Table 1. Pregnancy complications and outcomes according to the timing of discontinuation of BEL.

	BEL STOPPED PRECONCEPTIONALLY (2)	BEL STOPPED AT POS PREGNANCY TEST (7)	BEL STOPPED DURING PREGNANCY (4)
Pre-eclampsia	0/2	0/7	1/4 (25%)
Eclampsia	0/2	0/7	1/4* (25%)
Gestational Diabetes	0/2	1/7 (14%)	0/4
IUGR	0/2	1/7 (14%)	1/4* (25%)
pPROM/PROM	0/2	0/7	1/4 (25%)
Live birth	1/2 (50%)	7/7 (100%)	4/4 (100%)
Severe pre-term birth (≤ 34 th week)	0/2	0/7	1/4* (25%)
Late pre-term birth (35 th –37 th week)	0/2	3/7 (43%)	0/4
Small for Gestational age neonate	0/2	4/7 (54%)	1/4 (25%)
Late miscarriage (>10th week)	1/2 (50%)	0/7	0/4
Perinatal death	0/2	0/7	1/4* (25%)

IUGR: IntraUterine Growth Restriction; PROM: Premature Rupture of Membrane; pPROM: pre-term PROM; *in the same patient (history of thrombotic and obstetric-APS and lupus nephritis) who underwent Assisted Reproductive Technologies (embryo donation).

Eight newborns received vaccinations according to national schedule (missing data for 3). Five newborns were breastfed, 1 received formula milk and 5 mixed-feeding. BEL was resumed in 7/13 patients after pregnancy (in 4 cases for flare), after a median period of 5 [4–22] months.

Conclusion: While more data are needed, this small series suggests that BEL might be a therapeutic option for SLE patients during pregnancy planning, similarly to other biological drugs used in chronic forms of arthritis.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.2862

POS0703

CARDIAC ADVERSE EFFECTS OF LONG-TERM USE OF HYDROXYCHLOROQUINE IN SYSTEMIC LUPUS ERYTHEMATOSUS. SINGLE UNIVERSITY CENTER STUDY OF 109 PATIENTS

A. Herrero-Morant¹, A. Margarida-de Castro¹, R. Pérez-Barquín¹, J. Zubiaur-Zamacola¹, M. Á. González-Gay¹, R. Blanco¹. ¹Hospital Universitario Marqués de Valdecilla, Rheumatology and Cardiology, Santander, Spain

Background: Hydroxychloroquine (HCQ) is a widely used drug especially in connective tissue disorders such as Systemic Lupus Erythematosus (SLE). Cardiac adverse effects of long-term use of HCQ remains controversial.

Objectives: To assess cardiac adverse effects of long-term use of HCQ in SLE.

Methods: Observational single center study of 109 patients with SLE treated with HCQ for more than 3 months. The main outcomes were cardiac structural and conduction disorders in a 12-lead electrocardiogram and/or echocardiogram at baseline and during HCQ treatment.

Results: We studied 109 patients (95 women/14 men; mean age 66.9±14.7 years). Main cardiovascular history was hypertension (n=61, 56.0%), diabetes mellitus (n=16, 14.7%) and renal impairment (n=11, 10.1%). HCQ was used for 11.7±8.9 years. Initial median SLE Disease Activity Index 2000 (SLEDAI-2K) was 7 [3.75–11]. At baseline, 27 (24.8%) patients had conduction disorders and 15 (13.7%) had structural abnormalities: Most prevalent cardiac alterations were Left Anterior Fascicular Block (LAFB) (n=9, 8.3%), left ventricular hypertrophy (n=9, 8.3%) and right bundle branch block (n=8, 7.3%). After 11.7±8.9 years of follow-up (mean HCQ cumulative dose: 1042.2±267.5 g; median SLEDAI-2K 1 [0–4]), there was a significant increase in conduction disorders (n=41, 37.6%, p=0.011) and in LAFB (n=16, 14.7%, p=0.021). There was no statistically significant increase in structural abnormalities (n=21, 19.7%, p=0.629).

Table 1. Main cardiac abnormalities at baseline and after follow-up.

	Baseline	After follow-up	p
Conduction disorders, n (%)	27 (24.8)	41 (37.6)	0.011
Left anterior fascicular block	9 (8.3)	16 (14.7)	0.021
Right bundle branch block	7 (6.4)	8 (7.3)	1.0
Atrioventricular block	4 (3.6)	11 (10.1)	0.092
Incomplete right bundle branch block	4 (3.6)	5 (4.6)	1.0
Short PR interval	2 (1.8)	4 (3.7)	0.5
Prolonged QT corrected interval	2 (1.8)	4 (3.7)	0.625
Left bundle branch block	1 (0.9)	5 (4.6)	0.125
Atrial Fibrillation	1 (0.9)	5 (4.6)	0.219
Structural abnormalities, n (%)	15 (13.7)	21 (19.7)	0.629
Ventricular hypertrophy	9 (8.3)	9 (8.3)	1.0
Atrial enlargement	6 (5.5)	13 (11.9)	0.096

Main cardiac abnormalities at baseline and after 11.7±8.9 years of follow-up are summarized in Table 1. Time of occurrence of cardiac adverse effect in relation to HCQ cumulative dose is shown in Figure 1.

Figure 1. Time of occurrence of cardiac adverse effect in relation to hydroxychloroquine cumulative dose.

Conclusion: Conduction disorders were more prevalent than structural abnormalities. Patients with SLE treated with HCQ had a significant increase in LAFB. Use of electrocardiogram and/or echocardiogram may be helpful in monitoring cardiac adverse effects.

Disclosure of Interests: Alba Herrero-Morant: None declared, Adrián Margarida-de Castro: None declared, Raquel Pérez-Barquín: None declared, Jon Zubiaur-Zamacola: None declared, Miguel Á. González-Gay Speakers bureau: AbbVie, Pfizer, Roche, Sanofi, Lilly, Celgene and MSD, Grant/research support from: AbbVie, MSD, Jansen and Roche, Ricardo Blanco Speakers bureau: AbbVie, Pfizer, Roche, Bristol-Myers, Janssen, Sanofi, Lilly and MSD, Grant/research support from: AbbVie, MSD, and Roche

DOI: 10.1136/annrheumdis-2021-eular.3471

POS0704

LONG-TERM CLINICAL OUTCOMES OF PATIENTS WITH LUPUS NEPHRITIS TREATED WITH AN INTENSIFIED B-CELL DEPLETION PROTOCOL: A PROSPECTIVE STUDY

D. Roccatello¹, S. Sciascia¹, C. Naretto¹, M. Alpa¹, R. Fenoglio¹, M. Ferro¹, G. Quattrocchio¹, E. Rubini¹, E. Rahbari¹, D. Rossi¹. ¹University of Torino, Department of Clinical and Biological Sciences, Turin, Italy

Background: B cells play a key role in the pathogenesis of Lupus Nephritis (LN).

Objectives: we aim to investigate the safety and efficacy of an intensified B-cell depletion induction therapy (IBCDT) without immunosuppressive maintenance regimen compared to standard of care in biopsy-proven LN.

Methods: Thirty patients were administered an IBCDT (4 weekly Rituximab 375mg/m² and 2 more doses after 1&2 months; 2 infusions of 10mg/kg cyclophosphamide (CYC), 3 methylprednisolone pulses), followed by oral prednisone (tapered to 5mg/day by the 3rd month). No immunosuppressive maintenance therapy was given. Thirty patients matched for LN class and age were selected as controls: 20 received 3 methylprednisolone pulses days followed by oral prednisone and mycophenolate mofetil (MMF) 2-3g/day, while 10 were given the Euro Lupus CYC.

Results: At 12 months, complete renal remission was observed in 93% of patients on IBCDT, in 62.7% on MMF, and in 75% on CYC (p=0.03); the dose of oral prednisone was lower in the IBCDT group (mean±SD 2.9±5.0mg/dl) than MMF (10.5±8.0mg/day, p<0.01) or CYC group (7.5±9.0mg/day, p<0.01). Mean follow-up after treatment was 44.5 months (IQR 36–120months), 48.6 months (IQR36–120months), and 45.3 (IQR36–120months) for IBCDT, MMF and CYC, respectively. At their last follow-up visit, we observed no significant differences in proteinuria and serum creatinine, nor in the frequency of new flares among the three groups.

Conclusion: In biopsy proven LN, the IBCDT without further immunosuppressive maintenance therapy was shown to be as effective as conventional regimen of MMF or CYC followed by a 3-year maintenance MMF regimen. Moreover, the use of IBCDT was associated with a marked reduction of glucocorticoid cumulative dose.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.3803