Objectives: To assess the use and drivers of SLEDAI and BILAG index in real world clinical practice.

Methods: A cross-sectional study of rheumatologists in the US and EU. Data were collected from the Adelphi Real World 2010/2013 Lupus Disease Specific Programmes (DSP). Physicians were asked to complete an attitudinal survey and patient record forms (PRFs) for the next 5 patients consulting with SLE; the same patients were asked to complete patient self-completion (PSC) forms describing how SLE affected them. PRFs collected data pertaining to the patient’s diagnosis, disease history, current clinical outcomes, treatment and management history. PSCs focused on similar data collection and included patient reported outcome measures (PROs) to assess the humanistic burden. 2015 DSP data was used to assess the profile of patients with a SLEDAI assessment were compared to those without a SLEDAI assessment, using Fisher’s Exact and Mann Whitney tests. Similar analysis was also conducted for those with/without BILAG index assessments. 2013 & 2010 DSP datasets were merged, and multiple linear regression was used to assess drivers of SLEDAI and BILAG index utility, respectively.

Results: Physicians provided 263 surveys, extracted from the 2015 DSP, indicating that 131 were aware of but did not use the BILAG index, and 92 of physicians were aware of but did not use the SLEDAI. Physicians provided 1376 record forms for SLE patients, extracted from the 2015 DSP; 71 (5.2%) had a BILAG index (1305, 94.8% had no BILAG index), and 373 (27.1%) had had a SLEDAI calculated prospectively (1003, 72.8% had No SLEDAI). Patients with SLEDAI had longer disease duration that patients who did not have a SLEDAI (mean: 6 vs 5.2 years, p=0.007); were less likely to have been described as mild at diagnosis (no SLEDAI mild: 18.7%; SLEDAI mild: 11.3%, p=0.0004) and consulted more with health care professionals in the past 12 months (no SLEDAI mean visits: 6.5, SLEDAI mean: 7.7, p=0.001). Patients with a BILAG index had flared more in the last 12 months (no BILAG: 30.6%, BILAG: 45.1%, p=0.012).

Physicians provided data on 220 SLEDAI and 75 BILAG assessments, extracted from the 2010 & 2013 DSPs. Multiple linear regression analyses revealed that flaring in the last 12 months (Coef: 3.27 [0.36 – 6.18], p=0.028), renal symptoms (Coef: 5.67 [1.84-9.51], p=0.004), and muscular symptoms (Coef: 4.58 [1.22-7.94], p=0.008) were all associated with a higher SLEDAI score, with r-squared 0.1948. Multiple linear regression showed that renal symptoms (Coef: 3.87 [1.00 – 6.75], p=0.009) were associated with a higher BILAG score, with r-squared 0.3717.

Conclusion: The use of SLEDAI and BILAG index in clinical practice is limited and seemingly reserved for use in more severe patient cohorts; understanding the ongoing impact of this selective use on the treatment and management of SLE would be beneficial. Additionally, understanding the drivers and barriers to the use of disease activity metrics is important to improve the management of SLE in the future.


Objectives: To evaluate serum PRL levels and DHEAS levels in patients with active SLE of recent onset vs patients with inactive chronic and healthy controls and their correlation with activity and chronicity scores

Methods: Serum PRL levels and DHEAS levels were studied, as well as their correlation with SLEDAI and SLICC scores. Group 1: 15 patients with SLE of recent onset (active SLEDAI >3) Group 2: 20 patients with inactive chronic SLE (SLEDAI<3) and Group 3: 20 healthy controls. SLEDAI and SLICC were calculated in group 1 and group 2 respectively. PRL and DHEAS was measured by radioimmunassay in all groups.

Statistical analysis: U-Mann Whitney and Spearman correlation.

Results: Group 1: serum PRL levels were 27.82±9.96 ng/dl vs group 2: 20.5±5.02 ng/dl (p = 0.004) and group 3: 19.58±9.52 μg/dl (p=0.004). Group 1: serum DHEAS levels were 14.58±9.26 μg/dl, group 2: 19.36±2.71 μg/dl (p=0.04) and group 3: 154.43±50.88 μg/dl (p =0.001). The average DHEAS was lower in patients with chronic SLE vs controls (p = 0.001). A positive linear correlation was found between serum PRL levels and SLEDAI score (Rho 0.92, p=0.001). No correlation was found between PRL and SLICC score. A negative linear correlation was shown between DHEAS concentration and SLICC score (Rho-0.46, p =0.03).

Conclusion: PRL levels were higher in active SLE patients vs. chronic inactive SLE and healthy controls. In contrast, serum DHAS levels were lower in patients with active SLE vs. inactive chronic SLE. We found a positive correlation between SLEDAI score and PRL serum concentrations and an inverse correlation between SLICC score and DHEAS serum levels.

REFERENCES:

Disclosure of Interests: None declared


Background: Different neurological manifestations have been observed in 20-25% of patients affected by Sjögren’s syndrome (SS). Among them, CNS demyelinating diseases, Neuromyelitis optica (NMO) and NMO spectrum disorders (NMOSD) with anti-aquaporin4 antibodies (anti-AQP4) positivity have been described.

Objectives: The aim of the present study was to assess the clinical characteristics and seroimmunological correlations in patients with Ro-SSA antibodies and Central and peripheral nervous system (CNS and PNS) involvement.

Methods: We retrospectively reviewed clinical records, laboratory and Magnetic Resonance Imaging (MRI) reports of patients followed-up at a tertiary level immunohematology and neuroimmunology clinic. We included patients showing an anti-SSA antibodies positivity and concomitant neurological symptoms at diagnosis. We excluded patients fulfilling SLICC criteria for SLE. We recorded clinical and laboratory and MRI data for all patients.

Results: Out of 9598 clinical records reviewed, we identified 511 patients with anti Ro/SSA positivity. 11 patients had prevalent neurological manifestations. 8 (72.7%) patients were women. The median age was 56 [IQR 31] years. CNS involvement was the main clinical feature in 7 patients (63.6%), 3 of them (27.3%) also had PNS manifestations. 4 patients showed exclusively PNS involvement. 3 subjects fulfilled criteria for SS while 8 patients were classified as undifferentiated connective tissue disease. 7 patients underwent spinal tap
which reported inflammatory alterations (high levels of CSF proteins in 2 subjects and oligoclonal bands in 4 patients).

Median Erythrocyte sedimentation rate (ESR) was 12 mm/h [IQR 18] while median C- Reactive protein was 0.34 mg/dL [IQR 0.32]. There was not complement deficiency in any patient. With regard to the tested auto-

Conclusion: Anti-SSA positive may show a wide spectrum of neurological manifestations; CNS involvement was not associated to anti-AQP4 positivity in our cohort, even in patients with NMOSD. Further investigations are required to better disclose this association and to search for novel autoantibodies.

Disclosure of Interests: None declared


FRI0259

SEROLOGICAL IMMUNE ABNORMALITIES ASSOCIATE WITH SPECIFIC PATHOLOGICAL ACTIVE LESIONS IN LUPUS NEPHRITIS

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Background: Serological immune abnormalities such as anti-double strand DNA (dsDNA) antibodies (Abs) and hypocomplementemia (HC) are characteristic of lupus nephritis (LN). International Society of Nephrology/Renal Pathology Society (ISN/RPS) Classification of LN defines pathological active lesions (ALs) including endocapillary hypercellularity, karyorrhexis, fibrinoid necrosis, cellular/fibrocellular crescents, and wire-loop lesion/hyaline thrombi [Reference 1]. Few reports have focused on the clinicopathological impact of serological immune abnormalities on pathological ALs.

Objectives: To identify the clinicopathological association between serological immune abnormalities and pathological ALs in LN.

Methods: We enrolled 126 Japanese LN patients who were subjected to renal biopsy in 11 hospitals from 2000 to 2018. We determined various clinical parameters at the time of renal biopsy, including creatinine (Cr), estimated glomerular filtration rate (eGFR), total protein (TP), IgG, IgA, IgM, C3, C4, CH50, anti-nuclear antibodies (Abs), anti-double strand DNA (dsDNA) Abs, anti-Sm Abs, anti-RNP Abs in the sera, urinalysis findings, presence of comorbidities (antiphospholipid antibody syndrome, hypertens-

RESULTS: Of 126 patients (104 females; mean age 41.8 years), dsDNA Abs (+) and HC (+) were found in 83 (65.9%) and in 80 (63.5%), respectively. There were no significant differences in renal function, comorbidities, immune deposits or immunosuppressive medications before renal biopsy. Renal biopsy findings were classified by ISN/RPS Classification including ALs. Immune deposits were evaluated by immunofluorescence. Elevation of serum anti-


FRI0260

THE INPATIENT BURDEN OF TAKAYASU’S ARTERITIS IN THE UNITED STATES: A NATIONWIDE ANALYSIS

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Background: Takayasu’s Arteritis (TAK) is a rare granulomatous inflammation of the large vessels. Its incidence has been reported to be 2-3 cases per million people in the United States. To our knowledge an inpatient nationwide study of TAK in the United States has not been published to date. The aim was to evaluate the demographic characteristics, reason for admission, procedures, mortality and resource utilization of patients with TAK using a national database.

Objectives: The primary goal was to estimate the national inpatient prevalence of admissions involving patients with TAK. Secondary outcomes were top reasons for admission, mortality, morbidity, resource utilization, length of hospital stay (LOS), and total hospitalization charges and costs, adjusted for inflation using the Consumer-Price Index.

Methods: All patients with a principal ICD9 diagnosis code for TAK were included using the NIS 2013 and 2014, the largest publicly available inpatient database in the US. Controls were 1:1 matched using a propensity score including age, gender, and Charlson Comorbidity Index (CCI). Multivariate logistic regression models were used to adjust for race, sex, patient zip code, income, CCI, hospital region, location, size and teaching status.

RESULTS: Of a total of 2,840 hospital admissions for patients with TAK, 2,680 were propensity-matched to admissions without TAK and included in the study. Mean age was 49 years, 81% were female. The inpatient prevalence of TAK was 4.6/100,000 admissions. After adjusting for con-


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REFERENCES: