patients with surgery, 1 patient with radiotherapy and 5 patients were not treated: 3 patients had to short follow-up or were lost, 1 died, 2 developed a DLBC, 4 were stable and 7 were in complete remission. Conclusions: IBCL and DLBCL were the most common type of lymphomas in SLE patients. Data suggest a role for EBV not only for exogenous immunosuppressant in the pathogenesis of SLE-associated lymphoma. The outcome of lymphoma in the setting of SLE seems not different from the outcome of lymphoma in the general population. A case-control study is ongoing to study the risk factors associated with the occurrence of lymphoma in SLE.

Disclosure of Interest: None declared


SAT0460

LONG-TERM IMMUNE PROTECTION FOLLOWING PNEUMOCOCCAL 13-VALENT/23-VALENT POLYSACCHARIDE VACCINE IN SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)

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Background: Systemic lupus erythematosus (SLE) patients are at increased risk for Streptococcus pneumoniae infection. Although pneumococcal vaccination is an attractive method to prevent invasive pneumococcal infection, vaccination coverage remains dramatically low in SLE. Moreover, the efficacy of vaccination may be reduced in SLE patients and sequential pneumococcal vaccination using new conjugated pneumococcal vaccines in combination with 23-valent pneumococcal polysaccharide vaccine (PPV23) is now advocated.

Objectives: We aimed to determine the efficacy of the prime-and-booster vaccination strategy using the 13-valent pneumococcal conjugate (PCV13) and 23-valent polysaccharide (PPV23) vaccines in SLE.

Methods: Consecutive SLE patients admitted from April to December 2015 in our daycare hospital unit (Paris, France) were enrolled to receive PCV13 vaccine followed by PPVS23 vaccine 8 weeks later. Immune protection, defined by an anti-gen-specific IgG concentration ≥1.3 μg/mL for at least 70% of 7 pneumococcal serotypes (4, 6 B, 9 V, 14, 18 C, 19 F, 23 F), was assessed at baseline, 2 and 12 months. The primary endpoint was immune protection 12 months (long-term) after PCV13 shot.

Results: 37 consecutive adult SLE patients admitted in our daycare hospital unit (Department of Internal Medicine, Bichat Hospital, Paris, France) were screened for pneumococcal vaccination. Among them, 8 patients were not vaccinated, 7 patients accepted the vaccination but refused to complete the 12 months immune response follow up and 1 patient had already been vaccinated against pneumococcal infection essentially (40–77 years; 85.7% female) SLE patients were included in the study and received the sequential PCV13/PPV23 pneumococcal vaccines. Only 12 patients (57.1%) reached the primary endpoint. Nine patients had no long-term protection with a seroconversion that never (n=4, not protected, NP) or only transiently (n=5, short-term protected, STP) occurred. B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status. A lower IgG2 serum level and a higher ratio of pre-germinal/post-germinal B-cells defects and immunosuppressive treatment were associated with the NP status.

Conclusions: The benefit of sequential PCV13/PPV23 vaccination in SLE is limited. Several factors are associated with long-term immune protection and may help to design selective schedule strategy and/or new vaccines.

Disclosure of Interest: None declared


SAT0462

PD-1+CXCR5-CDA4 T CELLS MAY PLAY AN IMPORTANT ROLE IN THE SEVERITY OF SYSTEMIC ERYTHEMATOUS LUPUS

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Background: CD4+ T cells are central mediators in specific autoimmune diseases; however, it remains challenging to define their key effector functions in systemic erythematous lupus (SLE), a chronic immune-mediated disease to the whole system. Programmed death 1 (PD-1), a negative T cell regulator to maintain peripheral tolerance, induces negative signals to T cells during interaction with its ligands. PD-1+CD4+ T cells could be divided into PD-1+CXCR5-CD4+ T (Tph) cells, which are known to promote B cell responses and antibody production in rheumatoid arthritis Rao DA, Nature, 2017. Tph cells were required for the generation of memory B cells and long-lived plasma cells in SLE. However, what the role of Tph cells in the pathogenesis of SLE was unknown.

Objectives: We assessed that whether Tph cells were associated with clinical profiles of patients with SLE.

Methods: This cohort study included 36 patients with SLE from the Division of Rheumatology, the first Affiliated Hospital, college of medicine, Zhejiang University. All SLE patients fulfilled the American College of Rheumatology revised classification criteria. 26 Age- and sex-matched healthy individuals had no connective tissue disorders, neoplasms or current infections. Here we used flow cytometry to analyse PD-1+CXCR5 CDA4 T cells in peripheral blood from patients with SLE. Correlation between Tph cells and other parameters was investigated by Spearman’s correlation coefficient test, and comparisons between groups were performed using nonparametric Mann-Whitney test.

Results: Firstly, we revealed a markedly expanded population of Tph cells (9.5 ± 6.35 vs. 2.67±1.22, p<0.0001) in the circulation of patients with SLE (n=36).