SLEDAI scores of 29 cases ranged from 0 to 18, with scores 15 points in 1 case (3.45%), 10–14 points in 9 cases (31.03%), 5–9 points in 11 cases (37.93%), 0–4 points in 8 cases (27.59%). Among the 29 patients, 13 patients (44.83%) were admitted to the hospital with chest pain or dyspnea as the first symptom. Only one case (3.45%) was admitted to the hospital with hemoptysis as the first symptom. Of the 29 patients, 21 (72.41%) had chest pain or difficulty breathing during the course of the disease. Among the 29 patients, 13 cases (44.83%) had SLE at the initial diagnosis, and the remaining 16 cases (55.17%) had SLE duration ranging from 1 month to 20 years, 3 (18.75%) in one year and 7 (43.75%) in 1 to 10 years. The course of disease was more than 10 years in 6 cases (37.50%). In this group of patients, 1 case (3.45%) with cerebral infarction, 2 cases (6.90%) with renal vein thromboembolism, and 14 cases (48.28%) with lower extremity venous thrombosis. Of the 29 patients, 3 were normal D-D dimers (normal value 0–0.55 mg/L), and the remaining 26 (89.66%) were elevated, with an average of 4.50 mg/L. All patients underwent echocardiography, 14 of whom (48.28%) indicated pulmonary artery widening. Of the 29 patients, 3 patients did not receive anticardiolipin antibodies, and of the remaining 26, 13 were positive and 13 were negative. In terms of prognosis, 3 of 10 patients (10.34%) died.

Conclusions SLE combined with PTE is easily missed and misdiagnosed. The clinical manifestations are not typical. In the active stage of SLE, or patients have chest pain and dyspnea symptoms, or test indicates that D-D dimer is elevated, or echocardiography indicates pulmonary artery widening, clinicians should think that it might be SLE merge PTE. For patients with anticardiolipin antibody negative, systemic lupus erythematosus should not be relaxed. During the treatment of patients with SLE combined with PTE, they should be alert to the occurrence of thrombosis in other sites.

Funding Source(s): NO

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CORTICOSTEROIDS IMPROVE PREGNANCY OUTCOME IN PATIENTS WITH OBSTETRIC ANTIPHOSPHOLIPID SYNDROME

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10.1136/lupus-2019-lsm.80

Background Recurrent pregnancy losses are the most common obstetric manifestation of antiphospholipid syndrome (APS). Despite standard therapy with low dose aspirin (LDA) and low molecular weight heparin (LMWH), the rate of successful pregnancies is not greater than 70%. Corticosteroids have been suggested as a potential therapy in these patients. Our aim is to describe a cohort of patients with obstetric APS treated with low dose corticosteroids.

Methods Retrospective study including 9 women diagnosed with primary APS. Clinical records were reviewed to obtain demographic and clinical data.

Results Two women had a history of thrombosis, while the remaining 7 had merely obstetric manifestations. All had suffered from early pregnancy losses and 1 of them also had a history of fetal death. We studied 42 pregnancies in these women. The mean number of pregnancies was 4.67 ± 0.71 per woman. Maternal age was 35.8 ± 4.6 years. Overall there were 30 abortions (71.4%) and 1 fetal death (2.4%). Regarding treatments used during pregnancy, 25 (59.5%) pregnancies were on some treatment: LDA (25), LMWH (24), corticosteroids (13), and intravenous immunoglobulins (IVIG) (4). As expected, in all pregnancies treated with corticosteroids, these drugs were combined with LDA and LMWH. When analyzing the effect of therapies, we found a tendency to decrease pregnancy loss in pregnancies treated with LDA (64 vs 82.4%; $p=0.3$) and LMWH (62.5 vs 83.3%; $p=0.18$). Treatment with corticosteroids significantly increased the rate of successful pregnancy (the rate of pregnancy loss was 38.5% in treated vs 86.2% in non treated pregnancies; $p=0.003$). The results of the global pregnancy analysis were confirmed by bivariate and multivariate GEE analysis. In the bivariate analysis, LDA tended to be protective (OR=0.38, CI 0.11–1.33; $p=0.129$) and LMWH and corticosteroids significantly protected against pregnancy loss (OR=0.34, CI 0.13–0.85; $p=0.021$; and OR=0.17, CI 0.06–0.51; $p=0.002$, respectively). After multivariate analysis, only corticosteroids remained inversely associated with pregnancy loss (OR=0.09, CI 0.012–0.683; $p=0.020$). However, the independent effects of LDA/LMWH could not be adequately tested because all patients on corticosteroids were also treated with LDA and LMWH. As adverse events, 2 cases of gestational diabetes and 1 of preeclampsia were observed.

Conclusions The addition of corticosteroids to standard therapy with LDA and LMWH seems to be safe and effective for improving the pregnancy outcome in women with obstetric APS.

Funding Source(s): This work was supported by a next-Val grant from IDIVAL (NVAL 17/19)

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ANTIPHOSPHOLIPID SYNDROME IN SYSTEMIC LUPUS ERYTHEMATOSUS LEADS TO A MORE SEVERE DISEASE

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10.1136/lupus-2019-lsm.81

Background Antiphospholipid antibodies (aPL) have been associated with organ damage and certain features in systemic lupus erythematosus (SLE) patients. Our aim was to

Abstract 81 Table 1 Main demographic data, clinical and laboratory features in the studied groups

	SLE no aPL, n (%)	SLE APS, n (%)	SLE aPL, n (%)	p
Female sex	2075 (90.9%)	455 (88.3%)	757 (90.1%)	0.178
Age, mean±SD (yr)	47.0±15.1	48.5±14.4	45.3±14.3	<0.001
Disease duration, mean±SD (mo)	141.5±100.7	156.8±109.8	136.4±94.0	0.001
Tobacco use:	335 (16.3)	91 (18.6)	125 (16.6)	0.743
• Current	494 (24.1)	119 (24.3)	189 (25.2)	
• Former				
High blood pressure	647 (28.6)	211 (40.1)	203 (24.4)	<0.001
Dyslipidemia	664 (30.3)	216 (41.9)	221 (27.3)	<0.001
Diabetes:				
Without organ damage	97 (4.3)	29 (5.6)	25 (3)	
With organ damage	17 (0.8)	8 (1.5)	3 (0.4)	0.022
Cutaneous manifestations	1700 (74.4)	358 (67.4)	611 (72.7)	0.005
Joint symptoms	636 (27.8)	164 (30.9)	204 (24.3)	0.022
Respiratory manifestations	241 (10.5)	125 (23.5)	70 (8.3)	<0.001
Cardiac manifestations	379 (16.6)	159 (29.9)	125 (14.9)	<0.001
Renal manifestations	862 (37.7)	249 (46.9)	298 (35.4)	<0.001
Neuropsychiatric manifestations	655 (28.7)	235 (44.3)	238 (28.3)	<0.001
Ophthalmological manifestations	315 (13.8)	111 (20.9)	103 (12.2)	<0.001
Positive anti DNA antibodies	1049 (46.9)	258 (50)	367 (45.1)	<0.001
Hypocomplementemia	1716 (76.7)	424 (82.8)	645 (77.9)	0.011

investigate the differences between SLE patients according to the presence of aPL and/or clinical antiphospholipid syndrome (APS).

Methods Patients from the RELESSER-T registry were included. RELESSER-T is a multicenter, hospital-based registry, with retrospective cross-sectional collection of data from a large representative sample of adult non-selected patients with SLE attending Spanish rheumatology services from the public national health system.

Results We included 3651 SLE patients and 1368 were positive for aPL (44.9% of patients were positive for anticardiolipin antibodies, 27.3% showed positivity for anti b2glycoprotein I and 24% for lupus anticoagulant). Overall 2283 patients were classified as SLE no aPL, 528 as SLE-APS and 840 as SLE-aPL. Demographic data, clinical and laboratory features in the different groups are showed in table 1. Regarding cardiovascular risk factors, SLE-APS patients had higher rates of hypertension, dyslipidemia and diabetes than SLE-aPL and SLE no aPL patients ($p<0.001$, $p<0.001$ and $p=0.022$, respectively). SLE-APS patients showed a lower prevalence of photosensitivity and higher frequencies of serositis, proteinuria (>0.5 grs), urinary cell casts, seizures and psychosis ($p<0.001$). Overall, SLE-APS patients showed a lower rate of cutaneous manifestations and higher rates of neuropsychiatric, cardiac, pulmonary, renal, joint and ophthalmological manifestations (table 1). In accordance with a more severe clinical profile, higher frequency of anti-DNA antibodies and hypocomplementemia were observed in the SLE-APS group ($p<0.001$). In addition to a higher disease activity (SLEDAI), SLE APS patients presented more damage accrual with higher values in SLICC (1.9 ± 2.2 in SLE APS, 0.9 ± 1.4 in SLE aPL and 1.1 ± 1.6 , $p<0.001$) and Katz indexes (3 ± 1.8 in SLE APS, 2.7 ± 1.7 in SLE aPL and 2.6 ± 1.6 in SLE no aPL, $p<0.001$).

Conclusions SLE-APS patients show a more severe clinical profile with higher frequency of major organ involvement and more damage accrual than SLE-aPL and SLE no aPL.

Funding Source(s): None

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DECREASED EXPRESSION OF ANKRD44 ASSOCIATES WITH THE OVERACTIVATION OF TYPE I IFN SIGNALING PATHWAY IN SLE

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10.1136/lupus-2019-lsm.82

Background Lupus is a complex chronic systemic autoimmune disease. Dysregulation of interferon-alpha (IFN-) response has been associated with the pathogenesis of lupus. Genetic variants constitute the risk factors for the development of lupus, with many SNPs identified to pose the risk of lupus. However, the functions of the host genes of these SNPs are not fully understood. Recent studies show SNP rs4850410 is associated with serum IFN- levels in European-Americans and African-Americans. Rs4850410 is located in the intronic region of ANKRD44 which encodes a subunit of ankyrin repeat domain of protein phosphatase 6 (PP6) that is involved in an array of important cellular processes, such as the regulation of metabolism, transcription, and apoptosis. However, if ANKRD44 regulates IFN responses is unknown. In this study, we aimed to investigate the function of ANKRD44 in controlling IFN response, and its association with the pathogenesis of lupus.