Conclusions: Our results demonstrated that the frequency of fQRS on ECGs would be greater in SLE patients with high disease activity.

REFERENCES:

Disclosure of Interest: None declared

AB0605
INITIAL CLINICAL AND IMMUNOLOGICAL FACTORS ASSOCIATED WITH MANIFESTATIONS IN PATIENTS WITH PRIMARY SJÖGREN’S SYNDROME: A SINGLE CENTRE RETROSPECTIVE STUDY

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Background: Primary Sjögren’s syndrome (pSS) is a prototypic systemic autoimmune disease that manifests various signs and symptoms. Although a few studies have focused on these manifestations over the long term,1,2 the association of initial clinical and immunological factors with subsequent longer-term manifestations has not been fully elucidated.

Objectives: To identify initial clinical and immunological factors associated with manifestations in patients with pSS.

Methods: A retrospective review was performed on pSS patients followed over a 10 year period at our department. Clinical and immunological data, including levels of serum immunoglobulin (Ig) and autoantibodies, were collected and statistically analysed.

Results: A total of 224 patients diagnosed with pSS who had met the classification criteria2 were enrolled. Among them, 201 patients were diagnosed with pSS at our hospital. Of these, we followed the 91 patients who continued to visit our hospital over 10 years. Of the other 110 patients, 69 suddenly interrupted treatment, 20 visited different hospitals, and 13 interrupted treatment at our department and visited dentistry or ophthalmology departments. During observation, 7 patients were newly diagnosed with rheumatoid arthritis in addition to SS and one patient died. We then analysed the 91 patients who continued to visit. Of these, 88 were female and 3 were males. Average age was 52 years, 72 and 33 patients had anti-SS-A antibodies and rheumatoid factor (RF), 82, 68 and 7 patients had neutropenia, anaemia and thrombocytopenia, respectively. 15% of patients used corticosteroid and/or immunosuppressant treatment. 10% of patients took traditional Chinese medicine. On follow-up for 10 years, titers of IgG, A and M were significantly decreased, whereas complement levels were elevated. The proportion of patients with extraglandular involvement decreased from 90% to 73%, whereas 14% of patients had new extraglandular organ involvement. The frequency of extraglandular involvement at 10 years was high in patients with hyper IgG at the initial test (39% vs 85%, p<0.01). The frequency of extraglandular organ involvement at 10 years was high in patients who were RF-positive at diagnosis (3% vs 15%, p<0.05). 9% of patients developed malignancies. 29% of patients without RF at diagnosis. Age, anti-centromere antibody, hyper IgG and anaemia were identified to be significant variables associated with malignancies. Extraglandular involvement was associated with the presence of hyper IgG (p<0.01), and extraglandular organ involvement was associated with RF positivity (p<0.05).

Conclusions: Procalcitonin levels were found higher in pSS patients. But, none of the patients had clinically significant increase in procalcitonin. We thought that with careful clinical evaluation, procalcitonin would be an indicator for differentiating infection from disease activation in pSS patients.

REFERENCES:

Disclosure of Interest: None declared

AB0605
PROCALCITONIN MIGHT BE USED FOR DISCRIMINATING INFECTIONS FROM INCREASED DISEASE ACTIVITY IN PRIMARY SJÖGREN SYNDROME

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Background: Procalcitonin is a polypeptide which is secreted as a response to bacterial stimulus and accepted as an early and sensitive marker of infection. In healthy subjects procalcitonin should be <0.1 ng/ml.1 In case of infection it may rise over 0.5 ng/ml.2 Its level in inflammatory diseases usually does not reach to such high levels as in infections. Differentiating infection and disease activation may be confusing in autoimmune diseases. For this purpose, there were several studies that evaluated the role of procalcitonin for excluding infection on suspicion of increased autoimmune disease activity.3

Objectives: As far as we know, there is no study in literature that evaluated procalcitonin levels in patients with primary Sjögren’s syndrome (pSS). Our aim is to evaluate procalcitonin levels in pSS and determine whether we can use it as a marker to differentiate infection from disease activation.

Methods: The following two groups of patients were included in the study: Forty-eight patients with pSS, who met ACR 2012 Classification Criteria for Sjögren’s Syndrome; and fifty-three subjects as control group who have no chronic diseases. Patients with possible infection were excluded according to their clinical evaluation and laboratory data. Then, serum procalcitonin levels were compared between the groups. Finally, we evaluated the correlation between disease activity, measured by Sjögren’s syndrome disease activity index (SSDAI) and procalcitonin levels.

Results: Procalcitonin levels in pSS group were found statistically higher than control group, whereas it was still in normal ranges (p<0.01). Furthermore, no correlation was found between disease activation and the procalcitonin levels (p=0.63).

Abstract AB0605 – Table 1. Demographic properties and Laboratory results of the subjects

<table>
<thead>
<tr>
<th></th>
<th>Sjögren (n=48)</th>
<th>Control (n=53)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender(M/F)</td>
<td>3/45</td>
<td>2/51</td>
<td>0.66</td>
</tr>
<tr>
<td>Age (years)</td>
<td>53 (48,50–58,75)</td>
<td>50 (43,50–55,00)</td>
<td>0.04</td>
</tr>
<tr>
<td>Sedimentation (mm)</td>
<td>22.00 (12.00–31.75)</td>
<td>18.00 (11.00–27.00)</td>
<td>0.13</td>
</tr>
<tr>
<td>CRP (mg/dl)</td>
<td>3.27 (3.27–3.27)</td>
<td>3.27 (3.16–3.27)</td>
<td>0.16</td>
</tr>
<tr>
<td>SSSAI score</td>
<td>1.00 (1.00–2.00)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Procalcitonin(mg/ml)</td>
<td>0.036 (0.031–0.044)</td>
<td>0.020 (0.020–0.020)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Haemoglobin (gr/dl)</td>
<td>12.50 (11.65–13.50)</td>
<td>12.80 (11.95–13.50)</td>
<td>0.82</td>
</tr>
<tr>
<td>Thrombocyte(10³/mm³)</td>
<td>231.00 (189.50–278.00)</td>
<td>265.00 (226.50–304.50)</td>
<td>0.02</td>
</tr>
<tr>
<td>WBC (/uL)</td>
<td>6000.00 (5400.00–7200.00)</td>
<td>6700.00 (5400.00–8000.00)</td>
<td>0.15</td>
</tr>
<tr>
<td>Creatinine (mg/dl)</td>
<td>0.66 (0.59–0.76)</td>
<td>0.57 (0.52–0.62)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>ALT (U/L)</td>
<td>18.5 (13.25–25.00)</td>
<td>18.00 (13.50–25.00)</td>
<td>0.74</td>
</tr>
<tr>
<td>AST (U/L)</td>
<td>22.50 (19.00–25.00)</td>
<td>21.00 (17.50–25.50)</td>
<td>0.30</td>
</tr>
</tbody>
</table>

Statistically significant P values were shown bold. Numerical values were summarised by median [interquartile range]

Conclusions: Procalcitonin levels were found higher in pSS patients. But, none of the patients had clinically significant increase in procalcitonin. We thought that with careful clinical evaluation, procalcitonin would be an indicator for differentiating infection from disease activation in pSS patients.

REFERENCES:

Disclosure of Interest: None declared

Ab0605: initial clinical and immunological factors associated with manifestations in patients with primary sjögren's syndrome.
Background: Neuropsychiatric (NP) lupus is common among patients with systemic lupus erythematosus (SLE). It occurs in about 30%–56% of all SLE patients. However, the diagnosis of neuropsychiatric SLE (NPSLE) remains difficult. Neuropsychiatric lupus (NPL) can present with a wide variety of clinical manifestations.

Objectives: The aim is to determine prevalence of NPSLE among a sample of Egyptian SLE patients from a single centre and to describe its features and characteristics.

Methods: The study included 301 adult SLE patients from Cairo University Hospital. The patients are classified according to the Systemic Lupus International Collaborative Clinics (SLICC) criteria for SLE. Neuropsychiatric manifestations were recorded using the ACR NPSLE nomenclature and case definitions (1999) Global disease activity was quantified by the SLE Disease Activity Index 2000 (SLEDAI-2K) at first and at last visit of the patient. Systemic Lupus International Collaborative Clinics/ACR Damage Index (SLICC/ACR-DI) was used to measure damage. The period of data collection took 4 months. The collected data included demographic, clinical, serologic data and medications.

Results: 301 SLE patients (87.4%) females and (12.6%) males with mean age 30.7±9.2 years and disease duration 72 months (2–286) were included. 101 (33.5%) were diagnosed as having NPSLE. The highest NP manifestation in frequency was headache (55.4%) followed by psychosis (33.7%) then seizures (21.8%). NP manifestation is the onset of the disease in 42.6% of all NPSLE patients. Compared to non-NPSLE group, NPSLE group is significantly older at onset of disease and have longer disease duration (p<0.05). They are significantly more active at the onset of the disease than non-NPSLE and have significantly more disease damage (p<0.05). Regarding clinical manifestations of lupus: NPSLE are significantly higher in frequency of discoid rash, cutaneous vasculitis, serositis, secondary anti-phospholipid syndrome (APS), associated avascular necrosis of the joints and osteoporosis (p<0.05). Anti-cardiolipin IgM antibodies are significantly more frequent in NPSLE group (p<0.05). Notably, frequency of psychosis, superior sagittal thrombosis and cerebrovascular disease were significantly higher in NPSL with positive APS than those with negative APS (p<0.05).

Conclusions: Filipino paediatric SLE patients typically present with cutaneous, mucocutaneous renal and musculoskeletal involvement. Hematologic and neurologic manifestations are found to be less common among them. Finally, it was noted that renal biopsy is not commonly performed among these patients.

Disclosure of Interest: None declared

included nucleotidic type (0.88%), centromere type (3.54%), cytoplasm type (7.96%), homogeneity (29.20%) and granularity (58.41%). Also, there was no significant difference in plasma Lp-PLA2 level between different karyotypes (p=0.153). The average level of ACA was 12.8±23.87 RU/ml and there was no significant correlation between plasma Lp-PLA2 level and ACA level (p=0.839).

Anti-Jo2/PL1 antibodies were classified as negative (<20 U/ml, 91.48%) and positive (>20 U/ml, 8.52%). Plasma Lp-PLA2 level did not differ significantly between anti-Jo2/PL1 antibody negative and positive patients (p=0.449). Lupus anticoagulant PT-IgG and PT-IgM were classified as negative<18 U/ml) and positive (>18 U/ml). PT-IgM were all negative and there was no significant difference in plasma Lp-PLA2 level between PT-IgG negative (96.59%) and positive (3.41%) patients (p=0.279).

Results: Plasma Lp-PLA2 level in patients with connective tissue disease have no significant correlation with age, gender, ANA titer, karyotype, ACA, anti-Jo1 2GP1 antibody and LA. The role of plasma Lp-PLA2 in connective tissue disease may be different from APL-Ab.

Disclosure of Interest: None declared


AB0611 DISEASE ACTIVITY AND ORGAN DAMAGE IN PATIENT WITH CHILDHOOD-ONSET SYSTEMIC LUPUS ERYTHEMATOSUS, FROM CHILDHOOD TO ADULTHOOD: A RETROSPECTIVE STUDY OVER THE LAST 25 YEARS

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Background: Although clinical symptoms and immunological findings are common in both children and adults with systemic lupus erythematosus (SLE), children generally have a more severe clinical presentation at the time of diagnosis with a larger number of affected organs, a much more aggressive clinical course and greater chance of developing organ damage over time.

Objectives: To compare the SLEDAI-2K disease activity index in patients with SLE at the time of diagnosis with SLEDAI-2K in the same patients in adulthood and to compare of the SLICC/ACR damage index (SDI) in patients with cSLE at the last follow up in childhood with SLICC/ACR of the same patients in adulthood.

Methods: This retrospective study included children who were diagnosed with cSLE according to the ACR 1997 and SLICC 2012 criteria, in the period from 1991–2016 at the Referral Centre for Paediatric and Adolescent Rheumatology Republic of Croatia, Department of Paediatrics, University Hospital Centre Zagreb and who by the end of March 2017 reached the age of majority at 18 and continued their treatment at the Department of Internal Medicine, University Hospital Centre Zagreb.

Results: Out of 95 children with cSLE, 48 patients (42 females and 6 males) who attained the age of majority, were included in the study. Mean age at the time of diagnosis was 13.5 years (range 6–18), and the mean disease duration was 11 years. Mean SLEDAI-2K was 19.25 (range 0–42) in childhood and 712.5 (range 0–30) in adulthood. In adulthood, thirty-two patients (66.7%) showed improvement, three (6.25%) disease progression, six (12.5%) had the same disease activity and seven patients (14.5%) were with SDI 4.03 (0–6) and 20 patients in adulthood (41.67%) had organ damage with SDI 0.75 (0–6). Cataract, erosive arthritis and avascular necrosis were the most common organ damage in both groups. The most common presenting symptoms in childhood were musculoskeletal (predominantly arthritis) occurring in 34 children (70.83%), mucocutaneous (rash) noted in 31 (64.58%) and fever in 21 patients (43.75%). Of different laboratory tests the most common were positive antinuclear antibodies (ANA) screen (95.83%) and hypocomplementaemia (75%). Proteinuria was noticed in 26 children (54.17%), Similarly, in adulthood the most common symptoms were arthritis in 10 (20.83%) and rash in 8 patients (16.67%). Alopecia, headaches and visual disturbances were represented with 12.5% each. ANA screen was positive in 27 patients (56.25%) and hypocomplementaemia present in 22 patients (45.83%).

Conclusions: At the time of diagnosis in childhood, disease activity is very high while in adulthood there is a significant decrease in disease activity. Higher disease activity in childhood is related to the development of the organ damage in adulthood.

RESULTS:


Disclosure of Interest: None declared