AB0548

ANTIBODY TO PURINUCLEOSIDO PHOSPHILILASE CAN BE USED AS AN ADDITIONAL MARKER OF INFECTIOUS COMPLICATIONS WITH SYSTEMIC LUPUS ERYTHROMATOsis


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.

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±1.79). Antibodies to PNP (anti-PNP) were determined in our indirect ELISA test using the immobilised form of the enzyme as an antigenic matrix.

Results: In the presence anti-PNP in the blood serum of patients with SLE we can define infection and/or the serological analyses are positive. Characteristics of disease expression in a cohort of patients with infection complications and without it; differences in the level of antibodies to PNP (p=0.008), while comparing the groups of SLE patients with the presence and absence of anti-PNP.

Conclusions: The level of anti-PNP in the serum is a sign of infection and points to the need for in-depth research directed to identify the pathogen.

Disclosure of Interest: None declared

AB0549

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


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 (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 outpatient 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), ≥17 if with APA (p=0.000). APA and another AID are associated with CVR factors [obesity (OB), diabetes (DB), arterial hypertension (AH), dyslipidaemia (DL), smoking (SM), present 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.

Abstract AB0549 – Table 1

<table>
<thead>
<tr>
<th>Women</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Current age</td>
<td>52.3±16.2 years</td>
</tr>
<tr>
<td>Age of diagnosis</td>
<td>44.9±17.4 years</td>
</tr>
<tr>
<td>Duration of disease</td>
<td>7.2±1.5 years</td>
</tr>
<tr>
<td>Another AID</td>
<td>30% (APS 60%, Sjögren syndrome 36%)</td>
</tr>
<tr>
<td>PPAPA</td>
<td>12%</td>
</tr>
<tr>
<td>CVR (AH 42.8%, DL 21.4%, OB 11.9%, DB 10.7%, SM 9.5%)</td>
<td></td>
</tr>
<tr>
<td>APA (LA 19%, aCL 15.5%, anti2GPI 7.1%)</td>
<td></td>
</tr>
<tr>
<td>Steroid use</td>
<td>61%</td>
</tr>
<tr>
<td>DMARDs</td>
<td>89%</td>
</tr>
</tbody>
</table>

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.

REFERENCES:

Disclosure of Interest: None declared
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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 1997 and SLICC 2012 criteria) at the Hospital of Leon between 1997–2017 and with an age of onset ≥65 years, obtaining a total of 88 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%. 38.6% 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%), 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: 10.9–19.38) with 4.4% of them showing triple positivity.

Discrimination of Interest: None declared