According to CT findings, 23% had nodules in the lung, nodule sizes were less than 1 cm, and patients were followed up for an increase in size. Hilier and sub-carinal lymph nodes were present in 6% of patients and their sizes was ranged from 5 mm to 15 mm. Bronchoscopy was performed for two patients due to mediastinal LAP. Biopsy results were evaluated as reactive changes. Interstitial lung disease (ILD) findings were present in 16 patients. (69% NSIP, 25% LIP, 6% UIP). All patients with ILD received steroid therapy. Two patients received 6 cycles of cyclophosphamide treatment for active alveolitis and aza-thioprine (AZA) was used in maintenance therapy. Due to ILD, one patient was receiving rituximab, one patient was receiving mycophenolate mofetil, while nine patients were using AZA.

It was found bronchiectasis in 3% of patients, emphysema in 5%, sequelae fibrotic changes in 13%, and 1% patients had thickening of the pleura. One patient was diagnosed with hypersensitivity pneumonitis and two patients had lung cancer (Table-1).

Conclusion: Lung findings are detected in 9-12% of patients in pSS, which can increase to 75% with the use of tomography, pulmonary function tests and bronchoscopy.

Since pSS has a wide spectrum from airway disease or interstitial lung disease to lung cancer.

The relationship between smoking and lung cancer development could not be assessed due to the absence of lung cancer in the non-smoking group (Table-2). The relationship between smoking and development of emphysema and malignancy.

There was a smoking history in 21% of the patients. There was a significant relationship between smoking and lung cancer development could not be assessed due to the absence of lung cancer in the non-smoking group (Table-2).

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Disclosure of Interests: None declared

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**Table 1. Lung Findings of Primary Sjogren’s Syndrome Patients**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Nodule % (N)</th>
<th>Mediastinal LAP % (N)</th>
<th>Interstitial Lung Disease % (N)</th>
<th>NSIP % (N)</th>
<th>LIP % (N)</th>
<th>UIP % (N)</th>
<th>Bronchiectasis % (N)</th>
<th>Emphysema % (N)</th>
<th>Sequelae Fibrotic Change % (N)</th>
<th>Tuberculosis Sequelae % (N)</th>
<th>Airway disease % (N)</th>
<th>Pleural effusion % (N)</th>
<th>Lung cancer % (N)</th>
</tr>
</thead>
</table>

**Table 2. Effects of smoking on lung findings**

<table>
<thead>
<tr>
<th>Smoking Status</th>
<th>Nodule</th>
<th>Mediastinal LAP</th>
<th>Interstitial Lung Disease</th>
<th>NSIP</th>
<th>LIP</th>
<th>UIP</th>
<th>Bronchiectasis</th>
<th>Emphysema</th>
<th>Sequelae Fibrotic Change</th>
<th>Tuberculosis Sequelae</th>
<th>Airway disease</th>
<th>Pleural effusion</th>
<th>Lung cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoker</td>
<td>31(21)</td>
<td>23(21)</td>
<td>11(16)</td>
<td>69(9)</td>
<td>6(1)</td>
<td>6(1)</td>
<td>5(7)</td>
<td>7(7)</td>
<td>13(19)</td>
<td>1(2)</td>
<td>1(1)</td>
<td>1(2)</td>
<td>1(2)</td>
</tr>
<tr>
<td>Non-Smoker</td>
<td>107(71)</td>
<td>96(10)</td>
<td>11(16)</td>
<td>69(9)</td>
<td>6(1)</td>
<td>6(1)</td>
<td>5(7)</td>
<td>7(7)</td>
<td>13(19)</td>
<td>1(2)</td>
<td>1(1)</td>
<td>1(2)</td>
<td>1(2)</td>
</tr>
</tbody>
</table>

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.2507

**AB0440**

**LDL-CHOLESTEROL AS A RISK FACTOR OF PROGRESSION TO ESRD IN PATIENTS WITH LUPUS NEPHRITIS**

D. J. Park1, S. E. Choi1, H. Xu1, J. H. Kang1, S. S. Lee1. 'Chonnam National University Medical School & Hospital, Gwangju, Korea, Rep. of (South Korea)

Background: Recent studies have shown that the simultaneous positive of anti-double stranded DNA, -nucleosome, and -histone antibodies (3-pos) is prevalent in lupus nephritis (LN) patients compared to non-renal systemic lupus erythematosus (SLE) patients.

Objectives: The aim of this study was to define the clinical, biologic, histopathologic, and prognostic differences according to the simultaneous reactivity to those antibodies in Korean patients with biopsy-proven LN.

Methods: We studied 102 patients who underwent kidney biopsy prior to the start of induction treatment and who were subsequently treated with immunosuppressives and followed-up for more than 12 months. Sociodemographic, clinical, laboratory, and treatment-related data at the time of kidney biopsy and during follow-up were obtained by a review of patients’ charts. Antibodies were detected by immunoblot analysis or ELISA at the time of renal biopsy.

Results: Fifty-eight (56.4%) of the total of 102 LN patients had 3-pos. In comparison with non-3-pos patients, the patients with 3-pos showed a higher SLE Disease Activity Index-2000 score (P=0.002), lower lymphocyte level (p=0.004), higher proportion of proteinuria >3.5g/24 hr (p=0.005), and higher positivity of urinary sediments (p=0.005) at the time of renal biopsy. In the renal histopathologic findings, the patients with 3-pos had more proliferative LN (P=0.015) and also showed more endocapillary hypercellularity, sub-endothelial hyaline deposits, fibrinoid necrosis, angiitis, and cellular crescents in the disease activity index (p=0.016, p=0.045, p=0.002, and p=0.022, respectively), as well as a higher activity score (p=0.011). After a median follow-up of 83.2 months, rapid glomerular filtration rate decline was frequently observed in patients with 3-pos compared to those without (p=0.012).

Conclusion: Our findings suggest that 3-pos is related to severe LN and, furthermore, that patients with 3-pos show a rapid decline of renal function compared to those without.

Disclosure of Interests: None declared

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**AB0442**

**RISK FACTORS ASSOCIATED WITH THROMBOTIC EVENTS IN KOREAN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS**

D. J. Park1, S. E. Choi1, H. Xu1, J. H. Kang1, S. S. Lee1. 'Chonnam National University Medical School & Hospital, Gwangju, Korea, Rep. of (South Korea)

Background: Up to 30~40% of all patients with systemic lupus erythematosus (SLE) experience thrombosis, presenting as stroke and myocardial infarction, and these thrombotic events cause substantial morbidity and mortality in SLE. We explored the risk factors associated with the occurrence of thrombotic events in SLE patients.

Methods: This study enrolled 259 SLE patients (mean age, 34.0 ± 13.7; 239 females) with available clinical data at the time of SLE onset from the lupus cohort at Chonnam National University Hospital. Sociodemographic, clinical, and laboratory data, and history of concomitant diseases were obtained. Thrombotic events were defined as the presence of arterial or venous thrombosis. The
multivariable Cox’s model was performed to investigate the possible risk factors for thrombotic events.

Results: During a mean follow-up of 103.3 months (SD, 53.4), 27 patients (10.4%) developed thrombotic events: stroke in 15 patients, venous thrombosis in five patients, myocardial infarction in four patients, and angina in three patients. In the multivariable Cox’s regression analysis, hypertension (hazard ratio [HR], 16.946; P=0.031), antiphospholipid syndrome (APS) (HR, 18.348; P=0.001), cumulative prednisolone >5 mg/day (HR, 14.374; P=0.001), use of ACE inhibitors (ACEi) or angiotensin receptor blockers (ARB) (HR, 0.110; P=0.004), and Systemic Lupus International Collaborating Clinics Group (SLICC) damage index (HR, 1.972; P=0.004) were significant predictors of the development of thrombotic events in patients with SLE.

Conclusion: Patients with SLE showed significant thrombotic events during the course of their disease. Risk factors associated with thrombotic complications were higher cumulative dose of prednisolone, diagnosis of APS, and higher SLICC damage index. On the other hand, the use of ACEi or ARBs was associated with a reduced risk of thrombotic complications in patients with SLE. Our results support the need for increased monitoring of thrombotic complications in SLE patients.

Disclosure of Interests: None declared

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Table 1. Demographic baseline characteristics and clinical manifestations of patients with renal transplantation due to LN.

<table>
<thead>
<tr>
<th>DEMOGRAPHIC PARAMETERS</th>
<th>Sex, n (%)</th>
<th>Age at SLE diagnosis (years), mean ± SD</th>
<th>Age at renal transplantation, mean ± SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7 / 16</td>
<td>26.37±12.70</td>
<td>39.80±11.27</td>
</tr>
</tbody>
</table>

SLE RELATED DATA

<table>
<thead>
<tr>
<th>SLE RELATED DATA</th>
<th>Renal involvement</th>
<th>Hematological involvement</th>
<th>Anemia, n (%)</th>
<th>Leukopenia, n (%)</th>
<th>Thrombocytopenia, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16.0 (69.56)</td>
<td>13.0 (58.53)</td>
<td>6.0 (26.10)</td>
<td>5.0 (21.73)</td>
<td>2.0 (8.70)</td>
</tr>
<tr>
<td>Peripheral, n (%)</td>
<td>1.0 (4.34)</td>
<td>Central</td>
<td>4.0 (17.40)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2. 1.1.

<table>
<thead>
<tr>
<th>SLE RELATED DATA</th>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

The main clinical manifestations at diagnosis were articular (n=12; 52.17%) and cutaneous (n=13; 56.52%). On the other hand, 16 patients (69.6%) presented impaired renal function at diagnosis. In the other 7 patients (30.4%), this manifestation appeared with a delay of diagnosis from the onset of symptoms of 13.17±7.73 years.

Renal biopsy had been performed in 21 patients with LN: type II LN (n=2; 9.1%), type III (n=8; 36.4%), type IV (n=9; 40.9%) and type V (n=2; 9.1%). Patient and graft survival function after transplantation is represented in Figure 1 and 2.

Figure 1.

Regarding lupus flares after transplantation, 3 patients (13.0%) developed a lupus flare: 2 cases presented as extrarenal disease (one of them was a pneumonitis and the other one was a cutaneous and articular flare) and only 1 case with histological recurrence in the graft (Mean follow-up 15.00±9.84 years).