Obsetrical  |  Thrombotic  |  Both
---|---|---
377  |  320  |  115
46.3%  |  39.7%  |  14 %

Miscarriages 40%
Foetal loss 31%
Preeclampsia 12%
IUGR 11%
Multiple type of obstetrical events 10%

Recurrent with HCO

The obstetrical manifestations were various as described in figure 2.
The number of thrombotic events were 190 arterial and 187 venous. Triple antiphospholipid antibody (aPL) positivity was found in 20% of patients and lupus anticoagulant (LA) in 22%. No bleeding was registered in 99.6% of cases with treatment by HCQ. HCQ use was associated with favourable outcome in 96% of cases (figure 3).

In multivariate analysis, age more than 65 years was associated with arterial events (odds-ratio 0.13 95%CI 0.03-0.32, p 0.005).
Conclusion: HCQ could be effective in cases of refractory APS but pro-
arterial events (odds-ratio 0.13 95%CI 0.03-0.32, p 0.005).
In multivariate analysis, age more than 65 years was associated with favourable outcome in 96% of cases (figure 3).

REFERENCES:
perspective studies are necessary.

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None declared

V, et al. Antithrombotic effects of hydroxychloroquine in primary antiphos-

FR0186 HYDROXYCHLOROQUINE ON THE TOP OF STANDARD TREATMENT WITH LOW DOSE ASPIRIN AND LOW MOLECULAR WEIGHT HEPARIN SIGNIFICANTLY REDUCES THE PROBABILITY OF PREGNANCY MORBIDITY IN WOMEN WITH MULTIPLE POSITIVITY FOR ANTI-PHOSPHOLIPID ANTIBODIES

Cecilia Chighizola1, Francesca Pregno1, Francesca Bartoli2,3, Maria Gerossi2,3, Chiara Comerci2,4, Maria Gabriella Raimondi2,5, Laura Trespidi4, Maria Orietta Borghi5, Ljudmila Stojanovich2, Karien Devree2,3, Laura Damiani2, Arsen E Mekinian2, Valentina Canti5

Background: Hydroxychloroquine is an anti-malarial drug that not only exerts immunomodulatory and anti-thrombotic properties, but also has been shown to reverse several effects mediated by anti-phospholipid anti-
bodies (aPL) in models of obstetric anti-phospholipid syndrome (APS). Not surprisingly, HCQ, whose prescription during gestation is perfectly safe, has been proposed as an additional therapeutic tool in obstetric APS, but evidence of its efficacy is still scant.

Objectives: This study investigates how treatment with HCQ, prescribed in different combinations with low-dose aspirin (LDASA) and low-molecular weight heparin (LMWH), affects the probability of pregnancy morbidity (PM).

Methods: Data on pregnancies in women with persistent aPL positivity at any titre, with or without autoimmune diseases, were retrospectively collected at a single centre.

A weighted generalized estimated equation (GEE) model was applied to quantify the effect of treatment with HCQ on PM, allowing to: i) evaluate pregnancy outcomes over time using available longitudinal data; ii) account that pregnancies of the same woman are not independent events; iii) consider that women had a different number of pregnancies; iv) estimate the role of several confounders and predictors.

The model envisaged as dependent variable pregnancy outcome as a binary outcome, defined for each pregnancy as “obstetric complication yes versus no” (pregnancy loss before 10 weeks, pregnancy loss after 10 weeks, premature birth before 34 weeks, according to updated APS classification criteria).

Results: Three-hundred-eighty-one women were recruited in this study: 155 women with aPL positivity (100 women with positivity for criteria aPL and 55 women with low titre aPL) and 226 women with autoimmune diseases but negative aPL. Data were collected on 847 pregnancies: 458 in women with positive aPL (172 in women with criteria aPL and 286 in women with low titre aPL) and 389 in women with autoimmune disease and negative aPL.

PM in untreated patients are presented in Table 1. Table 2 reports PM in women receiving LDASA+/- HCQ, LMWH +/ - HCQ.

Conclusion: HCQ, when added to LDASA or on the top of standard treatment with LDASA and LMWH, allows to reduce PM. Most importantly, HCQ plus the combo LMWH + LDASA leads to a significantly
reduction of P_PM even in women at highest risk, namely those with multiple criteria aPL positivity.

REFERENCES:

Table 1. Probabilities of P_PM in untreated women with or without aPL.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>aPL negative</th>
<th>Low titer single aPL positivity</th>
<th>Low titer double aPL positivity</th>
<th>Criteria single aPL positivity</th>
<th>Criteria multiple aPL positivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low titer single aPL positivity</td>
<td>38% (29-48)</td>
<td>62% (52-71)</td>
<td>83% (75-89)</td>
<td>80% (71-87)</td>
<td>89% (81-94)</td>
</tr>
<tr>
<td>Low titer double aPL positivity</td>
<td>(23-41)</td>
<td>(14-30)</td>
<td>(9-23)</td>
<td>(6-17)</td>
<td></td>
</tr>
<tr>
<td>Criteria single aPL positivity</td>
<td>57% (44)</td>
<td>34% (23-41)</td>
<td>30% (23-41)</td>
<td>34% (22-40)</td>
<td>35% (26-44)</td>
</tr>
<tr>
<td>Criteria multiple aPL positivity</td>
<td>(42-62)</td>
<td>(31-50)</td>
<td>(22-40)</td>
<td>(14-30)</td>
<td></td>
</tr>
</tbody>
</table>

Data are expressed as P_PM (95% confidence interval).

Table 2. Probabilities of P_PM in treated women with aPL.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>LDASA</th>
<th>LDASA + HCO</th>
<th>LDASA + LMWH</th>
<th>LDASA + HCO + LMWH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low titer single aPL positivity</td>
<td>31% (23-41)</td>
<td>65% (52-71)</td>
<td>70% (62-78)</td>
<td>72% (64-80)</td>
</tr>
<tr>
<td>Low titer double aPL positivity</td>
<td>57% (44)</td>
<td>34% (23-41)</td>
<td>30% (23-41)</td>
<td>34% (22-40)</td>
</tr>
<tr>
<td>Criteria single aPL positivity</td>
<td>(42-62)</td>
<td>(31-50)</td>
<td>(22-40)</td>
<td>(14-30)</td>
</tr>
<tr>
<td>Criteria multiple aPL positivity</td>
<td>(59)</td>
<td>(47-66)</td>
<td>(38-57)</td>
<td>(26-45)</td>
</tr>
</tbody>
</table>

Data are expressed as P_PM (95% confidence interval).

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REFERENCES:

Figure 1. Changes in the number of Th17 cells (number/μl) before and after treatment in the two groups.

(a)

(b)