ANTIBODY TO PuriNucleosoid PhosphiLASE 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 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 it 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 prevalence 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) with lupus anticoagulant (LA),>7 with anticardiolipin antibodies (aCL) and >12 with anti-β-2glycoprotein-I antibody (antiβ2GPI) (p<0.000).

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 reflect 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:

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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 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 (55.2%). 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 asciites 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 haematological 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.

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