DESPITE THE HIGH RATE OF RESPONSE TO TREATMENT, A CASE OF LUPUS ENTERITIS SUCCESSFULLY TREATED WITH ANTI-TNFALPHA INHIBITOR

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Background Gastro-intestinal manifestations in systemic lupus erythematosus (SLE) can affect up to 40% of patients, including enteritis presenting as mesenteric vasculitis, pseudo-obstruction or protein-losing enteropathy. We present a case of lupus enteritis successfully treated with anti-TNFalpha inhibitor.

Methods A 28-year-old woman was evaluated for diarrhea, abdominal pain, fever and rectal bleeding not responsive to antibiotics. She had a thirteen-year history of SLE in remission with Mycophenolate Mofetil and previous mucoco- cutaneous and haematologic relapses, myocarditis and end-stage renal disease (IV-class glomerulonephritis). She previously underwent multiple immunosuppressants including cyclophosphamide, cyclosporine, anti-CD20, immunoglobulins. One month before the onset of symptoms she discontinued MMF for worsening anemia. Simultaneously we reported signs of lupic flare (low C3, haemolytic anemia, lymphopenia, fever, arthralgias and malar rash). Pulse-steroids and IVIg followed by cyclosporine were initially performed with only temporary benefit. Enteric CT-scan and endoscopy revealed chronic and/or early atherosclerosis in SLE is of value. In addition we showed impaired microcirculatory function as measured with EPOS in SLE patients. Further validation of macro and microcirculatory lesions are warranted in larger studies.

Results Seventy-six patients were included, mean age: 33 years; mean disease duration: 14 years; mean follow-up (since LN diagnosis): 8.5 years. LN class III, IV and V were present in 22%, 75% and 3% of the cases, respectively. Cyclophosphamide was the most used treatment to induce remission (55%). At 3, 6 and 12th months, the mean proteinuria was 2.3 g/24h, 1.53 g/24h, 1.1 g/24h, respectively (p<0.001). Fifty-five (77.5%) achieved complete response and 61 (84.7%) maintained remission.

Conclusions An absolute level of proteinuria below 0.7 g/day measured at 6 months is the best predictor of long-term renal outcomes.

Abstracts

P175 DESPITE THE HIGH RATE OF RESPONSE TO TREATMENT, LUPUS NEPHRITIS STANDARD OF CARE IS STILL ASSOCIATED WITH HIGH INCIDENCE OF CHRONIC KIDNEY DISEASE: A RETROSPECTIVE LONGITUDINAL STUDY, FROM THREE SOUTH-EUROPEAN CENTERS OF PATIENTS IN FOLLOW-UP SINCE 2000

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Background One of the most important complications of lupus nephritis (LN) is the chronic kidney disease (CKD) development.

Methods Multicenter retrospective observational study of SLE patients (ACR97) with biopsy proven LN attending to three South European Rheumatology departments in the last two decades. Variables: demographics; SLE-related, including global activity (SLEDAI-2K), renal flares, therapies, ACR response criteria and CKD. Statistical analysis: bivariate and multivariate analysis exploring factors associated to CKD. ROC curves and area under the curve were calculated to test each proteinuria level as predictor of long-term renal outcome.

Results Seventy-six patients were included, mean age: 33 years; mean disease duration: 14 years; mean follow-up (since LN diagnosis): 8.5 years. LN class III, IV and V were present in 22%, 75% and 3% of the cases, respectively. Cyclophosphamide was the most used treatment to induce remission (55%). At 3, 6 and 12th months, the mean proteinuria was 2.3 g/24h, 1.53 g/24h, 1.1 g/24h, respectively (p<0.001). Fifty-five (77.5%) achieved complete response and 61 (84.7%) complete or partial response. Median time to renal remission: 12.5 months (6,17.5). Sixteen (21.9%) patients developed CKD.

In the logistic regression model, using genetic algorithms, we found that proteinuria at 6 months was significantly associated with CKD (OR:2.95; 95%CI 1.19,9.29, p=0.03). Hypertension and male sex were marginally associated (p=0.06, both). The optimal cut-off point of proteinuria at 6 months was 0.7 g/day, (sensitivity: 50%; specificity: 93%).

Conclusions A considerable percentage of LN developed CKD. Proteinuria at 6 months was associated with CKD.