prevalence of atherosclerosis. This has been characteristically attributed to the inflammation present in both diseases

Objectives: To analyze the differences in the role of traditional cardiovascular risk factors in the subclinical atherosclerosis between the two diseases.

Methods: Cross-sectional study encompassing 602 subjects, 276 SLE and 326 RA patients. Carotid plaques were assessed by ultrasonography. A multivariable regression analysis was performed to evaluate if classic cardiovascular-related risk factors influence differentially on subclinical carotid atherosclerosis in SLE compared to RA patients.

Results: Traditional cardiovascular risk factors were found to be prevalent in RA and SLE patients. Age (interaction factor $p=0.000$), hypertension (interaction factor $p=0.034$), and diabetes (interaction factor $p=0.037$) were found to have a higher effect on cIMT in RA patients compared to SLE subjects. No differences between RA and SLE were discovered in the effect of traditional cardiovascular factors over the presence of carotid plaque when univariate interaction was performed. After final adjustment for demographics, the presence of others traditional cardiovascular factors, and disease related data, no differences were found in the influence of hypertension, diabetes, dyslipidemia or current smoking over cIMT or the presence of carotid plaque. Moreover, the effect of the addition of various cardiovascular risk factors on the subclinical carotid atherosclerosis did not differ between both diseases.

Conclusion: The influence of traditional cardiovascular risk factors (hypertension, diabetes, dyslipidemia and smoking) over cIMT and carotid plaque is equal in RA and SLE. No interaction was found between traditional cardiovascular risk factors and disease related data in the effect of the former on subclinical atherosclerosis.

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FRI0251

SYSTEMATIC REVIEW OF PREDICTOR MARKERS OF POOR RENAL EVOLUTION IN PATIENTS WITH LUPUS NEPHRITIS

Esther Rodríguez Almaraz¹, Elena Gutiérrez Solís², Elena Rabadan¹, Paola Rodríguez Ramos², Enrique Morales Ruiz², María Galindo-Izquierdo¹. ¹Hospital 12 De Octubre, Rheumatology, Madrid, Spain; ²Hospital 12 De Octubre, Nephrology, Madrid, Spain

Background: Lupus nephritis (LN) affects 30-45% of patients with lupus and causes great morbidity and mortality. About 10-25% of patients will develop chronic kidney disease (CKD), and it has been described a mortality of 10-20% at 10 years^{1,2}. Currently there is no ideal biomarker or composite indexes that help us to better assess and monitor.

Objectives: To identify and perform a critical analysis of the prognostic markers and indexes published through a systematic review of the literature in order to subsequently develop an index that helps us to estimate the prognosis of patients with LN.

Methods: We conducted a systematic review and meta-analysis according to the guidelines of the "Cochrane Collaboration" and our results are exposed in accordance with the "Preferred Reporting Items for Systematic Reviews and Meta-Analyses PRISMA statement". We did an electronic search in MEDLINE, EMBASE, CINAHL and Web of Science using free text and MeSH terms. The selection was made by 2 independent authors using a bibliographic manager. First, a selection was made by title and if it seemed relevant, a review of the abstract was made. In case of doubt, the full text was evaluated for a possible inclusion. The articles had to fulfill the following criteria: marker or prognostic index of LN, longitudinal studies, to collect the prognostic factor retrospectively without variable biases suitable for good/poor renal prognosis and LN diagnosed by biopsy. Six authors independently extracted data from the articles on previously tested forms to determine their feasibility, and differences were discussed. The data included the general characteristics and results measured. Also adverse events were reported.

Results: We selected 1010 articles initially, of which we discarded 853 per title. Of the 157 remaining, 84 were selected per abstract, and finally, 62 articles were excluded after the review of the full text. In total,

the 22 studies included 2301 patients, all older than 18 years. Most were single-center and retrospective (65%). Among the analytical markers, serum creatinine (Cr) was one of the most used variables as a predictor of time to CKD depending on the value, which varied according to the studies. It was also associated as a damage predictor according to the SLICC scale. Proteinuria appears in several studies as a marker of progression of LN, associating the amount with renal response, the development of end-stage renal disease (ESRD), the need for dialysis and the appearance of extrarenal events. Other variables analyzed were: demographic (ethnicity, socioeconomic level), immunological (anti-Ro, anti-DNA, anti-C1q and anti-CRP antibodies with poor renal evolution), histopathological (increased need for dialysis in glomerulonephritis IV, thrombotic microangiopathy, C4d deposits or tubular atrophy and association of chronicity index with remission) or therapeutic (hydroxychloroquine with remission).

Conclusion: Although there are several biomarkers to evaluate the LN prognosis, we have no found indexes for LN prognosis assessment in literature. The development of easily reproducible compound index is necessary for the assessment of the prognosis and the severity of patients with LN on debut and during evolution.

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FRI0252

CLINICAL AND SEROLOGICAL LUPUS ACTIVITY BEFORE AND AFTER DEVELOPING END STAGE RENAL DISEASE

Maria Salgado Guerrero¹, Alejandra Londono Jimenez², Chrisanna Dobrowolsky², Shudan Wang², Anna R. Broder². ¹Jacobi Medical Center/Albert Einstein College of Medicine, Internal Medicine, Bronx, NY, United States of America; ²Montefiore Medical Center/Albert Einstein College of Medicine, Rheumatology, Bronx, NY, United States of America

Background: SLE disease activity tends to diminish after the development of end stage renal disease (ESRD)^{1, 2}. Nonetheless, some patients continue to show signs of active disease and experience flares after ESRD³. To date, little is known about the evolution of SLE-related symptoms pre and post ESRD. Whether specific symptoms abate after ESRD or a shift towards different manifestations occurs deserves further study. Prompt identification of subtler SLE manifestations is further complicated by a trend towards poor rheumatology follow once ESRD develops. SLE manifestations post-ESRD may be underdiagnosed and undertreated contributing to increased morbidity and mortality.

Objectives: To study the different clinical manifestations and serological markers of SLE disease activity before and after ESRD development.

Methods: We performed a retrospective chart review of SLE patients with ESRD at a tertiary care center between the years of 2010 and 2017. SLE was defined by ACR and/or SLICC criteria. SLE ESRD patients were included if they had at least one visit with rheumatology, nephrology, or primary care pre- and post-ESRD. SLE-related symptoms and serologic markers of disease activity were identified from chart review before and after ESRD onset.

Results: Fifty-eight patients were included. Twenty-five patients had at least one clinical non-renal criteria documented pre-ESRD. Of them, 14 achieved complete clinical remission post-ESRD. Post-ESRD, cytopenias persisted in 49 of the 55 patients who were cytopenic pre-ESRD. Arthritis persisted in 3 of the 13 patients who had arthritis pre-ESRD. Of the 37 patients with hypocomplementemia pre-ESRD, 29 remained hypocomplementemic post-ESRD. Twenty-nine had elevated dsDNA pre-ESRD, of them, dsDNA remained elevated in 16 patients post-ESRD. Six patients developed at least one new clinical criteria post-ESRD. Three patients developed low complement, 5 developed elevated dsDNA, 3 developed new onset of serositis and 4 new onset of arthritis post-ESRD.

Conclusion: Lupus activity may diminish after ESRD onset. However, many patients experience persistent disease activity. New arthritis, serositis, low complements and elevated dsDNA may develop after ESRD. Limited evaluation and documentation of disease activity by non-rheumatology

providers may have resulted in under-reporting of SLE signs and symptoms on this study. SLE ESRD patients should be carefully evaluated for subtle signs of active SLE.

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FRI0253

RENAL TRANSPLANTATION IN LUPUS NEPHRITIS VS NON-AUTOIMMUNE TRANSPLANTATION. LONG TERM FOLLOW-UP. STUDY FROM A SINGLE TERTIARY CENTER

Lara Sánchez Bilbao¹, Iñigo González-Mazón¹, Marina de Cos-Gómez², Belén Atienza-Mateo¹, José Luis Martín-Varillas¹, Monica Calderón-Goercke¹, D. Prieto-Peña¹, Juan Carlos Ruiz-San Millán², Miguel Á. González-Gay¹, Ricardo Blanco¹. ¹Rheumatology. Hospital Universitario Marqués de Valdecilla, IDIVAL., Santander, Spain; ²Nephrology. Hospital Universitario Marqués de Valdecilla, IDIVAL., Santander, Spain

Background: Lupus nephritis (LN) is a severe complication of systemic lupus erythematosus (SLE), affecting up to 30-40% of patients. Unfortunately, approximately 10-20% of LN develop end stage renal disease (ESRD) and need replacement therapy. Renal transplantation may be a good option. However, concerns about LN recurrence after renal transplantation have been reported.

Objectives: In a series of patients with first renal transplantation due to LN our aim was to assess a) long-term post-transplant survival and, b) comparison of post-transplant survival with a control group due to a non-autoimmune nephropathy, the polycystic kidney disease (PKD).

Methods: We study two groups of patients with first renal transplantation: a) LN and b) control group with PKD. All these patients were transplanted in a single reference University Hospital. The main outcome variables were a) graft and patient survival up to 20 years and b) evolution of renal function (serum creatinine and proteinuria) in the first 5 years of follow-up. Cumulative survival rates after transplantation were estimated by the Kaplan-Meier method and compared between groups using the log-rank test. Mann-Whitney test was used to compare quantitative variables and chi²/Fisher's exact test for qualitative variables.

Results: We included a total of 53 patients with renal transplant; a) LN group (n=21), b) PKD group (n=32). No significant differences at baseline were observed between the 2 groups regarding sex and cardiovascular risk factors. Significant differences were found in terms of age at kidney transplantation, with a mean of 39.80±11.27 years in LN group and 46.59±5.01 years in the PKD group (p=0.004). Renal biopsy had been performed in 16 patients with LN: type II LN (25%), type III (25%) and type IV (50%), (according to the World Health Organization and International Society of Nephrology/Renal Pathology Society classification). From 48 patients (of 53) in which a renal biopsy was performed during the first-year post-transplant, rejection was found in 21 patients (43.7%) without significant differences between the 2 groups (p=0.444). The evolution of serum creatinine and proteinuria after renal transplantation is shown in **TABLE-1**. Regarding serum creatinine, significant differences were found in creatinine levels only at the 6th month post-transplant (p=0.032) with no differences in the following measurements. In LN group, 3 patients (14.3%) developed a lupus flare: 2 cases presented as extrarenal disease and only 1 case with histological recurrence in the graft. No significant differences were found in terms of patient or graft survival between the two groups in 20 years of follow-up (**Figures 1 and 2**).

Conclusion: Despite concerns about LN recurrence after renal transplantation, data obtained in our sample indicate that this procedure as a safe alternative therapy for ESRD in this population and can provide a long-term survival.

TABLE 1. Evolution of creatinine and proteinuria levels after renal transplant in LN and PKD.

Serum Creatinine mg/dL	1 Month		4 Months		1 Year		3 Years		5 Years	
	PKD	SLE	PKD	SLE	PKD	SLE	PKD	SLE	PKD	SLE
N	28	17	26	17	26	17	22	14	18	13
Mean	2.45±1.12	1.82±1.41	1.82±1.71*	1.47±0.89*	1.89±1.03	2.03±1.56	1.74±1.12	2.26±1.51	2.08±1.75	2.64±1.39
Proteinuria mg/dL	PKD	SLE	PKD	SLE	PKD	SLE	PKD	SLE	PKD	SLE
N	24	15	24	12	25	17	21	13	16	11
Mean	315.38±218.59	581.67±1032.88	372.67±279.79	681.67±479.01	322.84±234.93	1426.35±4413.40	378.81±333.91	409.46±335.64	871.81±1488.35	487.36±474.62

*p<0.05

FIGURE 1. Patient survival

FIGURE 2. Graft survival

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FRI0254

COMBINED PANEL OF NINE TESTS HAS THE GREATEST SENSITIVITY BUT THE LOWEST SPECIFICITY TO DETECT ANTIPHOSPHOLIPID ANTIBODY SYNDROME IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

Saika Sharmeen¹, Katalin Banki², Andras Perl¹. ¹State University of New York, Upstate Medical University, Medicine, Syracuse, United States of America; ²State University of New York, Upstate Medical University, Clinical Pathology, Syracuse, United States of America

Background: Antiphospholipid antibody syndrome (APS) is an autoimmune hypercoagulable state caused by antiphospholipid antibodies (aPL) which represent a diagnostic criterion and underlie significant comorbidities in patients with and without systemic lupus erythematosus (SLE). Although several tests exist for APS diagnosis, their utilization has been highly variable among laboratories and physicians.

Objectives: We have evaluated a panel of nine tests and conducted a retrospective study to determine their sensitivity and specificity for supporting the diagnosis of APS in SLE at our Institution between 2010 and 2018.

Methods: 1633 SLE patients, who satisfied the ACR criteria for a definitive diagnosis [1 2], were evaluated for the presence of APS as earlier described [3]. Lupus anticoagulants were assessed by Staclot LA hexagonal phase phospholipid neutralization assay (HPPNA; delta <8 seconds), Staclot diluted Russell viper venom test (dRVVT; <1.2 normalized ratio)