walking, moderate, and vigorous intensity, according to SLEDAI-2K and SDI were not found. In addition to high PCS of SF-36 ($p=0.006$) and SLEDAI-2K ($p=0.038$), less vigorous physical activity were related with lupus nephritis ($p=0.033$). However, the risk of CVD was not associated with physical activity of SLE.

Conclusions: This study showed that patients with lupus nephritis had less vigorous physical activity. It implicates that SLE-related organ damage might be associated with levels of physical activity.

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AB0628 INFECTIONS IN HOSPITALISED PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS- A PROSPECTIVE OBSERVATIONAL STUDY FROM A TERTIARY CARE CENTRE IN SOUTHERN INDIA

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Background: Infections are one of the main causes of morbidity and mortality in SLE.¹ The high prevalence of infection is attributed to use of immunosuppressive agents and disease activity. There is paucity of literature from India on infections, types of infections, predictors and outcome.

Objectives: To determine the frequency, types and determinants of major infections in hospitalised patients with SLE.

Methods: Patients with SLE (2012 SLICC-ACR criteria) aged ≥ 13 years, admitted to Clinical Immunology and Medicine wards were included. Clinical evaluation for major organ involvement of SLE, disease activity was assessed by SLEDAI-2K. Whenever there was a suspicion of infection appropriate work up to find the etiology of infections was done. Major infection was defined as presence of either one of the following a) sepsis b) pneumonia, or pyelonephritis, or endocarditis, or meningitis. c) skin or soft tissue infection requiring hospital admission for treatment d) Infection requiring IV antibiotic therapy. The diagnosis of infection was made by compatible clinical, microbiological and imaging criteria.

Results: From December 2016 till January 2018, 63 (55 women and 8 men) were included; Mean age was 28.8 ± 9.8 years; mean SLEDAI-2K was 14.6 ± 7.03 . Median duration of hospital stay was 14 days; range 2–64 days. Disease manifestation (including present and ever present) were arthralgia/arthritis in 51 (81%), oral ulcers 56 (88.9%), myositis 10 (15.9%), lupus nephritis 35 (55.6%), CNS lupus 14 (22.2%), serositis 14 (22.2%), cardiac involvement 13 (20.6%), APS 3 (4.8%). At the time of enrollment thrombocytopenia was present in 13 (20.6%), and leukopenia 11 (17.5%).

Twenty-three of 63 (36.5%) had infections (table 1), 14/23 (60.8) were microbiologically proven, remaining (39.2%) were confirmed by compatible clinical features and imaging.

Seven of 63 (11.1%) died; 5 (21.7%) in the infection group versus 2 (5%) in no infection group, $p=0.08$ OR 5.58 [CI 0.98–31.7]. Thirty-four of 63 (54%) had fever on admission; 17/23 (74%) patients with infection had fever compared to 17/40 (42.5%) in no infection group, $p=0.02$ [OR=3.8, CI 1.2–11.7]. There was no association of lupus nephritis, CNS lupus, leukopenia, receipt of cyclophosphamide, rituximab, methylprednisolone pulse therapy with occurrence of infection.

Abstract AB0628 – Table 1. Infections in SLE patients

Type of Infections	n=23 (%)
Bacterial Pneumonia	3 (13.7)
Fungal Pneumonia	2 (8.7)
(Invasive Aspergillosis)	
Pulmonary tuberculosis	2 (8.7)
Disseminated tuberculosis	2 (8.7)
Urinary tract infection	4 (17.4)
Skin and soft tissue infection	4 (17.4)
Blood stream infections	3 (13)
Suspected brain abscess	1 (4.3)
Pyogenic meningitis	1 (4.3)
Disseminated Varicella	1 (4.3)
Viral bronchiolitis	1 (4.3)

Conclusions: Almost 36% of SLE patients in hospital have infections. There appeared to be an increase in number of deaths among patients with infections. There was no association of infections with the dose of prednisolone or previous immunosuppression with cyclophosphamide.

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AB0629 PREVALENCE OF ASYMPTOMATIC VERTEBRAL FRACTURES IN POSTMENOPAUSAL WOMEN WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Objectives: To investigate the prevalence of vertebral fractures and to identify risk factors associated with vertebral fractures in postmenopausal women with systemic lupus erythematosus (SLE).

Methods: 86 consecutive postmenopausal women with SLE were included in this study. Bone mineral density (BMD) measurements of the hip and spine were performed using the dual energy X-ray absorptiometry (DEXA). Vertebral fracture assessment (VFA) was done for detection vertebral fractures using a method described by Genant. Accumulated damage was scored using the SLICC/ACR damage index (SDI).

Results: Vertebral fractures were defined in 42 (48.8%) postmenopausal women with SLE. Half of all patients with SLE ($n=22$, 25.6%) had asymptomatic vertebral fractures which were diagnosed only in this study. Every patient had 1.7 vertebral fractures on average (from 0 to 4). Distribution of vertebral fractures along the spine showed one peak at Th7. Univariate analyses of variables associated with fractures were longer duration of postmenopausal status in women with SLE, longer glucocorticoids intake, higher cumulative dose of glucocorticoids, higher SDI, lower BMD of the spine. Multivariate analysis showed longer duration of postmenopausal status in women with SLE (odds ratio 4.05, $p=0.007$), cumulative dose of glucocorticoids ≥ 60000 mg of prednisone (odds ratio 3.68, $p=0.009$), SDI ≥ 7 (odds ratio 2.94, $p=0.028$) and low BMD ($T \leq -2.0$) of the spine (odds ratio 2.48, $p=0.015$) were significantly associated with vertebral fractures in the thoracic and/or lumbar spine.

Conclusions: Vertebral fractures were occurred in 48.8% of postmenopausal women with SLE and half of them were asymptomatic. The current method using DEXA to predict the presence of vertebral fracture has limited value and there is a need for assessment of bone quality. Vertebral morphometry in patients with SLE is recommended and early therapeutic intervention is necessary to prevent vertebral fractures in postmenopausal women with SLE.

Disclosure of Interest: None declared

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AB0630 EXPRESSION OF TNF-A AND IL-6 IN SYSTEMIC LUPUS ERYTHEMATOSUS: RELATIONSHIP WITH DISEASE ACTIVITY

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Background: Cytokines play an important role in the pathogenesis of SLE. TNF- α , IL-6 are the cytokines with suggested proinflammatory and immunoregulatory actions in the pathogenesis of SLE with differential effects on B or T cells, as well as on programmed cell death. Fas/APO-1 and Fas ligand (FasL) are involved in the apoptosis. FasL is a marker of apoptosis, it induces cell apoptosis when binds to Fas/APO-1. Both are expressed in membrane-associated and soluble forms (sFas/APO-1 and sFasL). sFas/APO-1 is known to inhibit the apoptosis via blocking the binding of Fas/APO-1 to FasL/sFasL.

Objectives: We evaluated the levels of IL-6 and TNF- α and their possible association with disease activity, apoptosis markers.

Methods: The study included 52pts (89% female, age 30.0 [26.5–44.5 years] (median [interquartile range 25% >75%])) with SLE ACR, 1997 and 20 controls (100% female without any rheumatic and infectious diseases, age 30.0 [25.0–39.5 years]). SLE-related factors, including disease duration, clinical features, SLE Disease Activity Index (SLEDAI 2K) and Systemic Lupus International Collaborating Clinics (SLICC) damage index were evaluated in parallel with relevant laboratory findings, autoantibodies. Serum levels of IL-6 and TNF- α (pg/ml), sFas/