Patients with hypoglb during RTX	38 (35.8%)
Severe hypoglb	4 (3.8%)
Patients with severe infections which required hospitalization	14 (13.2%)
With hypoglb	7 (6.6%)
Without hypoglb	7 (6.6%)
Severe infections which required RTX discontinuation	2 (1,9%)
Respiratory	0
HBV reactivation	2 (1,9%)
Skin (Erisipela and celulitis)	
Exitus	0 (0%)

Conclusion: Hypogammaglobulinemia happens in a third of the patients who receive RTX, especially in those who have low previous IgG levels; therefore a follow up during the treatment should be encouraged. Low IgM and IgA levels during the treatment could also be associated with severe infections.

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AB0474 MORTALITY ACROSS RITUXIMAB-TREATED PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS: RESULTS FROM THE BRITISH ISLES LUPUS ASSESSMENT GROUP (BILAG) REGISTRY

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Background: Mortality in Systemic Lupus Erythematosus (SLE) is elevated in comparison to the general population. Previously we have demonstrated improved disease control in response to Rituximab (RTX) therapy in a cohort of refractory SLE patients.
Objectives: To investigate mortality in refractory SLE patients treated with RTX and identify risk factors that may be associated with death.
Methods: All patients recruited to the BILAG-BR (both RTX treated and standard of care-SOC) were included from initial study visit to death or 3 years post last treatment change. Demographics, concurrent medication use, disease activity (BILAG/SLEDAI) and damage scores (SLICC-DI) were recorded. Information regarding mortality was collected from study centres and NHS digital national death registry. Baseline demographic data are presented using descriptive statistics performed using Stata (version 14).
Results: 830 patients were included (715 RTX-treated, 115 standard therapy). RTX-treated patients tended to have longer disease duration (10 vs 6.5 years respectively) and were more likely to have active musculoskeletal disease (% BILAG A or B: 39% vs 23%). Rates of renal (11% vs 16%) and neurological disease (12% vs 9%) were comparable between groups as were baseline SLICC-DI and SLEDAI scores.
33 deaths were reported. 28 (3.9%) RTX-treated patients (1.2 deaths/100 pt yrs follow up) and 5 (4.3%) non-RTX patients (1.5 deaths/100 pt yrs follow up).
Cause of death was identifiable in 20 RTX treated patients. Infection was the commonest cause of death (10/20, 50%) followed by ischaemic heart disease (5/20, 25%) and malignancy (3/20, 15%). Median time to death for RTX-treated was 481 days.
Risk factors associated with mortality within the RTX group included male gender, older age at diagnosis, renal disease, hypogammaglobulinaemia, high SLICC-DI and higher steroid use at last review (Table 1). Median cumulative RTX dosing was 2g for deceased and alive.
Deceased RTX patients had a greater total number of co-morbidities at baseline (2.5 vs 0, $p < 0.01$) driven predominantly by the presence of hypertension (11/28, 39% vs 159/687, 25%, $p = 0.05$), ischaemic heart disease (4/28, 14% vs 11/687, 2%, p= 0.00) and diabetes (7/28, 25% vs 15/687, 2%, p = 0.00).
Conclusion: RTX treated patients do not appear to have higher mortality rates compared to patients starting SOC treatment. Mortality is associated with cardiovascular risk factors, higher steroid doses, hypogammaglobulinaemia and renal disease. Active management of these risk factors may lead to improved mortality outcomes.

Table 1. Deceased and alive RTX treated patients

	Deceased (n=28)	Alive (n=687)
Gender (M: F%) (n= 708)	7:21 (25% M, 75% F)	63:617 (9.26% M, 90.74% F)
Median Age at Diagnosis in years (IQR) (n = 713)	51.5(42.5-66.5)	39(30-49)
Median Disease duration in years (IQR) (n=647)	13(11-19)	12.27(6-16)
Median Cumulative Rituximab dose in mg (IQR) (n=567)	2000 (2000-4000)	2000 (2000-4000)
Ethnicity (Caucasian: Non-Caucasian) (n =491)	17:5 (77.27% Caucasian, 24% Non-Caucasian)	291:178 (62.05% Caucasian, 37.95% Caucasian)

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AB0475 BELIMUMAB: EXPERIENCE IN CLINICAL PRACTICE SETTINGS AT A RHEUMATOLOGY DEPARTMENT IN A TERTIARY HOSPITAL

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Background: Belimumab is a human IgG1l monoclonal antibody directed against BAFF, a B lymphocyte survival factor. It is indicated as adjuvant treatment in adult patients with active systemic lupus erythematosus (SLE), with positive autoantibodies and with a high degree of activity of the disease despite standard treatment.

Case	Gender	Age	Indication	Start date	Withdrawal	Reason for withdrawal	Initial and final daily prednisone dose	Time in treatment
1	♀	56	thrombocytopenia	26/01/2012	Yes	Inefficiency	0 → 0	8 months
2	♀	33	arthritis	17/03/2012	No		10 → 5	6 years and 6 months
3	♀	48	arthritis	22/03/2012	Yes	Neutropenia	7.5 → 2.5	8 months
4	♀	64	thrombocytopenia	03/04/2012	Yes	Urothelial carcinoma	15 → 2.5	5 years
5	♀	45	cutaneous	07/05/2012	Yes	Inefficiency	30 → 30	4 months
6	♀	70	cutaneous thrombocytopenia	09/12/2013	No		15 → 2.5	4 years and 9 months
7	♀	54	arthritis	18/12/2014	No		15 → 2.5	3 years and 9 months
8	♀	46	arthritis	30/11/2015	No		0 → 0	2 years and 10 months
9	♀	58	arthritis	30/05/2017	No		7.5 → 5	1 year and 4 months
10	♀	31	arthritis	17/01/2018	No		10 → 5	8 months
11	♀	46	arthritis	15/02/2018	No		5 → 2.5	7 months
12	♀	49	serositis	11/04/2018	No		5 → 5	5 months

Objectives: This study aims to describe a sample of patients diagnosed with SLE who received treatment with belimumab in a tertiary hospital.

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