AB0379

IS MYCOPHENOLATE SODIUM (MYFORTIC) SIMILARLY EFFECTIVE AS MYCOPHENOLATE MOFETIL (CELLCEPT) IN TREATMENT OF LUPUS NEPHRITIS? EXPERIENCE FROM NON-MEDICAL SWITCHING REAL WORLD DATA IN TAIWAN

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Background: Lupus nephritis is the most important predictive factor of morbidity and mortality in SLE. Though Mycophenolate mofetil is recommended for induction and maintenance treatment of class III, IV V lupus nephritis, it is not approved by US or Taiwan FDA (TFDA). In previous reports of kidney transplantation, no efficacy differences were observed between mycophenolate sodium (Myfortic) and mycophenolate mofetil (Cellcept). However, no clinical trial was conducted to compare these two widely-used mycophenolic acid derivatives in lupus nephritis. In December, 2016, TFDA approved Mycophenolate sodium in treatment of lupus nephritis. For reimbursement issue, patients treated with mycophenolate mofetil were non-medically switched to mycophenolate sodium in Taiwan.

Objectives: To compare the treatment efficacy of mycophenolate mofetil and mycophenolate sodium in lupus nephritis patients with non-medical switching.

Methods: Between 2016 and 2018, a retrospective observational study enrolled 50 biopsy-proven LN patients in Taichung Veterans General Hospital, Taiwan. All these patients were initially treated with Cellcept for at least one year. Treatment response was evaluated by urinalysis and daily urine protein one year before and after switching to Myfortic.

Results: Before switching, 72% patients were classified as responder if complete remission or partial remission were achieved, while 28% patients were categorized as non-responders (Table 1). After switching to Myfortic, 75% of the responder group achieved or maintained complete remission or partial response. In for non-responder group, 85.7% exhibited complete remission or partial response (Table 2). We did not observe new safety signals after switching.

Table 1. Comparisons demographics and renal pathologies of responder and non-responder groups

	Non-responder (N=14)	Responder* (N=36)	Total (n=50)	p value
Age	31.12±11.48	32.58±9.39		0.660
Female	23(88.5%)	20(76.9%)	43(82.7%)	0.465
Daily urine protein (g)	4.44±4.40	4.43±3.81		0.835
Creatine (mg/dl)	1.44±0.92	1.22±1.16		0.212
Renal pathology class				0.649
III	6(23.1%)	4(15.4%)	10(19.2%)	
III+V	2(7.7%)	4(15.4%)	6(11.5%)	
IV	16(61.5%)	15(57.7%)	31(59.6%)	
IV+V	2(7.7%)	3(11.5%)	5(9.6%)	

*complete remission and partial remission.

Table 2. Response rates of non-medical Switch from Cellcept to Myfortic

Initial treatment with Cellcept			
	Non-responder	Responder	p value
Non-medical switch to Myfortic			0.705
Non-responder	2(14.3)	9(25)	
Responder	12(85.7)	27(75)	

Conclusion: This real-world data indicated similar efficacy of Cellcept and Myfortic. Further prospective study is needed to confirm our findings.

Disclosure of Interests: None declared

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AB0380

THERAPEUTIC CHOICES AND OUTCOMES IN CHINESE PATIENTS WITH SEROLOGICALLY ACTIVE CLINICALLY QUIESCENT SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: Patients with systemic lupus erythematosus (SLE) who achieved the clinical state as serologically active clinically quiescent (SACQ). It appears to account for 6–12% of all patients with SLE, but there is disagreement about whether such patients are indeed clinically stable [1-3], especially in Chinese

patients. And there is no conclusion as to what kind of treatment should be taken for such patients.

Objectives: To clarify the frequency and outcome of SACQ patients in lupus. And to identify factors associated with the flare of disease.

Methods: Clinical data of patients diagnosed as SLE and followed in Peking University First Hospital from 2009 to 2015 were retrospectively reviewed. 682 patients with systemic lupus erythematosus who were followed up for more than 6 months at Peking University First Hospital from January 2007 to December 2015 were summarized. SACQ was defined as an at least a 6-month period with persistent serologic activity and without clinical activity and could be taking a daily dose of prednisone or equivalent less than 7.5mg. Serologically quiescent clinically quiescent (SQCQ) patients and serologically active clinically active (SACA) patients served as control groups. Data including demographics, initial symptoms, duration to SACQ, treatments before and after SACQ, and characteristics of the flare group were analyzed.

Results: Of the 682 patients, 170 were SACQ patients (24.9%), 187 were SQCQ patients, and 325 were SACA patients (47.7%). SQCQ patients (38.61±15.08 years old) were older at study start than SACQ patients (38.61±15.08 years vs. 32.09±14.35 years, p<0.001), but there was no significant difference between that of SACQ and SACA patients. 56 of the 170 SACQ patients (32.9%) experienced flare. Corticosteroids (OR 1.317, 95% CI 1.131 to 1.534; p<0.001) was an independent risk factor for flare, while antimalarials (OR 0.265, 95% CI 0.118 to 0.599; p=0.001) and immunosuppressants (OR 0.316, 95% CI 0.149 to 0.670; p=0.003) were protective factors.

Conclusion: About one third of SLE patients with SACQ experience flare, more than that of patients with SQCQ. Thus, approach to prevent relapse in SACQ patient is required. Maintenance therapy of hydroxychloroquine and immunosuppressant agents may be protective and beneficial treatment strategy in these patients need further investigation.

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AB0381

THE UTILITY OF HYDROXYCHLOROQUINE (HCQ) THERAPY FOR TWO YEARS AS A SPARING CORTICOSTEROID AGENCY IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)

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Background: Prednisolone (PSL) and HCQ are key drugs in the therapy of SLE. However, since PSL induce many harmful adverse events, PSL is preferred to be reduced especially in the maintenance therapy. The efficacy of HCQ for reducing the dose of PSL has not been revealed yet. So, we focused on the cessation of PSL under the treatment of HCQ with conventional SLE therapy.