

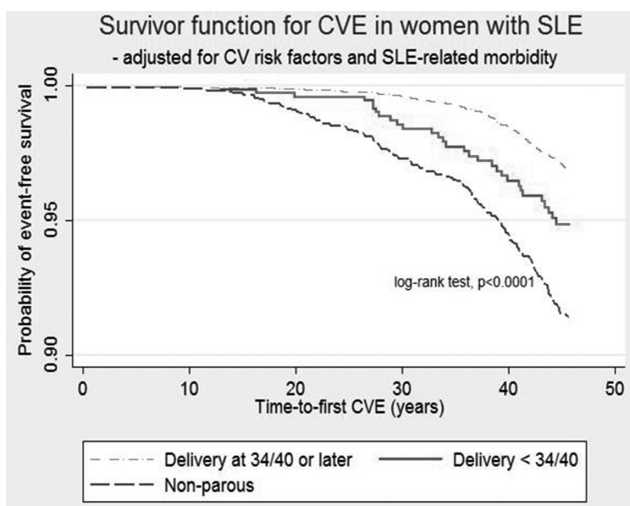


<b>Title</b>	<b>Pre-emptive treatment for asymptomatic serological reactivation in lupus nephritis patients – impact on clinical flare rate and renal function</b>
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Abstract 424 Table 1 CVE in women with SLE born in Sweden between 1951-1971.

	Non-parous (n=915)	Preterm < 34/40 (n=194)	Delivery ≥ 34/40 (n=2,119)
<b>CVE, n (%)</b>	138 (15.1)	30 (15.5)	166 (7.9)
<b>Age at 1<sup>st</sup> CVE, years (IQR)</b>	41 (33–48)	40.5 (31–48)	46 (40–51)
<b>Incidence, per 1,000 person-years (95% CI)</b>	3.44 (2.91–4.07)	3.53 (2.47–5.05)	1.75 (1.50–2.03)
<b>Adjusted hazard of a CVE, adjHR* (95% CI)</b>	1.42 (1.14–1.78)	1.22 (1.09–1.37)	1.0

CI – confidence interval; \* adjusted for CV risk factors and SLE-related morbidity.



Abstract 424 Figure 1

52% respectively,  $p=0.044$ ) (Figure 1). LN diagnosed in 1998–2013 was associated with 5 year and 10 year relapse-free survival rates of 93% and 86% respectively, compared with 81% and 66% respectively ( $p=0.017$ ) for patients who presented in 1983–1997 (Figure 2).

**Conclusions** The risk of renal relapse has decreased in the current era, probably attributed to replacement of AZA with MPA as maintenance treatment.

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#### PRE-EMPTIVE TREATMENT FOR ASYMPTOMATIC SEROLOGICAL REACTIVATION IN LUPUS NEPHRITIS PATIENTS – IMPACT ON CLINICAL FLARE RATE AND RENAL FUNCTION

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#### ANTIPHOSPHOLIPID ANTIBODY POSITIVITY AND RELATED CLINICAL CHARACTERISTICS IN KOREAN LUPUS PATIENTS

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**Background and aims** Pre-emptive immunosuppressive treatment for asymptomatic serological activation (ASR) in lupus nephritis (LN) patients remains controversial, and its impact on subsequent flare rate and long-term renal outcome is unclear.

**Methods** We conducted a retrospective study on all episodes of ASR in 1993–2015 to investigate the relationship between pre-emptive treatment and subsequent clinical flares and renal outcomes.

**Results** 138 episodes of ASR occurred in 98 patients during the study period. 53 episodes (in 38 patients) were treated with pre-emptive increase in immunosuppression while 85 episodes (in 60 patients) were not, and patients were followed up for  $88.8 \pm 77.3$  months and  $82.8 \pm 89.7$  months respectively after ASR occurred. Pre-emptive treatment was associated with superior renal relapse-free survival (100%, 95% and 90% at 6, 12 and 24 months respectively) compared with no pre-emptive treatment (93%, 68% and 65% respectively,  $p=0.007$ ), while extra-renal relapse-free survival did not differ between the two groups (Figure 1). 5 (9.4%) of 53 ASR episodes treated pre-emptively developed renal flare at  $14.3 \pm 6.7$  months after ASR. Patients who received pre-emptive treatment for ASR and did not develop renal flares showed also better eGFR slope ( $+0.54 \pm 0.43$  ml/min/1.73 m<sup>2</sup>/year) compared with the non-pre-emptive groups with or without renal flares ( $-2.11 \pm 0.50$  and  $-1.00 \pm 0.33$  ml/min/1.73 m<sup>2</sup>/year respectively,  $p=0.001$  and  $0.012$ ) (Figure 2). Pre-emptive treatment was associated with more gastrointestinal adverse events related to increased mycophenolate dose ( $p=0.031$ ). Infection rate was similar between both groups.

**Conclusions** Renal flares have a negative impact on renal function and pre-emptive treatment for ASR could reduce renal flare risk and its consequences in LN patients.



## 428 Pre-emptive treatment for asymptomatic serological reactivation in lupus nephritis patients – impact on clinical flare rate and renal function

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