Background: Systemic lupus erythematosus (SLE) is a chronic autoimmune disease with myriad of systemic features. While the disease manifestations and therapy remain same for both paediatric onset (cSLE) and adult onset SLE (aSLE), disease manifestation and burden of disease differs in the two populations.

Objectives: To study disease profile within 6 months of disease onset and burden of disease by SLEDAI of aSLE and cSLE to understand the similarities and differences and to compare those from around the world

Methods: Retrospective review done of 100 aSLE and cSLE patients, from June 2015 to June 2016, fulfilling SLICC criteria. Demographic data, clinical profile and SLEDAI at onset(highest of >6-9 rns of ds onset) by SLEDAI 2K were recorded on a predesigned proforma

Results: The incidence of skin involvement (acute and chronic cutaneous lupus, alopecia) serositis more in aSLE. Oral mucositis, neuropsychiatric SLE(NPSLE) and alopecia which oft herald aSLE. cSLE and aSLE though being the same disease with myriad of systemic features. While the disease manifestations and optimum therapy remain same for both paediatric onset(cSLE) and adult onset SLE (aSLE), disease manifestation and burden of disease differs in the two populations.

Conclusions: This study showed significant difference in initial systemic involve-ment and onset of presentation in aSLE and cSLE. cSLE and aSLE though being the same disease often have a varied spectrum of presentation and the generalist and the treating teams need to be aware of these for prompt recognition of the disease and optimum therapy

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antihypertensive drug (69%) use were similar across ethnic subgroups (all p>0.2). After a mean follow-up of 95 months, eight patients (9%) had died, six (7%) received renal replacement therapy and five (6%) had developed CKD. Five and ten years patient survival was similar for Asian and Caucasian patients (95%) and poorest in Aboriginals (81% and 70%) (p=0.016) with no impact of gender, ISN class, full house IF findings or PCR >300. Renal 5 and 10 year survival (endpoint RRT) was 100% for Asian, 100% and 96% for Caucasian vs 86% and 64% for Aboriginals(p=0.02). PCR >350 predicted worse renal survival (p=0.03), which was not influenced by gender, increased baseline creatinine, ISN class, A/A/C subclass or presence of full house IF deposits.

**Conclusions:** Asian patients have similar clinical and histological LN findings and experience equally good renal and patient outcomes as Caucasian patients in Western Australia, where the incidence rate of LN is comparable with Europe. Whether the grim outlook for Aboriginal patients relates to intrinsic differences in LN pathophysiology and/or socioeconomic circumstances deserves further study.

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**AB0587**

### HAEMATOLOGICAL ALTERATIONS IN COLOMBIAN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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**Background:** Systemic Lupus Erythematosus (SLE) is an autoimmune disease, with multiple organs and system involvement. The most usual haematological findings are anaemia, leukaemia, and thrombocytopenia. The prevalence of SLE in Colombia was 8.77 per 10,000 persons between 2012 and 2016.

**Objectives:** To evaluate the haematological alterations in a cohort of patients with SLE in Bucaramanga, Colombia.

**Methods:** A retrospective cohort study of 149 patients diagnosed with SLE according to the Systemic Lupus International Collaborating Clinics (SLICC) criteria. Descriptive analysis with frequencies, measures of central tendency and dispersion was done using Stata 12.0 software. The primary outcome was the presence of cytopenia, the secondary outcomes were anaemia, leukaemia, and thrombocytopenia. In the group comparison analysis, a chi-square test was used for qualitative variables and Wilcoxon or t student test for quantitative variables according to their distribution. Bivariate analysis using logistic regression with OR measurement, p-value, and confidence intervals was performed.

**Results:** 82.5% were women, average age was 36.8 years. The primary outcome was found in 133.8%, anaemia in the 76.5%, thrombocytopenia in the 22.1% and leucopenia in the 18.7%. In group comparison analysis (cytopenia vs no cytopenia) was found in the 79.8%, anaemia in the 76.5%, thrombocytopenia in the 22.1% and leucopenia in the 18.7%. In group comparison analysis (anaemia vs no anaemia) was found in the 82.5% were women, average age was 36.8 years. The primary outcome was found in the 38.4%, anaemia in the 24.2%, thrombocytopenia in the 18.7% and leucopenia in the 9.7%.

**Conclusions:** Asian patients have similar clinical and histological LN findings and experience equally good renal and patient outcomes as Caucasian patients in Western Australia, where the incidence rate of LN is comparable with Europe. Whether the grim outlook for Aboriginal patients relates to intrinsic differences in LN pathophysiology and/or socioeconomic circumstances deserves further study.

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**AB0588**

### IDENTIFICATION OF RISK FACTORS FOR HERPES VIRUS INFECTIONS WITH IMMUNOPHENOTYPING DURING INDUCTION THERAPY IN PATIENTS WITH ACTIVE LUPUS NEPHRITIS

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**Background:** Herpes virus infections (HVI s) including cytomegalovirus infections (CMVs) and herpes zoster (HZ) remains as major complications during treatments with immunosuppressant (IS) in patients with autoimmune diseases. Previous reports have suggested the associations between virus infections and characteristics of T cells. Previous reports have suggested the associations between virus infections and characteristics of T cells. Previous reports have suggested the associations between virus infections and characteristics of T cells. Previous reports have suggested the associations between virus infections and characteristics of T cells.

**Objectives:** To elucidate the characteristics of peripheral immune cells associated with risk factors of HVI s during induction therapies in patients with active lupus nephritis (LN).

**Methods:** Standardised peripheral immunophenotyping was performed using flow cytometry in active LN and ANCA-associated vasculitis (AAV) patients starting induction therapy and also with inactive LN patients with maintenance therapy between April 2015 to April 2017. The definition of HVI s was the infection necessary to administer anti-viral agents.

**Results:** Sixty-two LN patients and 11 AAV patients were enrolled. Among 30 active LN patients, 27 were analysed except for 3 patients (2 died and 1 withdrawn consens). Mean age was 41.7 years, 9 patients (33%) had newly-onset, and mean SLE disease activity index (SLEDAI) was 19.3. All active LN patients were treated with prednisolone (PSL) (mean 51.7 mg/day) and 25 were treated with an additional IS (cyclophosphamide [CYC]:13, mycophenolate mofetil;8, tacrolimus;3, rituximab [RTX];1). Six (22.2%) patients developed HVIs (5 CMVs and 1 HZ) within 3 months following induction therapy. None of the 32 LN patients in maintenance phase (mean age, 54.8; SLEDAI, 2.5; PSL, 2.5 mg/day) developed HVIs during the mean 2.8 years observational period. Two (18.2%) AAV patients developed HVIs within 3 months following induction therapy. All AAV patients (mean age, 64.3) were treated with PSL (mean 41.8 mg/day) and 10 with IS (CYC, RTX;3, azathioprine;1, methotrexate;1).

Among active LN patients, univariate analysis revealed that older age, lower proportions of naïve CD8 +T cells, higher proportions of effector CD8 + T cells and HLA-DR +regulatory T cells (Tregs) at baseline and lower naïve CD8 + T cells at month 3 associated with HVIs (p=0.011, p<0.001, p=0.009, p=0.024, p=0.001 respectively). Unexpectedly, lymphocyte count, IgG titer, usage of CYC at baseline, renal response and change in SLEDAI at month 3 did not associate with HVIs. Multivariate analysis revealed that low proportions of naïve CD8 + T cells and high proportions of HLA-DR + Tregs at baseline were the only detectable independent risk factor for HVIs (p=0.014).

Among AAV patients, univariate analysis showed that older age, lower proportions of naïve CD8 + T cells, higher proportions of naïve CD8 + T cells at month 3 associated with HVIs (p=0.001, p=0.001, p=0.009, p=0.024, p=0.001 respectively). Unexpectedly, lymphocyte count, IgG titer, usage of CYC at baseline, renal response and change in SLEDAI at month 3 did not associate with HVIs. Multivariate analysis revealed that low proportions of naïve CD8 + T cells and high proportions of HLA-DR + Tregs at baseline were the only detectable independent risk factor for HVIs (p=0.014).

**Conclusions:** Our results suggest that active LN patients with low proportion of naïve CD8 + T cells and high HLA-DR + Tregs at the time of induction therapy should be closely monitored for HVIs. The different results between LN and AAV implicated the different risks of HVIs by immunophenotyping. Larger prospective study is desired to confirm our results.

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