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 temporarily 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.

Conclusion The patient had complications in unrecognized systemic lupus erythematosus (SLE) at the University Hospital Coventry and Warwickshire (UHCW) NHS Trust over a 10yr period. Ethical approval was obtained from the Research and Development. Ethics approval was obtained from the Research and Development.

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. 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.