Among the 22 (18.5%) women with at least one bleeding event (n=28), 9 (7.6%) had events defined as severe. Six of nine (67%) severe haemorrhages occurred in the postpartum and were directly related to the delivery. Two required an intrauterine balloon tamponade, two uterine arterial embolisation, and three surgery, including one hysterectomy.

No women died.

Finally, thrombotic and/or severe bleeding events during the postpartum period (n=9) were more frequent in women with lupus anticoagulant (14% versus 0%; P=0.01), with associated placental insufficiency (29% versus 3%; P=0.001) and with preterm delivery ≤34 weeks (33% versus 4%, P=0.002).

Conclusion: Even though most women in our cohort received treatment based on current recommendations, a substantial number of maternal thrombotic and haemorrhagic events (10%) occurred. Despite several life-threatening complications, including CAPS, no women died.

Most of the thrombotic or haemorrhagic events occurred in the peripartum period, and they were more frequent in women with the lupus anticoagulant, placental insufficiency, and preterm delivery.

Although this morbidity rarely appears preventable, knowledge of the risk factors should increase awareness and help physicians to manage APS patients at particularly high risk.

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AB0434 PREVALENCE OF ANTIPHOSPHOLIPID SYNDROME COMPONENTS IN MEN WITH STABLE CORONARY HEART DISEASE AND POSTINFARCTION CARDIOSCLEROSIS AND CONECTION WITH ECHOCARDIOGRAPHIC EVALUATION OF CARDIAC STRUCTURE AND FUNCTION 1.0.0.20

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Background: Antiphospholipid syndrome (APS) as an independent factor in different forms of coronary heart disease (CHD) has been attracting more attention in recent years [1]. The prevalence of AFS in the general population is low (1-5%) but among patients with acute coronary syndrome it ranges from 6.1% to 43.3%. The persistence of high titers of antiphospholipid (aPL) antibodies, especially antibodies to cardiolipin, accelerates the development of endothelial dysfunction and atherothrombotic lesions of the coronary arteries, worsens the course of acute myocardial infarction. It has been experimentally demonstrated that aPL antibodies can directly affect myocardial status through pro-apoptotic signaling pathways and increased cardiomyocyte apoptosis [2].The impact of aPL antibodies on the course of postinfarction myocardial remodeling in patients with CHD has not been established.

Objectives: To study the prevalence of APS components in men with stable CHD with postinfarction cardiosclerosis and to evaluate the relationship with structural and functional state of left ventricular myocardium.

Methods: 164 patients with CHD with postinfarction cardiosclerosis were examined (100% males at the average age of 53,0±9,14 (M±σ)). The diagnosis of CAD was made according to the recommendations of the ANA / ACC (2014) and ESC (2013). The content of IgG and IgM of aPL antibodies - antibodies to cardiolipin, phosphatidylserine, phosphatidylinositol, phosphatidylacetate and levels of IgG and IgM to β2-glycoprotein I (β2-GP-I) in the blood serum were determined by ELISA. Echocardiography in M-, B- and D-modes was performed.

Results: Among 164 patients with post-infarction cardiosclerosis: 75% had Q myocardial infarction (MI), 10.4% had recurrent MI, 7.9% had a stroke or transient ischemic attack and 4.2% had livedo reticularis. 93 (56.7%) patients had positive levels of total aPL antibodies and antibodies to β2-GP-I of IgG class (58 (35,4%) patients had low positive levels of antibodies, 35 (21.3%) patients had medium positive levels of one or both types of antibodies. Positive levels of aPL antibodies and antibodies to β2-GP-I of IgM were detected in 11.6% of patients. Positive levels of aPL antibodies and antibodies to β2-GP-I were more commonly found in men who had Q MI (OR 2.58 95% CI 1.26 - 5.28) and recurrent MI (OR 2.52 95% CI 0.83 - 7.67). Increases of levels of aPL antibodies and antibodies to β2-GP-I correlated with an increase of left ventricle (LV) mass index (r = 0.259 and 0.331, p <0.001). In patients with positive levels of antibodies of IgG to β2-GP-I in postinfarction LV remodeling was more likely to occur by concentric type of hypertrophy of LV than in patients with negative levels of antibodies to β2-GP-I (OR 6.50, 95% CI 2.49 - 16.9, p <0.001). Hypertension had no significant differences within these groups.

Conclusion: The risk of persisting positive levels of aPL antibodies and antibodies to β2-GP-I in the postinfarction period is significantly increased in men who had Q MI. Patients with CHD with positive antibodies to β2-GP-I of IgG are associated with an increased risk of postinfarction LV myocardial remodeling by concentric type of hypertrophy of LV.

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AB0435 RISK OF SERIOUS INFECTION IN LUPUS NEPHRITIS AND RHEUMATOID ARTHRITIS MEASURED USING THE JAPANESE REAL WORLD HOSPITAL CLAIMS DATABASE

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Background: Patients with lupus nephritis (LN) and rheumatoid arthritis (RA) are at risk of serious infections (SIs) due to the impact of the disease itself and treatments that modulate immune system. Though the epidemiology of RA has been well-established by developing many targeted DMARDs (tDMARDs) including biologics and targeted synthesized DMARDs, LN is a very rare disease. Therefore, a large sample size with a significant number of cases is required to determine the exact risk of SIs in LN.

Objectives: To compare the incidence rates of SIs resulting in an inpatient claim in adult patients with LN compared with RA with or without tDMARDs using hospital claims data in Japan.

Methods: LN and RA were identified using claims data provided by Medical Data Vision Co., Ltd (Tokyo, Japan) between April 2008 and June 2019 which was extracted 5th September 2019. Data between January 2010 and December 2018 was used for analysis. Patients with LN and RA were identified using modifications to algorithms developed before [1, 2]. LN patients were required to have continuous insurance claim for both systemic lupus erythematosus (SLE) and LN for ≥ 6 months after index date and then RA patients had continuous insurance claim for RA for ≥ 6 months after index date. First incident SIs were defined as those that resulted in an inpatient claim for a pre-specified set of ICD-10 code. Incidence rates (IRs) were calculated along with 95% confidence intervals (CI).

Results: The LN, RA, RA treated with tDMARDs and RA treated without tDMARDs cohorts included 6,403, 108,317, 16,450, and 91,867 patients, respectively. As anticipated, the LN and RA cohorts were predominantly female and the RA cohort was generally older than the LN cohorts. IRs per 1,000 person-year(PY) [95% CI] for pneumocystis carini pneumonia were 28.2 [26.0-30.4] in LN, 8.5 [8.2-8.8] in RA, 12.6 [11.7-13.5] in RA with tDMARDs and 7.7 [7.4-8.0] in RA without tDMARDs. IRs per 1,000 PY for septicaemia infection were 23.3 [21.3-25.3] in LN, 12.1 [11.7-12.4] in RA, 13.3 [12.3-14.2] in RA with tDMARDs and 11.8 [11.5-12.2] in RA without tDMARDs. IRs per 1,000 PY for cytomegalovirus infection were 13.4 [11.9-14.9] in LN, 4.4 [4.2-4.6] in RA, 6.2 [5.6-6.8] in RA with tDMARDs and 4.1 [3.8-4.3] in RA without tDMARDs. IRs per 1,000 PY for tuberculosis were 7.2 [6.0-8.3] in LN, 6.7 [6.5-7.0] in RA, 18.2 [17.1-19.3] in RA with tDMARDs and 4.4 [4.2-4.7] in RA without tDMARDs.

Conclusion: In this population-based analysis of claims data from Japan, the IRs of SI such as pneumocystis carini pneumonia, septicemia infection and cytomegalovirus infection were higher in LN than in RA. And also, the incidence of tuberculosis in RA treated with tDMARDs was highest among these cohorts. These findings demonstrate the relative contribution of age, immunosuppressive therapies and disease-related factors in LN and RA.

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