In Group 1, regardless of ethnicity, 29 (90.6%) patients developed LN within 5 years or less from the onset of SLE symptoms, while the remaining 3 (9.4%) developed LN after 5 years. In contrast, in Group 2, 24 (55.8%) patients developed LN within 5 years or less while 19 (44.2%) developed LN after 5 years. (P value = 0.002)

Further stratification was based on ethnicity and antibody (AB) status to investigate the time to develop LN from SLE symptom onset: African ancestry with positive AB, African with negative AB, Asian with positive AB, Caucasian with positive AB and Asian & Caucasian with negative AB. Analysis showed that of 29 (38.7%) African ethnicity patients with the autoantibody combination, 19 (65.5%), developed LN within 5 years. In comparison, 46 (61.3%) patients, independent of ethnicity and AB status, developed LN after 5 years (P value = 0.01).

Conclusion: Patients with the unusual autoantibody combination of Sm, Ro & RNP developed LN significantly earlier than patients who did not have this combination. This autoantibody combination was significantly over represented in the African ancestry patients. Our data suggests that African ancestry patients with this autoantibody combination are at increased risk of developing LN soon after SLE symptom onset and merit close monitoring for the development of renal disease.

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Table 1.1 Ethnicity with Autoantibody status showing the rate of progression into Lupus Nephritis.

		Duration of LN onset		Total
		Less than 5 years after SLE onset	More than 5 years after SLE onset	
Ethnicity with AB status	African with positive	19	3	22
	African with negative	9	4	13
	Asian with positive	5	0	5
	Caucasian with positive	5	0	5
	Other negatives	15	15	30
Total		53	22	75

Graph 1. Ethnicity with Autoantibody status showing the rate of progression into Lupus Nephritis (P value= 0.01)

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CARDIAC INVOLVEMENT IN NEWLY DIAGNOSED SPANISH PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS: DATA FROM THE RELES COHORT

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Background: Cardiac involvement is one of the most important causes of disability and mortality in patients with systemic lupus erythematosus (SLE). Transthoracic echocardiography (TTE) is a sensitive and specific technique in detecting cardiac abnormalities, particularly mild pericarditis, valvular lesions and myocardial dysfunction in SLE.

Objectives: Using data of patients from the inception cohort Registro Español de Lupus Eritematoso Sistémico (RELES), we aimed to analyse the echocardiographic features of cardiac involvement of systemic lupus erythematosus (SLE). **Methods:** Prospective observational study on a multicenter Spanish inception cohort. Patients with SLE, diagnosed by the American College of Rheumatology (ACR) criteria, since January 2009, who had at least one TTE performed were selected. Demographic data, diagnostic criteria, follow-ups, treatments and SLEDAI were analyzed.

Results: We included 289 patients diagnosed with SLE with TTE performed. The mean age was 40.5 ± 1.9 years, of which 86.9% (251) were women and 82.4% (238) Caucasian. The ACR score at diagnosis was 4.98 ± 0.1. Most frequent SLE manifestations were arthritis (59.2%), photosensitivity (49.5%), malar rash (39.1%) and serositis (31.1%). The main immunological findings were: ANA (97.6%), anti-DNA (66.4%), hypocomplementemia (58.7%), antiphospholipid antibodies (31.5%). One third (31.5%) of the TTE performed were pathological. Of these, 13.8% had pericardial effusion, 13.3% valvulopathy, 6.5% myocardial dysfunction, 5.2% pulmonary hypertension and 3.2% myocardial infarction. Regarding valvulopathies, 9.5% presented valvular dysfunction, 3.2% valvular thickening and 0.6% vegetation. The most frequently injured valve was the mitral (9.1%), followed by the aortic (2.8%). The majority of patients (88.26%) were asymptomatic at the time of TTE. However, patients with pathological TTE had more dyspnea than those in the normal TTE group (24.7% vs. 5.8%, p<0.001). Presenting a pathological TTE was associated with higher SLICC score (p<0.001), greater number of admissions (p<0.001) and mortality (p=0.002). A higher SLEDAI was also associated with higher mortality (p<0.001).

Conclusion: Cardiac involvement in SLE is not only related to damage accrual but can also be an early manifestation (beyond pericarditis), especially in active SLE. TTE assessment should be considered as a part of routine examination for SLE due to the high prevalence of heart disease even in asymptomatic patients.

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ESTIMATED 10-YEARS CARDIOVASCULAR RISK IN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS: PRELIMINARY RESULTS FROM THE "CARDIOVASCULAR OBESITY AND RHEUMATIC DISEASE (CORDIS)" STUDY GROUP OF THE ITALIAN SOCIETY OF RHEUMATOLOGY.

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