be the strongest inhibitor of TNF- α among cytokines involved in pSS pathogenesis, iii) results may explain the ineffectiveness of anti-TNF drugs in the treatment of pSS

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THU0272 FUNCTIONAL GASTROINTESTINAL DISORDERS IN WOMEN WITH SYSTEMIC LUPUS ERYTHEMATOSUS

Pamela Munguía Realpozo^{1,2}, Claudia Mendoza Pinto¹, Mario García Carrasco^{1,2}, Socorro Méndez Martínez³, Tania Mogollán Delfín¹, Jose Álvaro Montiel Jarquín³, Aurelio López Colombo³. ¹CIBIOR-UMAE, Instituto Mexicano del Seguro Social, Systemic Autoimmune Diseases Research Unit, Puebla, Mexico; ²Medicine School, Benemérita Universidad Autónoma de Puebla, Rheumatology and Immunology Department, Puebla, Mexico; ³UMAE Instituto Mexicano del Seguro Social, Puebla, Mexico

Background: Systemic lupus erythematosus (SLE) is a chronic autoimmune disease with multisystemic involvement. Gastrointestinal (GI) manifestations are frequent in patients with SLE, but functional gastrointestinal disorders (FGIDs), a heterogeneous group of GI diseases have hardly been evaluated in SLE patients.

Objectives: We evaluated the prevalence of FGIDs in SLE patients compared with age-matched controls and the role of potential risk factors for FGIDs.

Methods: SLE patients who met the ACR classification criteria for SLE and age-matched controls completed the Rome III questionnaire to assess the prevalence of FGIDs. Exclusion criteria were organic gastrointestinal disorders. Patients completed a structured interview to assess sociodemographic, clinical and treatment variables. Logistic multivariate analysis was performed to determine potential clinical factors (alcohol ingestion and medications) for FGIDs.

Results: The study responders included 116 SLE patients and 122 controls. The prevalence of FGIDs was higher in SLE patients than in controls (74.1% vs. 54.1%; $p = 0.01$). The most frequent FGIDs were nausea and vomiting disorders, belching disorders and globus pharyngeus. Anorectal disorders, mainly anorectal pain, were more frequent in SLE patients than controls (14.7% vs. 5.7%). After adjusting for confounding variables, SLE was associated with globus pharyngeus (OR: 3.5, 95%CI: 1.3-9.3), functional heartburn (OR: 2.5, 95% CI: 1.5-4.4), nausea and vomiting disorders (OR 7.1, 95% CI 2.7-19.1) and anorectal disorders (OR: 3.4, 95% CI 1.4-8.4). Overlap symptoms were present in 69.8% of patients vs. 31.8% of controls. When only SLE patients were evaluated, glucocorticoid therapy and non-steroidal anti-inflammatory drugs (NSAIDs) were associated with any FGID and functional bowel disorders, while alcohol ingestion was associated with gallbladder and sphincter of Oddi disorders.

Conclusion: There is a higher prevalence of FGIDs in patients with SLE and a wider distribution of various GI tract symptoms compared with controls. Medication that may alter gastrointestinal homeostasis, such as NSAIDs and protein pump inhibitors, were associated with FGIDs in SLE patients.

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THU0273 EVALUATION OF RELAPSE RATE AND LIFE PROGNOSIS AFTER INDUCTION THERAPY IN PROLIFERATIVE AND MEMBRANOUS LUPUS NEPHRITIS

Momoko Okamoto¹, Kunihiro Ichinose¹, Mineaki Kitamura², Shuntaro Sato³, Keita Fujikawa⁴, Yoshiro Horai⁵, Naoki Matsuoka⁶, Masahiko Tsuboi⁶, Fumiaki Nonaka⁷, Yukitaka Ueki⁸, Toshimasa Shimizu¹, Tomohiro Koga¹, Shinya Kawashiri¹, Naoki Iwamoto¹, Mami Tamai¹, Hideki Nakamura¹, Tomoki Origuchi⁹, Tomoya Nishino², Atsushi Kawakami¹. ¹Nagasaki University Graduate School of Biomedical Sciences, Department of Immunology and Rheumatology, Nagasaki, Japan; ²Nagasaki University Hospital, Department of Nephrology, Nagasaki, Japan; ³Nagasaki University Hospital, Clinical Research Center, Nagasaki, Japan; ⁴JCHO Isahaya General Hospital, Department of Rheumatology, Nagasaki, Japan; ⁵Nagasaki Medical Center, Department of Rheumatology, Nagasaki, Japan; ⁶Nagasaki Medical Hospital of Rheumatology, Nagasaki, Japan; ⁷Nagasaki University Graduate School of Biomedical Sciences, Department of island and rural medical research, Nagasaki, Japan; ⁸Sasebo Chuoh Hospital, Rheumatic disease center, Nagasaki, Japan; ⁹Nagasaki University Graduate School of Biomedical Sciences, Department of Rehabilitation Sciences, Nagasaki, Japan

Background: The most common cause of morbidity and mortality in systemic lupus erythematosus (SLE) is lupus nephritis (LN). Renal flares are disadvantageous to the renal function of patients with severe LN, and the flares contribute to morbidity in patients with SLE. The reported incidence of renal flares has varied with the populations studied, the distribution of histological classes of LN, the treatment administered and the definitions of renal flare.

Objectives: Here we evaluated the relapse rate and life prognosis after induction therapy in proliferative and membranous LN.

Methods: We retrospectively analyzed the cases of 151 patients who underwent renal biopsy at our hospital and community hospitals from 1993 to 2016. We determined the complete response (CR) rate at 6 and 12 months after induction therapy and evaluated the predictive factors for CR, relapse rate, and life prognosis in proliferative and membranous LN.

Results: We were able to examine the therapeutic response, relapse rate and life prognosis at 6 and 12 months after therapy was introduced in 140 cases. Most of the patients were female (84.3%). The median age at LN onset was 34.0 years (interquartile range [IQR] 25.3-45.0 years), and the disease duration of SLE was 42 months (IQR 2.0-121.0 months). The median follow-up duration after renal biopsy was 96 months (IQR 44.0-168.0 months). The renal pathology of 99 (70.7%) patients was classified as ISN/RPS Class III or IV, and 41 (29.3%) patients were ISN/RPS Class V. Thirty-five patients (35.4%) were Class III or IV, and 17 patients (41.5%) in Class V achieved a CR at 6 months. Fifty patients (50.5%) in Class III/IV and 22 patients (53.7%) in Class V achieved a CR at 12 months. A multivariate analysis showed that a lower index of chronicity as assessed by the NIH histological scoring system in Class III/IV, and neutrophil infiltration and CH50 in Class V were predictive factors for achieving a CR at 12 months. A Kaplan-Meier analysis showed that the relapse rate and life prognosis were not different between proliferative and membranous LN.

Conclusion: Our results suggest that the predictive factors for a CR at 12 months after induction therapy are a lower index of chronicity in class III/IV and neutrophil infiltration and CH50 in Class V. In general, proliferative LN is more immunologically active than membranous LN, but we observed no significant differences in the achievement of a CR at 6 or 12 months after induction therapy, the relapse-free period, of life prognosis between proliferative and membranous LN. The therapeutic response and life prognosis of membranous LN as well as proliferative LN should be monitored closely.

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