SLE with or without Anti-U1 RNP negativity. Patients satisfying criteria for MCTD were recruited as disease controls. Individual NFC parameters were analysed by a blinded assessor. Changes in three groups were compared using non-parametric tests. Ordinal logistic or linear regression were used wherever applicable to assess any independent association of NFC changes with disease groups.

**Results:** Total of 81 patients were studied, of which 28 had SLE with RNP+ (age 30.0±10.37; 26 females), 26 had SLE without RNP positivity (age 29.4±2.19; 25 females) and 26 had MCTD (age 37.0±9.86; 25 females). Capillary density was significantly reduced in MCTD as compared to RNP+SLE patients (5.1±1.69/ mm2 vs 7.25±1.38/ mm2, p=0.0001), as well as in RNP+SLE as compared to RNP negative SLE patients (7.25±1.38/mm2 vs 8.92±1.13/mm2, p=0.0001). Conversely, patients with RNP+SLE had more frequent giant capillaries, enlarged capillaries and ramified/branched capillaries as compared to RNP negative SLE patients (p=0.047, 0.01 and 0.029 respectively). However, there was no statistical difference in number of haemorrhages among these groups. These changes were more severe in patients with MCTD as compared to RNP+SLE. Ordinal logistic regression showed more severe reduction in capillary density in patients with RNP+SLE as compared to RNP negative SLE (OR=9.5, p=0.007) independent of the presence of Raynaud’s, ILD and disease duration.

**Conclusions:** Presence of anti-U1 RNP antibody is associated with micro-vascular abnormalities in SLE as detected by NFVC. Patients with MCTD have more profound abnormalities as compared to RNP+SLE patients.

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**AB0619**

**MANY PERIPHERAL FRACTURES DESPITE NORMAL BONE MINERAL DENSITY CAUCASIAN SLE PATIENTS**


**Background:** Clinical outcome has improved in systemic lupus erythematosus (SLE) and thus, early management of comorbidities like cardiovascular disease and osteoporosis has become highly important. In this disease, osteoporotic risk factors such as female gender, early onset of disease leading to long disease duration, high degree of systemic inflammation, high frequencies of glucocorticoid usage often at higher doses, and chronic fatigue or pain compromising physical activities are often present in combination.1 Rh-GIOP (NCT02719314) is an ongoing prospective study monitoring glucocorticoid (GC)-induced osteoporosis of rheumatic patients, established in 2015 at the Charité University Hospital. To date, the database comprises clinical data and bone mineral density data measured by dual x-ray absorptiometry (DXA) of 592 patients with inflammatory rheumatic diseases.

**Objectives:** To quantify bone mineral density and fractures in SLE patients.

**Methods:** Bone mineral density (BMD) data of SLE patients as measured by dual x-ray absorptiometry (DXA) were analysed with regard to their relation to detailed clinical data.

**Results:** 43 female and 6 male SLE patients aged between 20 and 77 years (mean: 46.31 years) were assessed by DXA (all of Caucasian ethnicity, mean disease duration: 15.49 years; 61% denied any physical activity). SLE medication included glucocorticoids (93.9%); mean cumulative dose: 25.5 g), antimalarials (67.3%), azathioprine (30.6%), mycophenolate-mofetil acid (22.4%), belimumab (16.3%), cyclophosphamide (10.2%) and methotrexate (8.1%). In 26 (60.5%) of all studied SLE patients, 36 (92.3%) peripheral and 3 (7.7%) vertebral fractures were recorded. Notably, 6 of these patients with fractures were younger than 30 and only 4 older than 60 years. 10 of all 39 fractures (25.6%) were low-trauma fractures. Of note, 11/26 patients (42.3%) with fractures had a normal BMD, 9/26 (34.6%) osteopenia and 6/26 (23.7%) osteoporosis, while only 4 (15.4%) of them initially received anti-osteoporotic medication.

**Conclusions:** There is a high occurrence of peripheral fractures in SLE. Moreover, 4 out of 10 SLE patients developed fractures despite a normal BMD, stressing that this parameter is of limited value for correctly identifying the fracture risk in SLE. The analysis of a larger number of patients and in-depth analyses are necessary to improve management of osteoporosis and to better prevent fractures in SLE patients.

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