DIFFICULT TO DIAGNOSE SLE MANIFESTATIONS ASSOCIATED WITH CARDIAC ARREST, MYOCARDITIS, CHRONIC PERICARDITIS, POLYNEUROPATHY

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Introduction Cardiac manifestations and polyneuropathy in lupus are common, although clinically manifest myocarditis is rare, estimated at 9%.

Case report Female patient 44 years old came to the Emergency Department due to general weakness and dizziness. She has lost 14 kg in the last 3 months, she has subfebrility, fatigue, hair loss, joint pain. A cardiac arrest with ventricular fibrillation (VF) occurred during the examination. Successful resuscitation was performed. Echocardiography indicates an ejection fraction (EF) of 5% and contractility disorder. Mechanical circulatory support to venous-arterial extracorporeal membrane oxygenation (V-A ECMO) was introduced. Extensive cardiac treatment and work up was done, coronaryography (normal), myocardial biopsy (lymphocytic myocarditis less likely gigantocellular), pericardial biopsy (chronic pericarditis), lysis of pericardial adhesion with improvement in EF. Cardiac MRI verifies diffuse inflammatory myopericarditis. The serology on Chlamidophila pneumonia was positive. Tetracycline therapy was started. Asymmetric tetraparesis occurred during cardiac treatment, muscle biopsy was...
without inflammatory infiltrate, cervical and thoracic spine MR was normal, EMNG indicated polynephropathy, and she was diagnosed with Critical illness polyneuropathy. There was a suspected ischemic lesion on the brain MR temporoparietally to the right. Thoracic CT was normal. In that moment, she was transferred to the Department of Immunology. The treatment was started according to cardiac guidelines for myocarditis, solumedrol 1 mg/kg, and 90 mg IVIG for 3 days after which she started recovering neuromuscular symptoms. Of the SLICC criteria she had nonscarring alopecia, arthritis, serositis, positive ANA, 1:320, homogenous, ds DNA, low complement (C3, C4). In maintenance therapy, she has a low dose of glucocorticoids, azathioprine 100 mg and has been in remission for 2 years.

Conclusion The patient had complications in unrecognized systemic lupus, critical illness polyneuropathy, infectious myocarditis and chronic constrictive pericarditis, who recovered only from cardiac support and medication. Accurate diagnosis in SLE-mimicking symptoms is possible with extensive diagnostics.

**TRENDS IN MORTALITY IN SYSTEMIC LUPUS ERYTHEMATOSUS: AN ANALYSIS OF SLE INPATIENT MORTALITY AT UNIVERSITY HOSPITAL COVENTRY AND WARWICKSHIRE NHS TRUST FROM 2007–2016**

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**Background** The aim of this study was to determine the causes of mortality in patients with systemic lupus erythematosus (SLE) at the University Hospital Coventry and Warwickshire (UHCW) NHS Trust over a 10yr period.

**Methods** This was a retrospective study of patients who had died in UHCW NHS Trust between 2007 and 2016, where SLE or lupus was mentioned on the death certificate. Ethics approval was obtained from the Research and Development. We identified 22 patients out of 1979 patients with SLE who had died during the period between 2007-2016, 7 of these patients were under 50. The leading cause of death was infection. Active disease was associated with higher mortality and younger age of death. We identified 3 patients with biopsy proven lupus nephritis and 1 patient with CNS lupus. Median age at death was 58.5 years, with median duration of disease of 14.5 years. Constitutional symptoms were the main symptoms of system involvement found in our study population, seen in 68.2%. Surprisingly, none of the patients died because of vascular problems.

**Conclusion** The study suggests a changing trend in SLE mortality with none of the deaths in this cohort being due to cardiovascular or cerebrovascular disease. Infection continues to be the biggest reason for mortality in this cohort.

**Note** This abstract is due to be published as a full paper in the Rheumatology International Journal.