Regarding pattern of lung involvement, 9 (52.9%) pts had ILD, 6 (35.3%) isolated bronchiectasis and 2 (11.8%) follicular bronchiolitis. In ILD pts, non-specific interstitial pneumonia (NSIP) was documented in 6 pts, lymphoctic interstitial pneumonia in 2 and 1 pt had unclassifiable ILD pattern with lymphocytic alveolitis in bronchoalveolar lavage. One of the pts with NSIP later developed radiographic characteristics suggestive of usual interstitial pneumonia (UIP).

Six ILD pts were treated with immunosuppressive drugs. One received cyclophosphamide (CYC), 2 azathioprine (AZA) and 4 mycophenolate mofetil (MMF). From pts receiving MMF, 1 was previously treated with CYC as induction treatment and the other with AZA, but with inefficacy. Rituximab (RTX) was given to 1 pt with refractory arthritis and new ILD onset. After 11 years on RTX (total 10 cycles) the pt complained of persistent dyspnoea and fatigue on minor exertion (cardiac causes excluded), with onset of subtle honeycombing in high resolution computed tomography. At this point prednifronde was added to RTX, with clinical improvement. Detailed lung function and imaging evolution of pSS-ILD pts is shown in table 2.

Conclusion: Lung involvement occurred in 12.4% of our cohort and was associated with older disease at pSS diagnosis and presence of constitutional involvement. Small airways disease and ILD had nearly the same prevalence and in the ILD sub-group, NSIP was the commonest pattern. Despite the small number of ILD pts receiving immunosuppression, these drugs seemed to be associated with disease stabilization in most of them. Only 1 pt with UIP pattern had disease progression and eventually died.

Disclosure of Interests: None declared


Table 2 – Evolution of patients with interstitial lung disease treated with immunosuppressive drugs

<table>
<thead>
<tr>
<th>Disease Duration</th>
<th>UIP</th>
<th>BSIP</th>
<th>EIP</th>
<th>CIP</th>
<th>Active NSIP</th>
<th>Stable NSIP</th>
<th>Stable LP</th>
<th>Stable ILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>24 months</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>36 months</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>48 months</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>60 months</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
</tr>
</tbody>
</table>

References


Disclosure of Interests: None declared


Clinicopathological Characteristics As Prognostic Markers In Patients With Active Lupus Nephritis Following The Induction Of Remission Phase

Faisal Elbadawi, Munther Khamashma, Nasir Elsidig, Jamal Alsaleh, Dubai Hospital, Rheumatology, Dubai, United Arab Emirates

Background: Systemic lupus erythematosus is polygenic autoimmune rheumatic disease with heterogeneous manifestations. Lupus patients with nephritis signal represents management challenge. With current induction and maintenance therapy the risk of developing lupus nephritis related ESRD at five, ten and fifteen years remains 11,17 and 22% for the last decade.

Objectives: To study clinicopathological characteristics of lupus nephritis patients as well as short term renal outcome following induction of remission attempts.

Methods: Retrospective, prospective observational study. We enrolled all patients with suspected active Lupus nephritis attending Dubai Hospital Rheumatology services. Data collected during outpatient, inpatient consultation using medical electronic system for all patients newly diagnosed to have lupus with renal involvement or patients who had nephritic or nephrotic flare from June 2016 till December 2018.

Results: Of 71 patients included during the study period, mean age was 36.4 years, 93% were female while 7% were males.65 Out of 71 were Arab (78%) while the rest 15 out of 71 (22%) from non-Arab ethnicity. 36.4 years, 93% were female while 7% were males.56 Out of 71 were Arab (78%) while the rest 15 out of 71 (22%) from non-Arab ethnicity.

In ILD pts, non-specific interstitial pneumonia (NSIP) was documented in 6 pts, lymphoctic interstitial pneumonia in 2 and 1 pt had unclassifiable ILD pattern with lymphocytic alveolitis in bronchoalveolar lavage. One of the pts with NSIP later developed radiographic characteristics suggestive of usual interstitial pneumonia (UIP).

Six ILD pts were treated with immunosuppressive drugs. One received cyclophosphamide (CYC), 2 azathioprine (AZA) and 4 mycophenolate mofetil (MMF). From pts receiving MMF, 1 was previously treated with CYC as induction treatment and the other with AZA, but with inefficacy. Rituximab (RTX) was given to 1 pt with refractory arthritis and new ILD onset. After 11 years on RTX (total 10 cycles) the pt complained of persistent dyspnoea and fatigue on minor exertion (cardiac causes excluded), with onset of subtle honeycombing in high resolution computed tomography. At this point prednifronde was added to RTX, with clinical improvement. Detailed lung function and imaging evolution of pSS-ILD pts is shown in table 2.

Disclosure of Interests: None declared

health, emotional health and fatigue) remained associated. Theses analyses are depicted in table 1.

**Conclusion:** Age at diagnosis is negatively associated with fatigue; HRQoL domains like physical health, emotional health and fatigue are positively associated with fatigue.

### Table 1: Factors associated with fatigue in systemic lupus erythematosus patients. Univariable and multivariable analyses.

<table>
<thead>
<tr>
<th>Age at diagnosis, years</th>
<th>Gender, female</th>
<th>Socioeconomic status</th>
<th>Low/middle low</th>
<th>Medium</th>
<th>High/middle high</th>
<th>Disease duration, years</th>
</tr>
</thead>
<tbody>
<tr>
<td>p value</td>
<td>p value</td>
<td>p value</td>
<td>p value</td>
<td>p value</td>
<td>p value</td>
<td>p value</td>
</tr>
<tr>
<td>-0.30 (0.06)</td>
<td>0.102</td>
<td>0.03</td>
<td>0.02</td>
<td></td>
<td>0.034</td>
<td></td>
</tr>
</tbody>
</table>

**REFERENCES**


**Disclosure of Interests:** None declared


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### AB0506 MICRONRMA A POTENTIAL MARKER OF LUPUS ACTIVITY IN AN EGYPTIAN LUPUS COHORT

Manwa Elkhalifa1, Manal Tayel1, Magdy Zehary1, Ahmed Elkeriae2, Dalal Mohamed Nsair Eldikfash3, Nahed Baddour4, 1Faculty of Medicine, Rheumatology, Alexandria, Egypt; 2Faculty of Medicine, Nephrology, Alexandria, Egypt; 3Faculty of Medicine, Clinical Pathology, Alexandria, Egypt.

**Background:** MicroRNAs play central roles in different stages of cellular activity, as well as contribute extensively to multifaceted aspects of systemic lupus erythematosus (SLE) pathogenesis. Screening from approximately a thousand human miRNAs, studies have concluded that their dysfunctions have been related to the development and activity of diseases. In addition, the expression levels of miRNAs in serum are stable, reproducible, and consistent. Thus, testing serum microRNA sequence provide novel biomarkers and potential therapeutic strategies in SLE patients.

**Objectives:** To study the role of micro-RNA-142-3p expression in SLE in an Egyptian cohort and its role as a potential biomarker of lupus activity.

**Methods:** Expression of microRNA-142-3p extracted from peripheral blood mono-nuclear cells determined using quantitative reverse transcription–polymerase chain reaction assay. A total of 60 plasma samples were obtained from 30 SLE patients without clinical and laboratory evidence of lupus nephritis (group A) and 30 SLE patients with clinical and laboratory evidence of lupus nephritis confirmed by renal biopsy (group B).

**Results:** We found a significant correlation between micro-RNA-142-3p expression levels and serum level of anti ds-DNA in both group A (p=0.007) and group B (p=0.19). We also found no significant correlation between micro-RNA-142-3p expression levels and SLEDAI score in both group A (p=0.001) and group B (p=0.007).

**Conclusion:** The expression level of micro-RNA-142-3p could be considered a potential activity marker in SLE patients with and without lupus nephritis.

**REFERENCES**


**Disclosure of Interests:** None declared

**DOI:** 10.1136/annrheumdis-2019-eular.4147

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### AB0507 HEARING LOSS IN SYSTEMIC LUPUS ERYTHEMATOSUS

Eloise Akemi Tanaka1, Harymy Barros1, José Fernando Polanski2, F. dos Santos. Thiago Alberto Santos. Eloise Akemi Tanaka1, Harymy Barros1, José Fernando Polanski2, F. dos Santos. Thiago Alberto Santos. Eloise Akemi Tanaka1, Harymy Barros1, José Fernando Polanski2, F. dos Santos. Thiago Alberto Santos. Eloise Akemi Tanaka1, Harymy Barros1, José Fernando Polanski2, F. dos Santos. Thiago Alberto Santos.

**Background:** Systemic lupus erythematosus(SLE) is a systemic disease that may affect the inner ear.

**Objectives:** To study hearing function in SLE and its possible association with clinical and serological profile as well as with antimalarial use.

**Methods:** Cross sectional study of 84 individuals(43 SLE patients and 41 controls) with audiometry and impedanciometry tests. Epidemiological, clinical, serological and treatment profile of SLE patients were extracted from the charts.

**Results:** SLE patients had more sensorineural hearing loss than controls (23.2% vs 0; p=0.001). The hearing loss was seen at 250 Hz, 500 Hz, 1000 Hz and 4000 Hz. No bone conduction impairment was observed. Serological and clinical profile in patients with and without hearing loss was the same (all p=ns). Patients on antimalarial had the same prevalence of hearing loss than those not using it but at 8.000 Hz, antimalarial non-users performed worse than users(p<0.03).

**Conclusion:** There is a high prevalence of hearing loss in SLE that is not affected by disease characteristics neither by antimalarial use.

**REFERENCES**


**TABLE 1:** Comparison of median auditory perception(in decibels) according to the studied frequency of the sound, speech recognition threshold and tympanometry between SLE patients and controls.

<table>
<thead>
<tr>
<th>SLE patients (98 ears)</th>
<th>Controls (98 ears)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency (Hz)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>500 Hz</td>
<td>10.00 (5.00-15.00)</td>
<td>15.00 (10.00-20.00)</td>
</tr>
<tr>
<td>1000 Hz</td>
<td>15.00 (5.00-15.00)</td>
<td>15.00 (5.00-15.00)</td>
</tr>
<tr>
<td>2000 Hz</td>
<td>5.00 (0.00-15.00)</td>
<td>10.00 (5.00-15.00)</td>
</tr>
<tr>
<td>3000 Hz</td>
<td>10.00 (5.00-15.00)</td>
<td>10.00 (5.00-15.00)</td>
</tr>
<tr>
<td>4000 Hz</td>
<td>15.00 (5.00-20.00)</td>
<td>15.00 (5.00-15.00)</td>
</tr>
<tr>
<td>6000 Hz</td>
<td>15.00 (8.75-25.00)</td>
<td>15.00 (10.00-25.00)</td>
</tr>
<tr>
<td>8000 Hz</td>
<td>15.00 (10.00-30.00)</td>
<td>10.00 (8.75-15.00)</td>
</tr>
<tr>
<td>Speech Recognition Threshold (%)</td>
<td>96.0 (90.6-100.0)</td>
<td>100.0 (100.0-100.0)</td>
</tr>
<tr>
<td>Tympanometry (MAC)</td>
<td>0 (0-0)</td>
<td>0 (0-0)</td>
</tr>
</tbody>
</table>

MAC= mean air conduction; Hz=Hertz, SRT= speech recognition threshold; TIMP= tympanometry.