Male gender, N (%)	25 (53%)
Current treatment, N (%)	31 (66%)
- Anti-TNF alpha	9 (19%)
- Jak-Inhibitor	3 (6%)
- Anti-Integrin	2 (4%)
- Anti-IL12-23	2 (4%)
- Anti-IL17	
Biologic treatment rank	23 (49%)
- 1	14 (30%)
- 2	5 (11%)
- 3	4 (8%)
- 4	1 (2%)
- 5	
Disease duration, years (SD)	11.6 (9.6)
Current treatment duration, years (SD)	1.6 (1.9)
Use of previous PSP, N (%)	15 (32%)
CQR score, mean (SD)	86.9 (6.8)

Importance of Patient Support Program Services

Abstract AB1238 Figure 1. Patient Support Program: Importance Assigned by the Patients to the different Services.

Disclosure of Interests: None declared

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Epidemiology, risk factors for disease or disease progression

AB1239 GENDER DIFFERENCE IN PULMONARY ARTERIAL HYPERTENSION, ASSOCIATED WITH CONNECTIVE TISSUE DISEASES

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Background: Pulmonary arterial hypertension (PAH) is a progressive fatal disease with a known gender dimorphism. However, data on gender differences at patients with pulmonary arterial hypertension, associated with connective tissue diseases (PAH-CTD), currently not enough.

Objectives: Therefore, this study aimed to investigate the role of gender in clinical future, hemodynamic data and survival PAH-CTD.

Methods: We examined the long-term prognosis of 97 consecutive PAH-CTD patients, mean age 49 years (7 males and 90 females) diagnosed in our Institute from January 2009 to December 2018. The primary outcome was death. We used nonparametric analysis, Cox regression and the Kaplan-Meier method to assess variables obtained at baseline. All patients received PAH-specific therapy according to the current recommendations.

Figure 1

Results: We found that male patients had differences in diagnosis duration, level of creatinine, uric acid, RAP. We did not reveal differences in age, a functional class, a risk scale, and the majority clinical, tool and hemodynamic indicators. However, there were significant differences in survival. So, in male group survival was 21 [12; 51] months, in comparison in female group 74 [48; 119] months, $p < 0.02$. Thus, the male sex was an independent predictor of poor prognosis (HR 2.92 [95%CI 1.21; 7.03], $p = 0.018$) of PAH-CTD.

Conclusion: These results indicate that female PAH-CTD patients have better long-term prognosis than male, despite lack of many distinctions. It needs to be considered at outcome assessment.

Disclosure of Interests: Alexander Volkov : None declared, Natalia Yudkina: None declared, Ekaterina Nikolaeva: None declared, Evgeny Nasonov Speakers bureau: Pfizer, Inc., MSD, Novartis, AbbVie Inc., Celgene Corporation, Biocad, Janssen, UCB, Inc.

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AB1240 CAUSES AND ASSOCIATION OF DEATH IN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS IN A TERTIARY REFERRAL UNIVERSITY HOSPITAL IN EGYPT

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Background: Systemic lupus erythematosus (SLE) is a chronic autoimmune disease with heterogeneous, multisystem involvements which can sometimes be severe and life threatening. Different causes of mortality have been described over different decades in SLE patients⁽¹⁾.

Objectives: To describe and analyze the causes of death in SLE patients and to identify the associated risk factors in Egypt.

Methods: A retrospective study was conducted on the SLE patients who died in the period from January 2014 to November 2019 in the Zagazig University hospitals. We collected demographic and laboratory data for all patients including; age of onset of SLE, age at death, disease duration, systems affected, last reported disease activity using the Systemic Lupus Erythematosus Disease Activity Index (SLEDAI), treatment received immunosuppressive regimen (dose and duration) and the cause of death.

Results: 41 SLE patients (33 female and 8 males) had died during period from January 2014 to November 2019 with mean age at onset (26.1±8.1), mean age at death (37.4±13.3), mean SLE duration (11.2±6.7) and mean SLEDAI (15.4±6.8). Majority of the dyed patients had lupus nephritis (87.8%), (26.8%) had neuropsychiatric lupus, (14.6%) had SLE vasculitis. (31.7%) had APS, (29.2%) had ILD, (14.6%) had pneumonitis, (19.5%) had carditis, and (14.6%) had PAH. All these patients were on a median dose of prednisolone 10 (2.5-20) mg daily with median of 10 (4-24) years of steroids. 11 of these patients (26.8%) had a family history of SLE. 21(51.2%) of them had received intravenous cyclophosphamide during their with mean cumulative dose of (6.7±4.6) gm, 16 (39%) had received MMF, 5 (12.3%) had received cyclosporine and 9 (22%) had received azathioprine. As regard causes of death, serious infection particularly pulmonary infection was the most common cause of death in 16 patients (39%), followed by stroke in 8(19.5%) patients, renal failure in 7 (17.1%), pneumonitis in 3(7.3%),cancer in 3 (7.3%), Disseminated Intravascular Coagulation (DIC) in 1 (2.4%), Macrophage Activating Syndrome (MAC) in 1 (2.4%), pancytopenia in 1 (2.4%) and one (2.4%) pregnant patient died from eclampsia in her third trimester with her fetus. The risk of death from serious pulmonary infections is higher in patients with ILD and pneumonitis ($p < 0.000$). The risk of stroke is higher in SLE patients with APS ($P = 0.03$) and neuropsychiatric lupus ($p = 0.002$).

Conclusion: pulmonary infections was the most common cause of death in SLE patients in a tertiary university hospital in Egypt.

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