and partial remission as more than 50% reduction in proteinuria to sub-nephrotic levels and serum creatinine within 10% from baseline.

Results: We have included 55 patients (80% women) with biopsy-proven LN (age at biopsy 38±13 years). On renal histology, one patient was class I LN, two patients were class II, 7 were class III, 5 were class III+V, 23 were class IV, two were class IV+V, 11 class VI and 4 had other features. Median baseline NLR was 3.64 (IQR: 1.85, 6.93), PLR was 167 (IQR: 116, 300) and MPV was 10.0 (IQR: 9.2, 10.8). There were no differences in any of the three parameters between different classess of LN (all $p>0.05$). Eighteen patients achieved complete remission (CR), 16 partial remission and 21 did not achieve remission. None progressed to ESRD and two patients died, both from sepsis. There no differences in NLR, PLR and MPV at the time of biopsy between group which achieved CR/PR vs. no remission (all $p>0.05$; Figure 1). We constructed a thorough multivariate regression model which showed that neither NLR, PLR or MPV are predictors of renal remission in LN.

Conclusion: NLR, PLR and MPV are not useful prognostic markers in predicting renal remission in LN.

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.4164

AB0350

MATERNAL AND FETAL OUTCOME IN MEXICAN WOMEN WITH PRIMARY ANTIPHOSPHOLIPID SYNDROME, SECONDARY ANTIPHOSPHOLIPID SYNDROME AND SYSTEMIC LUPUS ERYTHEMATOSUS WITH ANTIPHOSPHOLIPID ANTIBODIES

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Background: Primary antiphospholipid syndrome (APS) is associated with a higher frequency of maternal-fetal adverse outcomes, with increased risk when APS is associated with systemic lupus erythematosus (SLE).

Objectives: We compared maternal-fetal complications in patients with primary APS, APS associated with SLE and SLE with anti-phospholipid antibodies (aPLs).

Methods: Observational, analytical, retrospective, cross-sectional, comparative study, between 2009-2019. Three groups were compared: primary APS, APS associated with SLE and SLE with anti-phospholipid antibodies (aPLs).

Results: We include 179 pregnant women, 31.8% with primary APS, 35.8% with APS associated with SLE, and 32.4% with SLE and aPLs. A history of a higher frequency of abortions was found in APS associated with SLE (62.5%, $p<0.001$) and thrombosis (61.9%, $p<0.001$) and aCL IgG + in primary APS (80.7%, $p=0.011$). More frequent use during pregnancy of antimalarials is applied in associated APS (81.30%, $p<0.001$) and aspirin / heparin in primary APS (96.5% / 94.7%, $p<0.001$). Abortions were observed more frequently in APS associated with SLE (23.80%, $p=0.021$) and preeclampsia / HELLP in primary APS (31.6% and 15.8%, $p=0.047$) who were also less frequently the use of antimalarial (24% vs. 81.3% vs. 72.4%, $p<0.001$) compared to the other groups. Table 1

Conclusion: Patients with APS and SLE have an increased risk of miscarriage whereas those with primary APS have an increased risk for preeclampsia / HELLP. The use of antimalarials could reduce the risk of hypertensive disorders of pregnancy.

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Table 1. Comparison between groups of adverse maternal-fetal outcome.

	Secondary antiphospholipid syndrome (n=64)	Primary antiphospholipid syndrome (n=57)	Systemic lupus erythematosus with antiphospholipid antibodies (n=58)	P
Fetal complications	48 (76.20%)	43 (75.40%)	31 (56.40%)	0.034
Growth restriction	9 (14.30%)	8 (14%)	7 (12.50%)	0.955
Oligohydramnios	6 (9.50%)	5 (8.80%)	5 (8.90%)	0.989
Prematurity	23 (52.30%)	25 (56.80%)	19 (42.20%)	0.37
Abortion	15 (23.80%)	3 (5.40%)	9 (16.10%)	0.021
Stillbirth	7 (11.10%)	10 (17.90%)	5 (9.10%)	0.343
Low birth weight	20 (52.60%)	21 (48.80%)	15 (37.50%)	0.373
Malformations	5 (8.10%)	0 (0%)	0 (0%)	0.01
Maternal complications	40 (63.50%)	25 (43.90%)	21 (36.80%)	0.01
Pre-eclampsia.	15 (23.80%)	18 (31.60%)	7 (12.30%)	0.046
HELLP	4 (6.30%)	9 (15.8%)	2 (3.50%)	0.047
Premature rupture of membranes	7 (11.10%)	5 (8.8%)	4 (7.10%)	0.75
Maternal death	1 (1.60%)	0 (0%)	1 (1.80%)	0.616

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.4187

AB0351

PROGRESSION TO SEVERE LUPUS NEPHRITIS IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS: UPDATE FROM A COLOMBIAN COHORT

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Background: Continuous monitoring of patients with Systemic lupus erythematosus (SLE) provides relevant information

Objectives: To update the analysis of clinical and immunological characteristics associated with time to severe renal involvement in patients with Systemic Lupus Erythematosus in a Colombian cohort followed from January 2015 to October 2020

Methods: A retrospective follow-up study based on clinical records. Patients with SLE diagnosis fulfilled either 1987 American College of Rheumatology Classification Criteria for SLE or 2011 Systemic Lupus International Collaborating Clinics (SLICC) classification criteria for SLE. We included patients with the diagnosis of lupus nephritis according to Wallace and Dubois criteria. Patients who did not have at least two follow-up measurements or had a cause of nephritis other than lupus were excluded. The primary outcome was defined as the time from diagnosis to severe renal involvement defined as creatinine clearance ≤ 50 ml/min, 24-hour proteinuria ≥ 3.5 grams or end-stage renal disease. Updated age and sex-adjusted survival functions and Hazard ratios (HR) with 95% confidence intervals and p-values were estimated using parametric Weibull models for interval-censored data. P values <0.05 were considered statistically significant. Descriptive statistics were previously reported in EULAR 2020 (1)

Results: 548 patients were analyzed: 67 were left-censored as they presented renal involvement at entry, 25 were interval censored as outcome occurred between study visits (19 new events), and 456 were right-censored as involvement was not registered during follow-up. In this cohort update Age and sex-adjusted Hazard Ratios for high blood pressure were HR = 3.1 (95%CI 1.5-6.3; p -value = 0.003) and Anti-RO (per unit increase) HR = 1.003 (95%CI 1.001-1.005; p -value = 0.029). Figure 1 shows the updated age and sex-adjusted survival function

Conclusion: In this cohort update, we found similar clinical and immunological characteristics associated with time to severe renal involvement in SLE patients to those reported in (1). However, continuous follow-up allows us to deepen our understanding of the progression to severe renal involvement in SLE patients

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