Abstract FRI0361 – Table 1. frequency of APOs, pPROM and PE in the 134 analysed pregnancies

	N (%)
N of live birth	120 (90%)
N of APOs	39 (29%)
Premature miscarriage (<10th w)	9 (7%)
Intrauterine fetal death (>10th w)	5 (4%)
with PE	1 (20%)
Perinatal death (<30th day of life)	1 (1%)
with PE	1 (100%)
All preterm birth (<37th w)	24 (18%)
Preterm birth (<34th w)	3 (2%)
with pPROM	2 (67%)
Preterm birth (34th-36th w)	21 (16%)
with pPROM	7 (33%)
with PE	2 (10%)

Abstract FRI0361 – Table 2. frequency of preterm birth and pPROM among the 120 live birth, according to exposure (or not) to corticosteroids >35 mg/week during the three trimesters

	CS >35w*	CS 0 or ≤35mg/w*	p*	CS >35w**	CS 0 or ≤35mg/w**	p**	CS >35w***	CS 0 or ≤35mg/w***	p***
N of pregnancies	39	81	-	48	72	-	41	79	-
All preterm birth (<37 th w)	14 (36%)	10 (12%)	0.006	15 (31%)	9 (13%)	0.023	14 (34%)	10 (13%)	0.011
Preterm birth (<34 th w)	2 (5%)	1 (1%)	0.246	3 (6%)	0 (0%)	0.616	3 (7%)	0 (0%)	0.038
Preterm birth (34 th -36 th w)	12 (31%)	9 (11%)	0.017	12 (25%)	9 (14%)	0.128	11 (27%)	10 (13%)	0.092
pPROM	8 (21%)	1 (1%)	0.001	8 (17%)	1 (1%)	0.003	8 (20%)	1 (1%)	0.001

* 1 st trimester; ** 2nd trimester; *** 3rd trimester

Conclusions: Use of IS seems to be associated with premature miscarriages; this could reflect their use in patients with a more severe disease phenotype. The exposure to CS in doses greater than 35 mg/w in the 1 st trimester seems to be associated with preterm birth at 34th-36th w, while in the 3rd trimester with severe preterm birth (<34 th w), that could be related to the strong association observed between CS use and pPROM.

Disclosure of Interest: None declared

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FRI0362

PREVALENCE, RISK FACTORS, AND IMPACT ON MORTALITY OF NEUROPSYCHIATRIC LUPUS: A LARGE PROSPECTIVE SINGLE-CENTRE STUDY

G.Y. Ahn¹, D. Kim¹, S. Won², S.T. Song¹, H.-J. Jeong¹, I.W. Sohn¹, S. Lee¹, Y. B. Joo³, S.-C. Bae¹. ¹Hanyang University Hospital for Rheumatic Diseases; ²Clinical Research Center for Rheumatoid Arthritis (CRCRA), Seoul; ³St. Vincent's Hospital, The Catholic University of Korea, Suwon, Korea, Republic Of

Background: Neuropsychiatric involvement is one of the most serious involvement of SLE and generally associated with a worse prognosis. However, previous reports about the prevalence and risk factors of neuropsychiatric systemic lupus erythematosus (NPSLE) have yielded inconsistent findings. Also, there are only few studies of the prognosis of NPSLE, especially in a large prospective cohort.

Objectives: To identify the prevalence, risk profiles, and impact on mortality of NPSLE.

Methods: Patients from the Hanyang BAE lupus cohort were registered and followed from 1998 to 2015. Demographics, autoantibodies, SLEDAI-2K and SLICC/ACR damage index were collected at baseline and then annually. Patients registered within 12 months of SLE development were grouped as the inception cohort and analysed separately to elucidate the clinical features at disease onset. NP manifestations were defined using the ACR 19 case definitions and Ainiola NPSLE that did not include minor NP events¹. Mortality data were derived by linking data from the Korean National Statistics Office.

Results: The prevalence of NPSLE by ACR 19 case definition was 38.3%, and 19.3% by Ainiola criteria. Higher SLEDAI, APLA positivity, absence of anti-dsDNA antibody at SLE diagnosis and fewer years of education increased NPSLE risk.

Patients with any NPSLE manifestation had a three-fold increased risk of mortality (HR 3.09, p=0.04), and patients with focal CNS NPSLE showed nearly an eight-fold increased risk of mortality in SLE patients (HR=7.83, p<0.01). Among the 216 patients with Ainiola NPSLE, sixty-four (29.6%) had multiple events. The two most common symptom combinations were seizure with CVA (18 patients) and seizure with psychosis (8 patients).

Abstract FRI0362 – Table 1. Risk factors for the development of NPSLE in the inception cohort (N=388).

	NPSLE (n=88)	Non-NPSLE (n=300)	P	Adjusted OR (95% CI)	P
Demographics					
Age at SLE diagnosis	28.2 ±11.6	29.3±11.3	0.42	0.99 (0.97–1.01)	0.45
Female sex	81 (92.1)	270 (90.0)	0.71	1.88 (0.71–4.96)	0.20
SLEDAI at diagnosis, NP manifestations excluded ^a	4.7 ±4.5	3.8±3.3	0.10	1.08 (1.01–1.16)	0.02*
SDI at diagnosis, NP manifestations excluded ^b	0.2 ±0.4	0.1±0.4	0.43	1.23 (0.72–2.11)	0.45
HTN	5 (5.8)	16 (5.4)	1.00	1.14 (0.38–3.37)	0.82
Education (years)	12.2 ±3.1	13.0±3.3	0.05*	0.92 (0.85–1.00)	0.04*
Anti-dsDNA antibody positivity	61 (69.3)	238 (79.3)	0.07	0.43 (0.24–0.78)	<0.01*
APLA positivity	40 (45.5)	96 (32.0)	0.03*	1.72 (1.03–2.87)	0.04*

*Values are number (percentage) or mean ±standard deviation. a. SLEDAI was calculated using the remaining items except CVA, seizure, organic brain syndrome, psychosis, visual disturbance, cranial nerve disorder. b.SDI was calculated using the remaining items except CVA, myelopathy, seizure, psychosis, cognitive impairment, carinal neuropathy, and peripheral neuropathy.

Abstract FRI0362 – Figure 1. Kaplan-Meier survival curves for NPSLE and non-NPSLE patients; Inception cohort and all analysed patients.

Conclusions: Higher SLEDAI, APLA positivity, absence of anti-dsDNA antibody at SLE diagnosis and fewer years of education are risk factors for development of NPSLE. Presence of NPSLE, especially focal CNS NPSLE, increased the risk of mortality in SLE patients.

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FRI0363

POSITIVE REMODELLING INDEX AND LOW ATTENUATION NON-CALCIFIED CORONARY PLAQUES: MARKERS OF VULNERABLE CORONARY PLAQUES IN SYSTEMIC LUPUS?

G. Stojan¹, L. Magder², M. Petri¹. ¹Rheumatology, Johns Hopkins University; ²Epidemiology, University of Maryland, Baltimore, USA

Background: Accelerated atherosclerosis leading to premature coronary artery disease remains the major cause of late death in SLE. Coronary plaques with a large necrotic/lipid core and/or a thin fibrous cap are prone to rupture, leading to acute coronary events. In coronary CT angiography, plaque lipid content correlates with lower CT attenuation values when compared with fibrotic tissue.