During treatment, 58% of patients (n=53) showed an improvement of $\geq 20\%$ and 23% of $\geq 50\%$, based on physicians' evaluation of disease activity. This was consistent with an improvement of SELENA-SLEDAI (mean) from 8.0 at therapy start to 3.6 after six months on the basis of all available data (n=27). Similar outcomes were observed for arthritis, fatigue, rash, dsDNA antibody and complement levels.

Among the 42 patients treated with GC at time of belimumab initiation, GC dose was reduced by 5.7 mg/day (mean) during treatment with belimumab (11.6 $\pm$ 5.9 mg/day at six months). During the six months before initiation of belimumab, GC dose was stable or had to be increased in the majority of patients; however, during the six months therapy with belimumab, GC dose could be reduced in the majority of patients and GCs was discontinued in two patients. The percentages of patients receiving SLE co-medication other than GC were stable over the first six months of belimumab therapy. Within the first six months of treatment, no included patient had discontinued therapy with belimumab.

Conclusions: Treatment with belimumab over six months after initiation led to clinical improvement in a significant number of patients in real life settings and had an overall steroid-sparing effect. Belimumab was well-tolerated; no included patient discontinued the treatment within the first six months.

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AB0529 AN AUDIT FOR SCREENING OF OSTEOPOROSIS AND ITS MANAGEMENT IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: Systemic lupus erythematosus (SLE) is an autoimmune, multi-system, chronic inflammatory condition. It is managed with long-term immunosuppressive therapy which includes steroid use. SLE is therefore considered an independent risk factor for osteoporosis.

Objectives: This clinical audit was undertaken to evaluate the screening of osteoporosis in patients diagnosed with SLE and assess adherence to national guidelines for the management of patients with low bone mineral density (BMD) on prolonged steroid therapy.

Methods: We studied 64 SLE patients seen at the Leicester Royal Infirmary. Demographic and clinical data was collected from the clinic letters. Steroid use for a cumulative period of over 4 weeks per year was considered significant and use of bisphosphonates or calcium and vitamin D supplements alone were taken into account for bone protection. BMD measurements by dual X-ray absorptiometry were performed. Osteoporosis was defined as a T score less than -2.5 SD in at least 1 region of measurement.

Results: Of the 64 patients studied, 54 (84.4%) were female and 10 (15.6%) male with an age range of 23 to 86 years and mean age of 47.45 years. Steroids were used in 46 (71.9%) patients while 18 (28.1%) patients did not receive any steroids. Twenty-one (32.8%) patients had DEXA scans and whilst 43 (67.2%) had not. Of those who had received steroids, 20 (43.4%) patients underwent DEXA scans and 26 (56.5%) did not. Osteoporosis was diagnosed in 3 (14.3%) patients out of the 21 scanned. The therapies used are summarised in figure 1.

Abstract AB0529 – Figure 1. Bone protection (n=64)

Conclusions: Studies have shown that SLE is an independent risk factor for low BMD and use of corticosteroids is already a well-recognised risk for osteoporosis. Our study has shown that a large section of patients (43.8%) did not receive any form of bone protection although, a significant proportion (71.9%) were on oral steroids. Although a small section of those scanned demonstrated osteoporosis (14.3%), many patients were already initiated on bisphosphonates without a DEXA. There was also no exclusion criteria set for young patients (age <45 years) or those who were newly diagnosed. Despite this, our study demonstrates the need for robust guidelines for the screening and management of bone health in patients with SLE in order to improve morbidity and mortality rates in this patient cohort.

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AB0530 TREATMENT OUTCOME IN LUPUS NEPHRITIS PATIENTS TREATED WITH MYCOPHENOLATE MOFETIL: FROM REAL-WORLD CLINICAL PRACTICE

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Background: Systemic lupus erythematosus (SLE) is a systemic autoimmune disease often characterised by the development of glomerulonephritis.¹ There is a growing interest in the use of mycophenolate mofetil (MMF) as induction therapy and maintenance therapy for lupus nephritis.^{2,3}

Objectives: This study aimed to evaluate the therapeutic outcome of MMF in lupus nephritis from real-world clinical practice, and identify the predictors for failure of remission after MMF treatment.

Methods: Korean patients with pathologically proven lupus nephritis class III, IV, and V were recruited from rheumatology clinic in Severance Hospital, Yonsei University College of Medicine between Nov 2011 and Aug 2017. Patients who treated with MMF for at least 3 months were included in the analysis. The probability of remission after MMF therapy, and the difference between patients who achieved remission or failed to achieve remission were analysed using Kaplan-Meier analysis and Cox proportional hazards model.

Results: Of 153 patients with lupus nephritis, 116 patients were included in this study. Seventy two patients continued MMF until the last follow-up. The mean age of patients was 34.2 years, and the median duration of SLE was 5.7 months. Anti-dsDNA antibody was positive in 82.8% of patients, and 9.5% of patients showed a histological class with pure V pathology. Mean protein/creatinine ratio in spot urine was 4.6, and active urinary sediment was found in 82.8% of patients. During median follow-up period of 5 years, 80% of patients achieved clinical remission of lupus nephritis. Median time to remission was 4.2 months (IQR 0.9–9.1). Risk factors for failure of remission were nephrotic-range proteinuria and seronegativity of anti-dsDNA antibodies.

Conclusions: This study shows the real-world data on MMF treatment in patients with lupus nephritis. Patients with risk factors for failure to remission may require more intensive treatment and management.

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