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SAT0238 VALIDATION OF THE ADJUSTED GLOBAL ANTIPHOSPHOLIPID SYNDROME SCORE AND CORRELATION WITH EXTRA-CRITERIA MANIFESTATIONS

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Background: Adjusted global antiphosholipid syndrome score (aGAPSS) is the simplified version GAPSS that was recently developed to assess thrombotic risk by the consideration of antiphospholipid antibody (aPL) profile and conventional cardiovascular risk factors.
Objectives: The aim of this study was to evaluate the validity of the aGAPSS in predicting thrombosis and extra-criteria manifestations in our antiphospholipid syndrome (APS) cohort.
Methods: Ninety-eight patients with APS were classified according to clinical manifestations as vascular thrombosis (VT), pregnancy morbidity (PM) or both (VT+PM). The aGAPSS was calculated as defined before. Arterial hypertension and hyperlipidemia definitions were made according to the ESC/ESH ve NCEP/ATP III guidelines, respectively.
Results: Demographic, laboratory and clinical characteristics of patients are summarized in table-1. Mean aGAPSS was calculated as 10.2 ± 3.8. Significantly higher aGAPSS values were seen in VT (n=58) and VT+PM (n=29) compared to PM (n=11) (mean aGAPSS 10.6 ± 3.7 vs 7.3 ± 2.9, P=0.005; 10.5 ± 4 vs 7.3 ± 2.9, P=0.01, respectively). AUC demonstrated that aGAPSS values ≥ 10 had the best diagnostic accuracy for thrombosis (figure-1). Higher aGAPPS values were also associated with recurrent thrombosis (mean aGAPSS 11.5 ± 3.7 vs 9.9 ± 3.6, P=0.04). Regarding extra-criteria manifestations, patients with livedo reticularis (n=11) and APS nephropathy (n=9) had significantly higher aGAPSS values (mean aGAPSS 12.9 ± 3.4 vs 9.9 ± 3.7, P=0.02; 12.4 ± 2.9 vs 10 ± 3.8, P=0.04, respectively).
Conclusion: Our results suggest that patients with higher aGAPSS values are at higher risk for developing vascular thrombosis (either single or recurrent) and extra-criteria manifestations, especially livedo reticularis and APS nephropathy.
Disclosure of Interests: None declared

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Table-1. Demographic, laboratory and clinical characteristics of patients.

	PAPS (*n*=42) *n* (%)	SLE/APS (*n*=56) *n* (%)	*P*
Female	36 (85.7)	47 (83.9)	0.52
Age, years (mean±SD)	44.6 (11.6)	40.8 (10.1)	0.42
Disease duration, years (mean±SD)	10 (8.8)	9.7 (7.1)	0.16
Thrombosis	35 (83.3)	52 (92.9)	0.12
•Arterial	24 (68.6)	34 (65.4)	0.47
•Venous	19 (54.3)	26 (50)	0.43
•Recurrent	15 (42.9)	22 (42.3)	0.56
Pregnancy morbidity	20 (47.6)	20 (35.7)	0.16
•<10 weeks, ≥ 3 abortions	5 (25)	4 (20)	0.5
•≥ 10 weeks, ≥ 1 abortion	14 (70)	15 (75)	0.5
•Pre-eclampsia/eclampsia	3 (15)	5 (25)	0.34
•<34 weeks, ≥ 1 premature birth	1 (5)	5 (25)	0.09
Convensional risk factors			
•Arterial hypertension	17 (40.5)	35 (62.5)	**0.02**
•Hyperlipidemia	21 (50)	26 (46.4)	0.41
•Diabetes mellitus	3 (7.1)	3 (5.4)	0.51
•Obesity	19 (45.2)	16 (28.6)	0.07
•Smoking	12 (28.6)	18 (32.1)	0.43
aPL profile			
•LA	29 (69)	48 (85.7)	**0.04**
•aCL IgG/IgM	31 (73.8)	28 (52.8)	**0.03**
•aβ2GPI IgG/IgM	22 (56.4)	27 (52.9)	0.45
•Triple positive	14 (33.3)	17 (30.4)	0.46

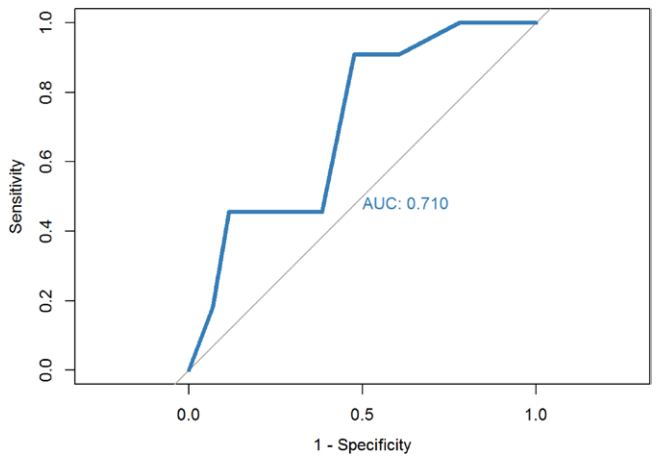


Figure 1. ROC curve according to cut-off aGAPSS value: 10 (AUC: 0.71, sensitivity: 0.52, specificity: 0.91, positive predictive value: 0.98, negative predictive value: 0.19, p-value: 0.01).

SAT0239 LONG TERM OUTCOMES IN PATIENTS WITH ANTIPHOSPHOLIPID SYNDROME AND RENAL ARTERY STENOSIS

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Background: Antiphospholipid syndrome (APS) is characterized by thrombosis and obstetric morbidity in the context of positive antiphospholipid antibody markers. More than a quarter of hypertensive APS patients (26%) have renal artery stenosis (RAS) (1). Treatment includes anticoagulation, blood pressure control and management of cardiovascular risks. In some cases, the severity of the renal vascular lesion requires surgical intervention
Objectives: To evaluate long term outcomes in APS patients with RAS.
Methods: Retrospective database study. All records of APS patients with RAS were analyzed and demographic variables, comorbidities, treatment received, renal outcome and mortality were recorded.
Uni- and multivariate analyses were performed by logistic regression with death and chronic kidney disease (CKD) as dependent variables. In the multivariate analysis, the covariates considered were age at diagnosis of stenosis, diabetes, smoking, dyslipidemia, unilateral or bilateral stenosis, stenosis greater than 50%, surgery and the use of immunosuppressants, anticoagulation and statins.
Research and development office has approved this study.
Results: 33 RAS patients were analyzed. Diagnosis of RAS was made by MRI renal angiography and in some cases by CT angiogram and intra-arterial digital subtraction angiography. Patient characteristics are detailed in Table 1. The median duration of follow-up was 152 months (IQR 65).

Table 1. Patient Characteristics.

N° Patients 33
Age median 48 (IQR 16)
Smokers% 18.1(6)
Comorbidities %
Diabetes mellitus type 2 6 (2) Hypertension 100(33)
High LDL 36.3(12)
Primary APS % 39.4 (13)
Secondary APS % 60.6 (20)
Unilateral RAS% 75.8 (25)
Bilateral RAS% 24.2 (8)
Degree of stenosis
< 30% 15.1 (5)
30-50% 30.3 (10)
50-80% 33.3 (11)
>80% 21.2 (7)
Treatment%
Medical treatment 75.7 (25)
Surgical treatment 30.3 (10)

Renal biopsy was performed in 3 patients: crescentic glomerulonephritis was found in 2 patients and one had a thrombotic microangiopathy.
Treatment: 25 patients (75.7%) were anticoagulated with vitamin K antagonists, 19 (57.6%) received immunosuppressive therapies, 18 (54.5%) were on statins. Ten patients (30.3%) were managed surgically with balloon angioplasty. Restenosis occurred in 4/10 patients (40%) and percutaneous renal artery stenting was performed successfully in all four. Ten patients died (30.3%). Renal outcomes are shown in Table 2.

Table 2. Outcome in APS with RAS Patients

N %
Died 10 30.3
Transplanted 1 3
Renal Dysfunction 17 51.5
CKD Stage III 10 30.3
CKD Stage IV 4 12.1
CKD Stage V 3 9

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