Methods We conducted a retrospective multicenter study among pediatric rheumatology centers in Oman over a 10-year period.

Results A total of 148 cSLE patients, n=44 males (30%) and n=104 (70%) females, with male to female ratio of 1:2.4 were included in the study. The overall mean age at diagnosis was 7.6 ± 3.5 years and median disease duration was 9.5 years. A total of 36% (n=53) of children with SLE were diagnosed with UV. cSLE with UV were more likely to be males (57% vs 15%; $p < 0.001$), with a family history of SLE (53% vs 36%; $p = 0.044$), diagnosed at a younger age (5.9 vs 8.5 years; $p < 0.001$) and originating from the Al-Sharqiya region of Oman (62% vs 29%; $p < 0.001$). Compared to cSLE without UV, the clinical features of UV cohort was more frequently associated with conjunctivitis (32% vs 5.3%; $p < 0.001$). However, the UV cohort was less likely to be associated with malar rash (5.7% vs 31%; $p < 0.001$), CNS involvement (20% vs 7.6% $p = 0.045$) and hematological manifestations such as leukopenia (9.4% vs 24%; $p = 0.028$), lymphopenia (28% vs 51%; $p = 0.009$) and thrombocytopenia (5.7% vs 18%; $p = 0.045$). When compared to cSLE without UV, the laboratory features of UV cohort was more likely to be associated with low C3 complement count (94% vs 66%; $p < 0.001$) and cytoplasmic antibody ANCA (11% vs 0%; $p = 0.022$). However, the UV cohort was less likely to be associated with ANA (65% vs 83%; $p = 0.016$), DsDNA (56% vs 72%; $p = 0.042$) and perinuclear anti-neutrophil cytoplasmic antibodies (33% vs 55%; $p = 0.047$).

Conclusion We describe relatively high occurrence of UV (36%) in a cohort of cSLE of Arab ethnicity with unique clinical and laboratory features. Further studies are needed to evaluate the relationship of UV with SLE and to study the role of genetic, ethnic and environmental factors in disease expression.

P45

ANA POSITIVITY IN IGA NEPHROPATHY: IS SYSTEMIC LUPUS ERYTHEMATOSUS COMING UP?

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Background IgA nephropathy is the most common chronic primary glomerulonephritis, leading to progressive renal failure in at least one third of patients. Although IgA nephropathy is a limited non-systemic renal disease, many systemic diseases are sporadically associated with mesangial IgA deposition. Henoch-Schönlein purpura, systemic illness, has been closely linked to IgA nephropathy. Other systemic diseases in which mesangial deposits of IgA are regularly observed include SLE, hepatitis, dermatitis herpetiformis, and ankylosing spondylitis. The occurrence of non-lupus glomerulopathies has been rarely reported in patients with SLE. We report of 11 patients with biopsy-proven IgA nephropathy and ANA positivity.

Methods Of all patients with biopsy-proven IgA nephropathy followed in our Unit we selected patients with ANA positivity.

Results Of 11 patients with IgA nephropathy and ANA positivity six were females, mean age was 32 ± 11 years. The median follow-up was 7 years (range: 3–38 years). Mean serum creatinine was 1.2 ± 0.75 mg/dl; mean 24h-proteinuria was 1.6 ± 2.3 g/day. In all patients there was low C3. In table 1 are summarized patient characteristics. All patients were on ACE-i or ARB therapy, of these three were treated with steroids, four received steroids+ immunosuppressive drug. Mean follow-up serum creatinine was 1.1 ± 0.7 mg/dl; mean follow-up 24h-proteinuria was 0.4 ± 0.3 g/day. One patient developed SLE.

Conclusions Our cohort suggests the hypothesis that IgA nephropathy could be a special subtype of Lupus Nephritis; however it needs more clinical observation and research.

P46

CASE REPORT: A PATIENT WITH HUMAN IMMUNE DEFICIENCY VIRUS MIMICKING SYSTEMIC LUPUS ERYTHEMATOSUS

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Background Systemic lupus erythematosus (SLE) is an autoimmune disease characterized by various clinical presentations. Human immune deficiency virus (HIV) causes acquired immune deficiency syndrome (AIDS) in case of progression of the infection. Patients with HIV can present different rheumatologic findings including arthralgia, arthritis, myalgia,

Abstract P45 Table 1 Patient characteristics and follow-up

N.	SEX	AGE (years)	sCreat at onset (mg/dl)	Uprot at onset (g/day)	Therapy	Follow-up (years)	sCreat (mg/dl) at follow-up	Uprot (g/day) at follow-up
1	F	32	1.6	0.9	steroids+MMF	7	1.9	0.3
	F	17	0.7	0.4	steroids	38	0.6	0.1
3	M	37	1.8	6	steroids+MMF	4	0.8	0.5
4	F	48	1.1	1	steroids+AZA	12	0.8	0.3
5	F	47	0.7	0.3	ARB	3	0.7	0.8
6	M	29	0.9	0.3	ACE-I	3	0.8	0.4
7	M	39	3	1	steroids+MMF	3	2.7	0.3
8	F	23	0.8	0.2	ACE-I	15	0.8	0.1
9	M	16	0.8	0.3	steroids	5	1	0.7
10	F	22	0.8	0.4	ARB	19	0.7	0.1
11	M	39	0.9	6	steroids	10	1	0.1

myositis, vasculitis, and gout. We herein present a patient mimicking SLE who was diagnosed with HIV.

Methods A 40-year-old man presented with a 3-month history of oral lesions and a 2-month history of blurry vision, vertigo, speech difficulty, and ataxic gait. His past medical history was unremarkable. His vital findings were within normal ranges. There were two oral lesions that were greater than 10 mm in diameter localized on the hard palate and tongue. Cerebellar tests including gait, finger-to-nose, and heel-to-shin were abnormal. He could not walk in tandem gait. However, muscle strength and sensory exam were normal.

On laboratory outcomes, fasting blood glucose, blood urea nitrogen, creatinine, and thyroid-function tests were normal. The rest of laboratory data were as follows: ALT 129 U/L, AST 102 U/L, GGT 72 U/L, hemoglobin 12.3 mg/L, WBC $3.6 \times 10^3/\text{mL}$, neutrophil count $1.8 \times 10^3/\text{mL}$, lymphocyte count $1.2 \times 10^3/\text{mL}$, CRP 1.5 mg/dl (normal, ≤ 5 mg/dl), ESR 42 mm/h.

Cranial MRI was reported as multiple hyperintense spots located on supratentorial white matter, corpus callosum, and brainstem on standard T2-weighted MRI sequence. On neurological consultation, these lesions were interpreted as encephalitis. Additionally, he was consulted to Ophthalmologist due to blurry vision. No pathological finding was found. He was also for autoimmune disorders causing cerebral involvement. Thus, ANA, ENA, anti ds DNA, ANCA were investigated. All autoantibodies, hepatitis screening, CMV, EBV, parvovirus B 19 were found negative. On the other hand, HIV positivity was detected by ELISA. Consequently, the patient was transferred to department of Infectious diseases.

Conclusion HIV causes autoimmune and systemic disorders via triggering immune dysregulation. The frequency of these autoimmune diseases has ranged from 1% to 60% according to literature. Both HIV and the treatment of HIV can cause rheumatologic findings.

P47 COGNITIVE IMPAIRMENT IN JSLE – THE ROLE OF INFLAMMATION

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Background Patients with juvenile-onset Systemic Lupus Erythematosus (jSLE) cope with physical and neuropsychiatric symptoms which may interfere with social and professional activities. Mild cognitive impairment may negatively impact quality of life and academic performance. We intend to assess cognitive state in JSLE and to explore laboratory and clinical markers associated with the presence of mild cognitive impairment.

Methods Thirty jSLE patients, currently aged ≥ 16 years, followed in an outpatient's unit performed the Mini Mental State Examination (MMSE) for cognitive testing; clinical and laboratory measures were collected from clinical records. Juvenile-onset was defined as age at diagnosis < 18 years. Statistical analyses were performed with SPSS software, version 25.

Results The mean age was 22.8(5.3) years with 90% females. Patients had a mean of 12.7(2.3) years of formal education. A mean MMSE of 27.7 (1.9) was found, and 23.3% of the population showed mild cognitive impairment. MMSE scores were negatively correlated with C-Reactive Protein (CRP) ($r = -0.38$, $p = 0.44$) and platelet count ($r = -0.37$, $p = 0.44$). Additionally, patients presenting positive anti-SSA ($n = 10$), anti-RNP ($n = 4$) and anti-SM ($n = 4$) autoantibodies, scored significantly lower MMSE scores compared to patients without these autoantibodies ($p = 0.029$; $p = 0.017$ and $p = 0.017$, respectively).

Conclusions Our population showed a low mean MMSE score, regardless of their educational level and age. The consistent relationship between the presence of cognitive impairment, higher inflammatory activity and autoantibodies frequently associated with neuropsychiatric involvement in jSLE seems to point to the need to screen jSLE populations for mild cognitive impairment with larger studies being required.

P48 ARE NEW 2019 SLE EULAR/ACR CLASSIFICATION CRITERIA USEFUL IN PATIENTS WITH RHUPUS?

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Background Concomitant presence of systemic lupus erythematosus (SLE) and rheumatoid arthritis (RA) in the same patient is known as Rhupus. Poliautoimmunity is not an uncommon phenomenon reported, but only a small series of patients have been described so far with Rhupus. This study aimed to explore the utility of 2019 EULAR/ACR criteria in patients with Rhupus.

Methods Cross-sectional study conducted in 11 Rheumatology Departments at Catalonia (Spain). We included prevalent cases classified as Rhupus (RA ACR/EULAR 2010 and SLE-ACR 1997). Data of patients with SLE were selected as control in a ratio 2:1, matched by sex.

Results 120 patients were included, 40 Rhupus and 80 SLE alone as controls. 95% were female, with a mean age of 51 yrs and mean of 13 yrs. The 2019 SLE EULAR/ACR criteria were met in 92,5% of the Rhupus and in the 96,3% of the SLE cohort ($p > 0.05$). Numerically, criteria score was higher in those patients with 'pure' SLE than Rhupus (21.3 ± 7.0 vs 18.8 ± 6.5 , $p = \text{NS}$). Excluding articular domain, there were no significant differences among those who meet new criteria (65% Rhupus vs. 77% SLE ($p > 0.05$)). Proteinuria was the only domain significantly more common in patients with SLE alone. No other differences were found in other clinical or serological characteristics.

Conclusion More than 90% of patients classified as Rhupus criteria fulfilled new SLE criteria. This study shows that the new 2019 SLE EULAR/ACR criteria are not useful to differentiate SLE and Rhupus patients. Further investigations are needed to measure their utility in clinical practice for detecting overlap presentation of RA and SLE.