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 polyneuropathy, and she
was diagnosed with Critical illness polyneuropathy. There
was a suspected ischemic lesion on the brain MR tempo-
parietally to the right. Thoracic CT was normal. In that
moment, she was transferred to the Department of Immunol-
ogy. The treatment was started according to cardiac guide-
lines 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 alope-
cia, 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 sys-
temic lupus, critical illness polyneuropathy, infectious myocard-
ditis and chronic constrictive pericarditis, who recovered only
from cardiac support and medication. Accurate diagnosis in
SLE-mimicking symptoms is possible with extensive diagnosti-
cs.

P51 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 erythema-
tosus (SLE) at the University Hospital Coventry and Warwick-
shire (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.

Results 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%. Surpris-
ingly, none of the patients died because of vascular
problems.

Conclusion The study suggests a changing trend in SLE mor-
tality with none of the deaths in this cohort being due to car-
diovascular 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
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P52 THE RELATIONSHIP OF VITAMIN D LEVELS WITH
DISEASE ACTIVITY IN SYSTEMIC LUPUS
ERYTHEMATOSUS

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Background Vitamin D is known to exert a potent immuno-
modulatory action. It has immunostimulatory properties and
in parallel exerts immunosuppression and inhibits tissue
destruction related to autoimmunity. Vitamin D deficiency,
thus, is related to immune activation and the development of
autoimmune diseases. Systemic lupus erythematosus (SLE)
is an autoimmune disease affecting all organ systems.
It develops in all age groups, however young female patients
are particularly vulnerable. Vitamin D status is currently
assessed by the measurement of 25(OH)D3 levels. The aim
was to assess vitamin D levels in a cohort of SLE patients
and examine the relationship of vitamin D levels with dis-
ease activity. Measurements were also performed in a con-

Methods In a cohort of 30 SLE patients, 27 female and 3
male and a control group 25(OH)D3 levels were measured. In
all SLE patients clinical and laboratory examination was per-
formed to assess the activity of the disease. Serum inflamma-
tion markers were measured. 25(OH)D3 levels were measured
by radioimmunoassay. The measurement of 25(OH)D3 was
performed in a two-step procedure. The first step aimed at
rapid extraction of 25(OH)D3 and other hydroxylated metabo-
lites from serum or plasma with acetonitrile. Following extrac-
tion, samples were assayed by competitive RIA using an
antibody with specificity to 25OHD. The sample, antibody
and tracer were incubated for 90 min at 20°C. Phase sep-

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