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AB0548

ANTIBODY TO PURINNUCLEOSIDE PHOSPHORYLASE CAN BE USED AS AN ADDITIONAL MARKER OF INFECTIOUS COMPLICATIONS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: Purine nucleoside phosphorylase (PNP, EC 2.4.2.1) plays a leading role in the assimilation of nucleosides and nucleotides by the cell, as well as in maintaining the immune status of the organism. Patients with PNP deficiency are highly susceptible to various infections, in view of the fact that the decreased activity of PNP is closely related to the insufficiency of cellular immunity.

Objectives: Study of the possibility of using the level antibodies to purine nucleoside phosphorylase as an additional marker of infectious complications in patients with systemic lupus erythematosus (SLE).

Methods: The study included 60 patients with SLE (women – 91.7%, mean age 36.32±15.27 years, average duration of the disease 7.96±7.35 years) with different clinical manifestations (SLEDAI activity 8.93±5.74, ECLAM activity 5.30±2.79, damage index SLICC/ACR 1.95±1.71). Antibodies to PNP (anti-PNP) were determined in our indirect ELISA test using the immobilised form of the enzyme as an antigenic matrix.

The presence of infectious complications in SLE patients was assessed by characteristic clinical manifestations and was considered to be confirmed when the causative agent was recognised and/or the serological analyses are positive. Infections were diagnosed in 38.3% of patients, the most frequent localization was the urinary system (n=12; 52.2%) and female genitalia (n=5; 21.7%).

Results: In the presence anti-PNP in the blood serum of patients with SLE we have often noted infectious complications (p=0.025, criterion χ^2) and less often lung damage (p=0.17) (when compared with a group of patients with SLE seronegative for the presence of anti-PNP).

Statistically significant differences (Mann-Whitney U-criterion) were detected only for pyuria (p<0.0005), C-reactive protein level (p=0.048) and the number of ceruloplasmin (p=0.008), while comparing the groups of SLE patients with the presence of infectious complications and without it; differences in the level of antibodies to CP (p=0.052) did not reach statistical significance. Other clinical and laboratory parameters do not have statistically significant differences between the two sessions. This fact complicates the recognition and differential diagnosis of infectious complications in SLE significantly.

The analysis of the characteristic curve of antibodies to PNP in the diagnosis of infectious pathology in SLE shows limited possibilities for using this parameter. The square under the curve was 0.687 (95% confidence interval 0.523–0.804, p=0.008), the separation point was 0.386 U/ml with a sensitivity of 55% and a specificity of 83%.

Taking into account that the typical clinical manifestations of infection with SLE can be erased as a result of the actual activity of SLE, and due to the use of immunosuppressive drugs, timely diagnosis and treatment become especially relevant. This study indicates the possibility of using the level of antibodies to PNP as an additional marker of infection, but the balance between specificity and sensitivity of this test does not allow to recommend it as a single study.

Conclusions: A high level of anti-PNP in the serum, especially combined with the C-reactive protein increase and in the absence of other markers of SLE activation allows to suspect the presence of infection and points to the need for in-depth research directed to identify the pathogen.

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AB0549

CAN THE OVERALL THROMBOTIC RISK IN SYSTEMIC LUPUS ERYTHEMATOSUS BE DETERMINED? THE COMBINED ROLE OF CLASSIC CARDIOVASCULAR FACTORS AND ANTIPHOSPHOLIPID ANTIBODIES

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Background: Systemic Lupus Erythematosus (SLE) is a chronic inflammatory disorder. Antiphospholipid syndrome (APS) is a thrombotic disorder associated with the presence of antiphospholipid antibodies (APA) and increased cardiovascular risk (CVR). Framingham (FRM) and SCORE (Systematic Coronary Risk Evaluation) scales are available CVR assessment systems. aGAPSS (adjusted Global Antiphospholipid Syndrome Score) combine positive APA and CVR factors, which was suggested to determine the thrombotic risk in persistently positive APA (PPAPA) patients.

Objectives: To determine the role of the thrombotic factors in SLE patients, considering CVR factors and APA. To access the application of different thrombotic risk scales.

Methods: A retrospective cohort study of 84 patients with SLE followed in an out-patient setting of a Portuguese central hospital was performed. The study evaluated patient gender, current age, age at diagnosis, duration of illness, presence of another autoimmune disease (AID), CVR factors [obesity (OB), diabetes (DB), arterial hypertension (AH), dyslipidaemia (DL), smoking (SM)], presence of APA, treatment, dose and duration of steroids. The FRM, SCORE and aGAPSS scores were calculated. The data was analysed using SPSS and considered significant if p<0.05.

Results: Table 1 characterises the study population. Male patients had a higher prevalence of AH (p=0.022), DL (p=0.047), and SM (p=0.001), with a risk of 11%–20% in the FRM scale and a risk of 5%–14% in the SCORE (p=0.000). Female patients had a higher presence of another AID (p=0.014) and treatment with disease-modifying antirheumatic drugs (p=0.014). FRM scale reveals a risk of 11%–20% in the presence of AH and >20% in SM (p=0.001). The SCORE scale reveals a risk of 5%–9% in the presence of AH (p=0.003) and 10%–14% in DL (p=0.024). When the risk is 6%–20% in the FRM scale, the risk is lower in SCORE (p=0.000). APA does not correlate with an increased CVR. All APA are associated with another AID, APS and PPAPA. The aGAPSS associates a score of 7–12 if another AID is present (p=0.000); 4–9 with APS; >7 with PPAPA (p=0.000); 4–6 with DB (p=0.039), DL (p=0.002) and AH (p=0.000); >7 with lupus anticoagulant (LA), >7 with anticardiolipin antibodies (aCL) and >12 with anti-β-2glycoprotein-I antibody (antiβ2GPI) (p=0.000).

Abstract AB0549 – Table 1

Women	74%
Current age	52.3±16.2 years
Age of diagnosis	44.9±17.4 years
Duration of disease	7.2±7.5 years
Another AID	30% (APS 60%, Sjögren syndrome 36%)
PPAPA	12%
CVR	AH 42.8%, DL 21.4%, OB 11.9%, DB 10.7%, SM 9.5%
APA	LA 19%, aCL 15.5%, antiβ2GPI 7.1%
Steroid use	61%
DMARDs	89%

Conclusions: This study highlights the existence of thrombotic factors in SLE. Their risk is even more elevated when another AID is present. The FRM and SCORE scales reflects the CVR. In SLE patients both the CVR factors and the presence of APA must be evaluated. Therefore, not only should the FRM scale be calculated, but also the global thrombotic risk, using the aGAPSS, must be accessed.

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AB0550

CLINICAL-EPIDEMIOLOGICAL FEATURES OF PATIENTS WITH A LATE-ONSET LUPUS IN A TERTIARY CARE HOSPITAL

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Background: Different frequency of clinical and serological manifestations has been detected according to the age of onset of the patients with Systemic lupus erythematosus (SLE). According to the literature, senile SLE manifests between 6% and 18% of the patients with lupus.

Objectives:

1. To identify and analyse the clinical-serological and epidemiological features of senile SLE in our environment.
2. To determine the average survival time and mortality in these patients, identifying its main cause.

Methods: Observational retrospective study of 319 patients diagnosed with SLE (according to ACR 1992 and SLICC 2012 criteria) at the Hospital of León between 1997–2017 and with an age of onset ≥ 65 years, obtaining a total of 68 patients with senile SLE.

Results: The mean age at diagnosis was 75.4 ± 12.1 years, with a female/male ratio of 2.4. The most frequent manifestations were as joint (63.2%) and haematological manifestations in the form of leuco-lymphopenia (55.9%). The hemolytic anaemia only appeared in 2.9% of the cases and the thrombocytopenia in 25%. 36.8% of patients showed photosensitivity and 29% had other cutaneous manifestations, being the malar erythema the most prevalent type (60%), followed by the discoid lupus erythematosus (20%) and the subacute lupus (15%). Alopecia was only observed in 4.4%. Lupus nephritis was detected in the form of proteinuria in 4.4% of the patients, and only one patient had microscopic haematuria. Lung involvement was uncommon (8.8%), taking precedence the UIP (33.3%) over the rest of the pulmonary manifestations. Only 11.1% of the patients with senile SLE had serositis, being in the form of pleuritis in 75% of the cases, pericarditis in the 37.5% and ascites in the 12.5%. Regarding the neurological involvement, 5 patients showed polyneuropathy and 1 had chorea. Likewise, the frequency of Sjögren, Raynaud and secondary antiphospholipid syndrome was of 16.7%, respectively.

The most important serological findings were: 97.3% ANA; 44.1% DNA and 20.6% hypocomplementemia, with 54.4% of the patients having serological activity. Only 5.9% had anti-Sm. Antiphospholipid antibodies were positive in 41.2% of the cases, with 4.4% of them showing triple positivity.

The average survival time was of 13.7 years (SD: 10.9–16.5). Out of the total patients, 14 died (20.59%), mostly due to infectious etiology (35.7%) and 14.28% due to disease activity. Other less common causes were neoplasia or ischaemic heart disease (7.14% respectively).

Conclusions:

- The late-onset SLE prevails in our environment, one of every 5 patients diagnosed with SLE in our consulting room is older than 65 years.
- It is found most often in women and it is confirmed a lower male/female ratio than expected.
- Joint and haematology manifestations and cutaneous involvement in the form of malar erythema define the clinical profile of our patients with senile SLE, with the renal involvement or the presence of serositis being uncommon.
- Half of the patients had serological activity at the onset, having hypocomplementemia only in 1 out of 5 cases.
- Infections were the first cause of mortality in our sample with an average survival time of around 13 years.

Disclosure of Interest: None declared

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AB0551

OBSTETRICAL MORBIDITY RELATED TO ANTI-SSA ANTIBODIES: DATA FROM A FRENCH MONOCENTRIC RETROSPECTIVE STUDY

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Background: Obstetrical morbidity is an issue among autoimmune diseases patients. Anti-SSA positivity is well known for its effect on fetus and risk of

congenital heart block but no evidence has been yet found for its effect on obstetrical morbidity

Objectives: To investigate anti-SSA positivity effect among a large monocentric cohort of obstetrical morbidity patients and to evaluate the efficacy of different treatment regimens

Methods: All women who were seen from January 2010 to January 2015 in Jean-Verdier University Hospital for obstetrical morbidities were retrospectively included. All patients had been tested for anti-nuclear antibodies and anti-SSA/Ro and anti-SSB/La antibodies.

Results: We included 244 women (median age 34 years [interquartile range 21–53]) with 869 pregnancies overall. In 27 (11%) patients with anti-SSA antibodies, the median age at the time of pregnancy was 29.5 (17–40) years, with mean number of 3.66 pregnancies per woman. For these 27 patients, 83/99 pregnancies (84%) had an adverse obstetrical outcome: fetal loss (n=65; at a median of 20 (4–38) weeks' gestation), preeclampsia (n=15), intrauterine growth restriction (n=7), prematurity (n=7), and congenital heart block (n=2). In comparing women with obstetrical antiphospholipid syndrome and unexplained adverse complications, there was no major difference in frequency of recurrent miscarriages, preterm deliveries, preeclampsia or fetal loss. Among factors associated with obstetrical outcome and fetal loss, aspirin and hydroxychloroquine treatments were significantly associated with a favourable obstetrical outcome: odds ratio 0.05 [95% confidence interval 0.01; 0.37] (p=0.003) and 0.15 [0.02; 0.98] (p=0.04).

Conclusions: Women with unexplained recurrent obstetrical complications should be screened for anti-SSA antibodies. The benefit of aspirin and hydroxychloroquine treatment to improve the obstetrical outcome should be confirmed in prospective studies.

Disclosure of Interest: None declared

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AB0552

THE CLINICAL AND LABORATORY FEATURES OF ANTIPHOSPHOLIPID ANTIBODY POSITIVE PATIENTS WITH OR WITHOUT SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: A multicenter antiphospholipid antibody (aPL) clinical database was created in 2016 with the participation of six rheumatology centres around the country. The purpose has been to better define aPL-related clinical manifestations and management strategies; and also to establish a resource for future clinical studies.

Objectives: In this first analysis, we compared the clinical and laboratory features of aPL-positive patients with and without systemic lupus erythematosus (SLE).

Methods: The demographic, clinical, laboratory, treatment characteristics of the aPL-positive patients with/without other systemic autoimmune diseases (SAID) are recorded at enrollment according to a predefined protocol. The inclusion criteria are positive aPL (lupus anticoagulant test [LA], anticardiolipin antibody [aCL], and/or anti β_2 -glycoprotein-I antibody [β_2 GPI]) based on the Updated Sapporo Antiphospholipid Syndrome (APS) Classification Criteria at least twice within one year prior to enrolment.^{1,2} For the purpose of this analysis, we only included aPL-positive patients without other autoimmune diseases (primary aPL/APS) and aPL-positive SLE patients (SLE aPL/APS).

Results: As of January 2018, 105 aPL-positive patients were recruited (mean age: 42.6 ± 10.1 [min-max: 19–70]; 83 [79%] female; and 67 [64%] with another SAID). Ten patients were excluded from the analysis due to their SAID history other than SLE. Of the remaining 95 patients, 38 (40%) had primary aPL/APS; 57 (60%) fulfilled the ACR SLE Classification Criteria; 42 (44%) had thrombotic APS (TAPS) (8 arterial, 24 venous, and 8 both); 21 (22%) had obstetric APS (OAPS); 22 (23%) had both TAPS and OAPS (7 arterial, 14 venous, and 1 both); and 10 (11%) had no TAPS/OAPS. Fifty percent of the patients had history of at least one non-criteria aPL-manifestation. Demographics, clinical and laboratory manifestations, and medications were similar between primary aPL/APS and SLE aPL/APS patients except increased frequency of autoimmune hemolytic anaemia, aCL IgG, and hydroxychloroquine use in SLE aPL/APS patients (table 1).