OR = 9.3 for adults with DScores of 2–3 and 4–6 [compared with DS 0–1], respectively. Odds of CS (vs FS) were also higher with higher DScores (OR = 6.9 and OR = 7.6 for adults with a DS of 2–3 and 4–6 [compared with DS 0–1], respectively).

Conclusion Smoking is highly prevalent in patients with pCCLE. DScores were positively associated with CS and inversely associated with FS. Smoking cessation is particularly important for adults with pCCLE, and such efforts should target individuals from the most disadvantaged sociodemographic groups.

Acknowledgements The GOAL Cohort is supported by the Centers for Disease Control and Prevention (CDC) Grant 1U01DP005119. The content of this research is solely the responsibility of the authors and does not necessarily represent the official views of the CDC. The authors have no conflicts of interest to declare.

Background This systematic review of literature and meta-analysis aimed to determine the prevalence, phenotype and treatment of systemic lupus erythematosus (SLE) in Native sub-Saharan Africans.

Methods PubMed, EMBASE, Web of Science, African Journals Online, and Global Index Medicus as well as references of retrieved papers were searched to select studies addressing SLE in Native sub-Saharan Africans and published during January 1, 2008- October 7, 2018. Results were pooled through narrative review and random-effects model. Heterogeneity (I²) was assessed via the χ² test. Pooled estimates are expressed with 95% confidence intervals. This study is registered with PROSPERO: registration number CRD42019139226.

Results Fifteen hospital-based studies were included out of 1502 records. The pooled prevalence of SLE was 1.7% (0.8–2.9). The mean age at diagnosis ranged from 28.8 to 39.2 years. The female proportion was 88%–100%. Rheumatological (5.1%–99.9%), dermatological (4.3%–100%) and hematological (1.4–86.9%) manifestations were the commonest. Patients had a high seroprevalence for anti-ribonucleoprotein 57.9% (36.4–77.9), anti-Smith 53.5% (40.4–66.2), anti-Sjögren syndrome antigen A 45.6% (19.2–73.4) and anti-Sjögren syndrome antigen B 33.7% (13.6–57.6) autoantibodies. The most used treatments were corticosteroids 99% (94.9–100) and antimalarials 62.8% (23.3–94.1). The pooled mortality rate was 10.3% (3.3–20.6); mainly due to infections, kidney and neurological involvement.

Conclusions Over the last 30 years, SLE was not rare among Native sub-Saharan Africans and its featured characteristics were earlier onset, female predominance, and high seropositivity for extractable nuclear antigen autoantibodies. The standard treatments were corticosteroids and antimalarials. The mortality rate was high. Population prevalence and incidence as well as full description of SLE characteristics in Native sub-Saharan Africans are needed.
Methods Single-centre retrospective observational study. Patients with biopsy-proven proliferative, membranous or mixed LN were included. Individual clinical files were reviewed to obtain demographic, clinical, laboratory and pathological data. Cox regression analysis was performed to investigate predictors of progression to ESRD and Kaplan-Meier curves were obtained.

Results We studied 187 LN patients (135 proliferative, 38 membranous and 14 mixed LN), followed for up to 42 years (mean 13±9 years). Cumulative renal survival rates at 5, 10, 15 and 20 years were 93%, 85%, 78% and 70%, respectively. In univariable analysis, urinary protein/creatinine ratio (uPCR) above 42 mg/mmol or estimated glomerular filtration rate (eGFR) below 76 mL/min/1.73 m², one year after the diagnosis of LN, were the strongest predictors of progression to ESRD (figure 1), with hazard ratios (HR) of 8.081 [95% CI:1.856–35.179] and 4.985 [95%CI:1.964–12.651], respectively. HR for uPCR and eGFR at the time of diagnosis were considerably smaller (2.508 [95%CI:1.062–5.922] and 2.833 [95%CI:1.156–6.945]) respectively. Other factors associated with increased risk of ESRD were Afro-Caribbean ethnicity (HR=3.861 [95%CI:1.817–8.206]), proliferative LN (HR=3.423 [95%CI:1.049–11.173]), not having taken antimalarials (HR=2.180 [95%CI:1.089–4.363]) and poorly controlled diastolic blood pressure (HR=1.016 [95%CI:1.001–1.030]). The effect of uPCR and eGFR at one year remained significant after adjusting for ethnicity, histological class, uPCR and eGFR at the time of diagnosis, use of antimalarials and diastolic blood pressure (table 1).

Conclusions uPCR above 42 mg/mmol and eGFR below 76 mL/min/1.73 m², one year after the diagnosis of LN, were the strongest predictors of progression to ESRD.