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**Evaluation of lupus anticoagulant, damage, and remission as predictors of pregnancy complications in lupus women: the French GR2 study.**

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## ABSTRACT

**Objectives:** The specific roles of remission status, lupus low disease activity state (LLDAS), and damage accrual on the prognosis of pregnancies in women with systemic lupus erythematosus (SLE) are unknown. We analysed their impact on maternal flares and adverse pregnancy outcomes (APOs).

**Methods:** We evaluated all women ( $\geq 18$  years) with SLE enrolled in the prospective GR2 study with an ongoing singleton pregnancy at 12 weeks (one pregnancy/woman). Several sets of criteria were used to define remission, disease activity, and damage. APOs included: foetal/neonatal death, placental insufficiency with preterm delivery, and small-for-gestational-age birth weight. First trimester maternal and disease features were tested as predictors of maternal flares and APOs.

**Results:** The study included 238 women (98.3% on hydroxychloroquine) with 230 live births. Thirty-five (14.7%) patients had at least one flare during the second/third trimester. At least one APO occurred in 34 (14.3%) women.

Hypocomplementemia in the first trimester was the only factor associated with maternal flares later in pregnancy ( $P=0.02$ ), while several factors were associated with APOs. In the logistic regression models, damage by SLICC-Damage Index (OR 1.8, 95% CI: 1.1-2.9 for model 1 and OR 1.7, 95% CI: 1.1-2.8 for model 2) and lupus anticoagulant (LAC, OR 4.2, 95% CI: 1.8-9.7 for model 1; OR 3.7, 95% CI: 1.6-8.7 for model 2) were significantly associated with APOs.

**Conclusion:** LAC and damage at conception were predictors of APOs, and hypocomplementemia in the first trimester was associated with maternal flares later in pregnancy in a cohort of pregnant patients with well-controlled SLE.

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5 **Clinical trial registration number:** ClinicalTrials.gov, <https://clinicaltrials.gov>, NCT02450396.  
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7

8 **Keywords:** systemic lupus erythematosus, pregnancy, adverse pregnancy outcome, damage, remission.  
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11  
12 **KEY MESSAGES**  
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- 14 • First trimester positive LAC predicts adverse pregnancy outcome (APO)
  - 15 • Chronic irreversible damage in the first trimester also predicts APOs
  - 16 • Damage should be considered in preconception counseling and in early pregnancy
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## INTRODUCTION

Systemic lupus erythematosus (SLE) mainly affects women of childbearing age, and optimal management of lupus pregnancies is essential [1,2]. Historically, we have moved from pregnancy being contraindicated in SLE to considering it not as a contraindication but as an indicator of high risk for flares and adverse pregnancy outcomes (APOs), to a progressive decline in these risks, which nonetheless continue to be higher than in the general population [3]. Guidelines issued by both the European League Against Rheumatism (EULAR) in 2016 [1] and American College of Rheumatology (ACR) in 2020 [2] currently recommend treating women with hydroxychloroquine during pregnancy and planning pregnancy when their SLE is in either remission or a lupus low disease activity state (LLDAS). The level of the risk reduction when these recommendations are applied remains unknown. Moreover, the lack of available data prevents from defining precisely which of these states should be achieved before attempting pregnancy [2]. While several definitions of remission and LLDAS [4] have been validated, those proposed by the DORIA/Zen [5] and DORIS [6] groups for remission and by Franklyn for LLDAS [7] have not been tested in pregnant women [8].

Optimizing the management of pregnancy in SLE requires the analysis of large prospective cohorts of pregnancies. The American PROMISSE study [9] was a major advance, showing that severe flares were uncommon in pregnant women with inactive or stable mild or moderate SLE [9] and that lupus anticoagulant (LAC), antihypertensive drug use, a physician global assessment (PGA) score >1, and a low platelet count were the main baseline predictors of APOs, while non-Hispanic white ethnicity/race was protective against them [9]. However, these findings may not be applicable to other settings, especially since hydroxychloroquine was given to only 64.7% of cases and severe SLE patients were excluded from the PROMISSE study [9].

In 2014, we set up a French prospective study of pregnancies in women affected with rare diseases including SLE (the GR2 study, [clinicaltrials.gov NCT02450396](https://clinicaltrials.gov/ct2/show/study/NCT02450396)). Here, we aim to report pregnancy

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3 outcomes (maternal flares and APOs) in this large cohort of pregnant women with SLE. We tested  
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5 remission definitions and LLDAS as well as cumulative damage (Systemic Lupus International  
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7 Collaborating Clinics-SLICCC-Damage Index) in the first trimester as predictors of poor outcome (flares  
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9 and APOs) later in pregnancy.  
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## 14 **PATIENTS AND METHODS**

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17 We report data from the GR2 (“Groupe de recherche sur la Grossesse et les Maladies Rares”) study,  
18  
19 a French multicentre prospective observational study of pregnant women with rare and/or  
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21 rheumatological diseases, including SLE and antiphospholipid syndrome (APS), conducted since  
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23 October 2014 in 63 active centres (not all recruiting patients with SLE as the cohort is intended to study  
24  
25 several rare and rheumatological diseases). Pregnant women are included by their clinicians (internists,  
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27 rheumatologists, and nephrologists) and are followed up to 12 months postpartum. The treating  
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29 physicians made all treatment decisions.  
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33 The GR2 study is part of the European network of pregnancy registers in Rheumatology (EuNeP)  
34  
35 supported by FOREUM (Foundation for Research in Rheumatology) [10] and follow EULAR  
36  
37 recommendations regarding core data sets for pregnancy registers in rheumatology [11].  
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40 **Inclusion criteria.** Criteria for the current analysis required inclusion in the GR2 before 13  
41  
42 weeks, SLE classified according to the SLICC 2012 criteria [12], and conception before July 15, 2019  
43  
44 (to have complete data at delivery), with an ongoing singleton pregnancy that reached 12 weeks. Only  
45  
46 the first singleton pregnancy per woman was analysed.  
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49 **Data collected.** At first-trimester consultations, we assessed demographic, clinical, serological,  
50  
51 and treatment features. Anti-phospholipid (aPL) status included anticardiolipin (aCL), anti-Beta2  
52  
53 glycoprotein type I antibodies (anti- $\beta$ 2GPI), and LAC. In France, all laboratories are regularly audited  
54  
55 and certified by a central agency. More details on the variety and types of assays are reported in  
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3 Supplementary Data S1, available at *Rheumatology* online. Triple positive aPL status was defined by  
4  
5 positive aCL, anti- $\beta$ 2GPI, and LAC.  
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8 All data were prospectively collected in electronic case report forms at each consultation. Because all  
9  
10 women received standard treatment, written informed consent was not required by French law. The  
11  
12 women were, however, informed of their right to oppose the use of their data for the study and orally  
13  
14 stated their lack of objection. This project adheres to the principles of the Declaration of Helsinki and  
15  
16 was approved by the Local Ethics Committee (CPP Ile de France VI, Groupe Hospitalier Pitié-  
17  
18 Salpêtrière, 29/08/2012).  
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24 **Definitions of remission, LLDAS, disease activity, and damage.** Disease activity was scored  
25  
26 by the SLE Disease Activity Index-2000 (SLEDAI-2K) [13] adapted to pregnancy (SLEPDAI) [14] and  
27  
28 we considered the first SLEPDAI available during the first trimester. Remission status was assessed by  
29  
30 the DORIA/Zen [5] and DORIS [6] criteria and by clinical SLEPDAI=0 [8]. Damage was scored by the  
31  
32 SLICC-Damage Index [15] (see definitions in Supplementary Data S2, available at *Rheumatology*  
33  
34 online).  
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38 **Definition of outcomes.** Maternal flares were defined according to the SELENA-SLEDAI Flare  
39  
40 Index, SFI [16]. This score divides flares into mild/moderate and severe flares and notably captures any  
41  
42 increase in the PGA or in the steroid dose, any introduction of an immunosuppressive drug, and any  
43  
44 hospitalization.  
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47 To make our results comparable to those of the PROMISSE study [9], we defined APO by a  
48  
49 composite binary variable (the occurrence of at least one of the following events versus the non-  
50  
51 occurrence of any of them): an otherwise unexplained intrauterine fetal death (IUFD)  $\geq$  12 weeks, a  
52  
53 neonatal death (within 28 days after birth), placental insufficiency (fetal growth restriction, i.e. FGR,  
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55 preeclampsia/eclampsia, HELLP syndrome, and/or placental abruption, see Supplementary Data S3,  
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3 available at *Rheumatology* online) leading to preterm delivery <37 weeks, small-for-gestational-age  
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5 (SGA: birth weight below the third percentile according to the French AUDIPOG curve) [17].  
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8 **Statistical analyses.** Continuous variables normally and not-normally distributed were  
9  
10 expressed, respectively, by their means and standard deviations (SD) and medians with interquartile  
11  
12 ranges (IQR). Incidence and 95% confidence intervals (CIs) were assessed for both maternal flares and  
13  
14 APOs. To identify their predictors, we tested the following variables during the first trimester: 1)  
15  
16 continuous: maternal age, disease duration, SLEPDAI, PGA, SLICC-Damage Index scores; 2)  
17  
18 categorical: family geographical origins (European descent, African descent and Asian descent), see  
19  
20 Supplementary Table S1, available at *Rheumatology* online), overweight (body mass index (BMI)  $\geq 25$   
21  
22  $\text{kg/m}^2$ ), tobacco and alcohol consumption (at least 10 units per week), associated APS, nulliparity,  
23  
24 previous thrombosis, IUFD, or renal involvement, low platelet count (platelets  $< 100 \times 10^9/\text{l}$ ), positive anti-  
25  
26 double-stranded (ds)-DNA, hypocomplementemia, positive aPL, 24-hour (h) proteinuria, concomitant  
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28 treatment, remission, and LLDAS.  
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33 Pearson's chi square test (or Fisher's exact test when appropriate) was used to evaluate univariate  
34  
35 associations between categorical variables. Student's t-test and Wilcoxon's rank-sum test were used to  
36  
37 compare the parametric and non-parametric continuous variables, respectively. The choice of  
38  
39 independent variables added to the logistic regression model in the multivariate analysis was based on  
40  
41 current knowledge and the variables significant at the univariate analysis ( $P < 0.1$ ). Significance for the  
42  
43 logistic regression analyses was set at 5%. When the univariate analysis found significant associations  
44  
45 between variables with high collinearity, separate multivariate models were tested for complete cases  
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51 All analyses were conducted with STATA v.16.1.  
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## 56 RESULTS

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3 **Patient characteristics at enrolment.** This study includes 238 women with SLE from 34 centres  
4 (see Supplementary Tables S2 and S3 and Figure S1, available at *Rheumatology* online). Their mean age  
5 was 31.6 (SD 4.5 years), 88 (37.0%) were nulliparous, and 34 (14.3%) had an associated APS.  
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10 Previous lupus nephritis (LN) was reported in 67 women (28.2%) and was biopsy-proven in 62  
11 (92.5%): 1 had class I, 1 class II, 12 class III, 19 class IV, 16 class V, 1 class VI, 5 class III+V, and 7  
12 class IV+V. Nine women had positive 24-hour proteinuria (>0.5 g/g or 0.5 g/day), attributed to active  
13 renal disease in only three.  
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18 All but four women (98.3%) took hydroxychloroquine, 119 (50%) prednisone, 56 (23.5%)  
19 immunosuppressive drugs, and 165 (69.3%) low-dose aspirin. Finally, five women (2.1%) received  
20 antihypertensive drugs.  
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25 The median (IQR) SLEPDAI was 2 (0-3). Remission was achieved by 200 women (86.6%) with  
26 the clinical SLEPDAI=0, by 154 women (64.7%) with the DORIA/Zen definition, and by 147 (61.8%)  
27 with the DORIS definition. LLDAS was achieved by 157 patients (71.7%).  
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32 Irreversible chronic damage was reported in 30 women (12.7%, missing data for 2). All had been  
33 treated with prednisone, 7 (23.3%) also had APS, and 16 (53.3%) had a history of renal involvement.  
34 Details of SLICC-Damage Index domains are reported in Supplementary Table S4, available at  
35 *Rheumatology* online.  
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40 **Maternal flares.** Thirty-five women (14.7%, 95% CI: 10.7-19.8) had at least one flare during the  
41 second or third trimesters; most of them were articular (n=18, 7.6%) and/or cutaneous (n=15, 6.3%).  
42 Eight (3.4%) women had other types of flares: serositis in 5 (2.1%), renal in 3 (1.3%), and/or  
43 haematological in 2 (0.8%).  
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48 A severe flare occurred in only three women during the second trimester: two renal flares and one  
49 pericarditis associated with cutaneous rash. All three women required the addition of an  
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3 immunosuppressive drug to the background treatment and had liveborn children, with an early delivery  
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5 at 28 weeks for early preeclampsia in the woman with pericarditis and a rash.  
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8 At univariate analysis, only first-trimester hypocomplementemia was associated with flares  
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10 ( $P=0.02$ ) (Table 1). Since hypocomplementemia is included in the SLEPDAI, no multivariate analysis  
11  
12 could be performed for flares.  
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15 Finally, we found no association between maternal flare and APOs ( $P>0.99$ ). Neither the  
16  
17 percentage of live births nor their median gestational age at delivery differed between patients with and  
18  
19 without flares (97.1 vs 96.5% and 37.4 vs 37.7 weeks, respectively).  
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22 **Obstetric and adverse pregnancy outcomes.** Almost the entire cohort (230, 96.6%) had a live  
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24 birth (median gestational age  $37.7 \pm 2.6$  weeks). For the remaining eight women, one had a termination  
25  
26 of pregnancy because of chromosomal abnormalities, and seven had an IUFD.  
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29 At least one APO occurred in 34 women (14.3%, 95%CI: 10.4-19.4) (Table 2), including 22  
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31 (9.2%) preterm births due to placental insufficiency at a median gestational age of 33 weeks, 7 (2.9%)  
32  
33 IUFDs, 5 (2.1%, 5 missing data for the weight) SGA infants, and one (0.4%) neonatal death. Among  
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35 patients with placental insufficiency leading to preterm delivery, 8 had FGR, 6 HELLP syndrome, 14  
36  
37 preeclampsia/eclampsia, and/or one placental abruption.  
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40 At univariate analysis, women with at least one APO were more likely to have LAC ( $P<0.001$ ),  
41  
42 at least one positive aPL ( $P<0.001$ ), an associated APS ( $P=0.01$ ), or prior thrombotic event ( $P=0.04$ )  
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44 (Table 2). They were also more likely to have positive anti-dsDNA ( $P=0.01$ ) and, accordingly, a higher  
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46 SLEPDAI ( $P=0.01$ ). APOs were also associated with damage accrual (SLICC-Damage Index) ( $P=0.01$ ),  
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48 immunosuppressive drug use ( $P=0.03$ ), low-dose aspirin ( $P=0.03$ ), and low molecular weight heparin  
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50 ( $P=0.01$ ). Finally, APOs were not associated with antihypertensive drugs ( $P=0.15$ ), a low platelet count  
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52 ( $P>0.99$ ), or skin colour ( $P=0.40$ ) (Table 2).  
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3 To minimize collinearity, two different logistic regression models were tested for DORIA/Zen  
4 remission and LLDAS (Tables 3, 4). Because prednisone, prednisone dosage, immunosuppressants, and  
5 SLEPDAI are already included in the DORIA/Zen and LLDAS definitions, we did not consider them  
6 although they were significant on univariate analysis. Similarly, to facilitate comparison with the  
7 PROMISSE study, we chose LAC instead of other related (and thus subject to collinearity) significant  
8 variables on univariate analysis (i.e., anti-aggregants, heparin, previous thrombosis, associated APS). Of  
9 note, age at pregnancy was forced in both models, based on the current literature, since the older the  
10 maternal age, the worse the obstetric outcome. Predictors of APOs in both analyses were SLICC-Damage  
11 Index (per 1 unit increase) and positive LAC in the first trimester (adjusted (a)ORs of 1.8 and 4.2 in  
12 Model 1 and 1.7 and 3.7 in Model 2, respectively) (Tables 3,4). Neither DORIA/Zen remission nor  
13 LLDAS predicted APO. Multicollinearity was ruled out in both models (VIF<2).

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30 **Analysis of the PROMISSE predictors of APOs.** Among the 121 women of European descent  
31 (corresponding to the White women of PROMISSE) who were concomitantly antihypertensive-free,  
32 LAC-negative, and had a PGA  $\leq 1$  in the first trimester and a platelet count  $> 100 \times 10^9/l$ , only 8 (6.6%)  
33 had an APO at any time; one of these foetuses died in utero and another after birth. By contrast, among  
34 the combined group of all but those of European descent women treated with antihypertensive drugs  
35 (n=2) or women with positive LAC (n=41), 15 (34.9%) had an APO at any time: two of these fetuses  
36 died in utero but no neonatal deaths occurred.

## 37 38 39 40 41 42 43 44 45 46 47 48 49 **DISCUSSION**

50  
51 After the large North American PROMISSE study, where 385 women with SLE were  
52 prospectively included between 2003 and 2012, we report the second largest prospective study carried  
53 out on 238 pregnant women with SLE included between 2014 and 2019. Overall, we found that flares,  
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3 especially severe ones, were uncommon and did not influence pregnancy outcomes. APOs were also rare  
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5 (14.3%) and mainly associated with positive LAC and damage accrual.  
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8 In contrast to the PROMISSE study [9], which aimed to identify risk factors for and mechanisms  
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10 of APOs specifically attributable to SLE and/or aPL, and because we wanted a sample closer to real-life  
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12 practice, we did not apply any of the following exclusion criteria: prednisone>20 mg/day, urinary  
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14 protein-creatinine ratio>1000 mg/g, erythrocyte casts on urine analysis, serum creatinine level>1.2  
15  
16 mg/dl, diabetes mellitus, or hypertension [9]. Apart from inclusion/exclusion criteria, several aspects  
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18 distinguish the populations of the two studies: their genetic background, with 12.3% of African descent  
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20 in our study vs 20.3% in PROMISSE, and the rate of overweight women (30.3% vs 39.7%, respectively).  
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22 The frequency of several baseline characteristics, which are well-known risk factors for APOs, was  
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24 similar or slightly higher in our cohort than in PROMISSE: previous biopsy-proven LN (26.1% vs  
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26 20.5%), positive LAC (17.7% vs 8.8%), at least one positive aPL test (26.3% vs 12.5%), and a history  
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28 of thrombosis (17.2% vs 8.1%) (the number of patients with APS in the PROMISSE study is not available  
29  
30 for comparison). However, SLE was probably better controlled in our study: fewer patients had  
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32 hypocomplementemia (26.4% vs 34.0%) and their disease activity was lower (mean SLEPDAI=1.96 vs  
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34 2.79). This latter difference may be due to the higher percentage of our patients on hydroxychloroquine  
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36 (98.3% vs 64.7%) as well as to the routine monitoring of hydroxychloroquine levels in France, which  
37  
38 leads to a better treatment adherence [18]. Finally, besides the difference in hydroxychloroquine  
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40 exposure, we had more patients on low-dose aspirin (69.3% vs 35.1%). The publication of the  
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42 PROMISSE study in 2015 before the current recommendations (1, 2, 9) may explain this difference  
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44 (Table 5).  
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51 Importantly, 71.6% of our patients with previous renal involvement and 91.8% of those with at  
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53 least one positive aPL received low-dose aspirin. This finding might explain the lower rate of APOs in  
54  
55 our cohort, and confirms the good application of current guidelines [1,2].  
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3 Severe maternal flares occurred in three women (1.2%) in our study: among them only one  
4 woman gave birth preterm, due to placental insufficiency at 28 weeks (with preeclampsia/eclampsia and  
5 HELLP syndrome); by contrast, both women with severe renal flares gave birth to healthy children at  
6 term. In the multicentre PROMISSE study [9], 5.5% patients had severe flares, even though patients with  
7 severe disease at conception were excluded. As we did not exclude such women in our study, a higher  
8 rate of flares (mild/moderate and severe) might theoretically be expected. Nevertheless, more than 60%  
9 of our patients were in remission/LLDAS in the first trimester, possibly because nearly all of our patients  
10 were on hydroxychloroquine, as recently recommended [1,19]. Antimalarials have been widely  
11 demonstrated to mitigate the risk of flares both during pregnancy and in the postpartum period [1,20]. A  
12 recent retrospective study of 398 pregnancies in 304 patients reported a higher flare rate during pregnancy  
13 (HR: 1.59; 95%CI, 1.27–1.96), but this was no longer true for patients on hydroxychloroquine: the HR  
14 for flares during pregnancy compared with non-pregnant/non-postpartum periods was 1.83 (95%CI:  
15 1.34–2.45) in patients not treated with hydroxychloroquine vs 1.26 (95%CI: 0.88–1.69) in those who  
16 were on hydroxychloroquine [20].  
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35 Maternal flares were associated with hypocomplementemia ( $P=0.02$ ), consistently with previous  
36 reports [9,21]. Notably, flares during the second and third trimesters were not associated with APOs  
37 ( $P>0.99$ ), in contrast to older cohorts and the PROMISSE study [9,22]. The discrepancies between our  
38 study and prior cohorts are probably due to the low rate of patients with severely active SLE in our study,  
39 which likely prevented us from finding an association between disease activity and APOs. This difference  
40 may be due also to the improvement in the management of SLE; both physicians and patients now  
41 understand the importance of achieving remission/LLDAS before conception as well as of maintaining  
42 hydroxychloroquine during pregnancy.  
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53 We evaluated three definitions of remission and found no substantial differences between them  
54 in terms of association with maternal flares or APO. This could be due to the high frequency of patients  
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3 on remission in the first trimester and consequently, to a lack of power. It may also be explained by the  
4 fact that the definitions of remission that were assessed are indeed relatively close and partially use the  
5 same variables. Hence, analyses of wider cohorts are needed to test each remission sub-class during  
6 pregnancy, including those with serologically active but clinical quiescent disease.  
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11 Overall, 230 (96.6%) women had liveborn infants who survived to discharge. APOs were  
12 observed in 14.3% of women, whereas they occurred in 19% of patients in the PROMISSE study. This  
13 difference might be due to the different definition of SGA (below the third percentile in our cohort vs.  
14 the fifth in PROMISSE) and the high proportion of patients treated with aspirin (69.3% vs 35.1%).  
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20 In our study, LAC and damage accrual predicted APOs. The PROMISSE study [9] had previously  
21 shown that LAC is a predictor of APOs, pinpointing that the risk of pregnancy complication in women  
22 with SLE is due to aPL antibodies more than SLE itself. In addition, we demonstrated for the first time  
23 that damage accrual is associated with APOs. Analysis of patients with damage (n=30, supplementary  
24 table S4) showed diverse irreversible damage, driven both by disease activity and glucocorticoid  
25 treatment, but also aPL status and/or associated APS. This finding suggests that damage should be  
26 considered in preconception counselling and in early pregnancy. It also reinforces the importance of  
27 achieving remission/LLDAS to prevent the accrual of additional damage [23–25].  
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41 In contrast to PROMISSE [9], we did not find any significant association between APOs and  
42 active disease or ethnicity. This finding may be due to different health-care systems and socioeconomic  
43 status of patients included in both cohorts [9].  
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48 Our study has some limitations. First, the assessment of aPL/anti-dsDNA antibodies was not  
49 centralized as in the PROMISSE study due to the real-life design of our study and the large number of  
50 centres. This limitation is at least partially offset by the fact that all laboratories in France require regular  
51 accreditation. The exact impact of disease activity in the first trimester could not be assessed since  
52 patients had to have an ongoing pregnancy at 12 weeks to be included, and it could be hypothesized that  
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3 some active patients were excluded because their pregnancies ended spontaneously during the first  
4 trimester. This limitation also applies to the PROMISSE study as we chose to have a similar design to  
5 enable comparison.  
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10 In conclusion, we confirmed that positive LAC predicts APOs and observed for the first time that  
11 chronic irreversible damage in the first trimester also predicts APOs. Neither remission nor LLDAS  
12 appeared to influence APOs in this cohort of women with stable, well-controlled SLE treated with  
13 hydroxychloroquine. These results should be helpful to physicians caring for pregnant women with SLE.  
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4 analyses. NCC, VLG, and GGI analysed and interpreted the data. NCC, VLG, GGI, EL, NM, NA, CMH,  
5 PO, ED, FSR, and AM collected clinical data on behalf of the GR2 study group. AD helped to critically  
6 revise the manuscript for important intellectual content. NCC, VLG, GGI, and ML wrote the manuscript.  
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**Table 1. Baseline patient characteristics associated with flares in the second and third trimesters**

<b>Maternal characteristics</b>	<b>Total (N=238)</b>	<b>Flare (N=35)</b>	<b>No flare (N=203)</b>	<b>P value</b>
Age at pregnancy, mean (SD)	31.6 (4.5)	30.9 (4.9)	31.7 (4.4)	0.37
Nulliparity	88 (37.0)	15 (42.9)	73 (36.0)	0.44
Family geographical origin (N=235)				
-European descent	166 (70.6)	25 (71.4)	141 (70.5)	
-African descent	29 (12.3)	4 (11.4)	25 (12.5)	
-Asian descent	17 (7.2)	2 (5.7)	15 (7.5)	0.99
-Others	23 (9.8)	4 (11.4)	19 (9.5)	
Overweight (BMI $\geq$ 25 kg/m <sup>2</sup> ) (N=234)	71 (30.3)	7 (20.0)	64 (32.2)	0.17
Active smokers (N=233)	21 (9.0)	3 (8.6)	18 (9.1)	>0.99
Alcohol consumption (N=226) <sup>§</sup>	6 (2.7)	1 (2.9)	5 (2.6)	>0.99
Previous IUFD (N=237)	16 (6.8)	2 (5.9)	14 (6.9)	1.00
Previous thrombosis	41 (17.2)	5 (14.3)	36 (17.7)	0.81
Associated APS	34 (14.3)	5 (14.3)	29 (14.3)	>0.99
SLE duration, years, median (IQR)	7.2 (3.6-12.4)	7.7 (3.3-12.9)	7.2 (3.6-12.4)	0.92
Previous renal involvement	67 (28.2)	12 (34.3)	55 (27.1)	0.38
<b>Laboratory characteristics</b>				
Low platelets (<100 $\times$ 10 <sup>9</sup> /l)	3 (1.3)	1 (2.9)	2 (1.0)	0.38
24 h proteinuria>0.5 g/d (or >0.5 g/g)	9 (3.8)	2 (5.7)	7 (3.5)	0.62
Positive anti-dsDNA (N=222)	104 (46.9)	19 (55.9)	85 (45.2)	0.25
Hypocomplementemia (N=216)	57 (26.4)	15 (42.9)	42 (23.2)	<b>0.02</b>
At least one positive aPL (N=232)	61 (26.3)	9 (26.5)	52 (26.3)	>0.99
IgG/IgM anti- $\beta$ 2GPI (N=232)	26 (11.2)	4 (11.8)	22 (11.1)	>0.99
IgG/IgM aCL (N=232)	37 (16.0)	4 (11.8)	33 (16.7)	0.62
LAC (N=232)	41 (17.7)	6 (17.7)	35 (17.7)	>0.99
Triple positive aPL (N=232)	17 (7.3)	2 (5.9)	15 (7.6)	>0.99
<b>SLE activity and damage</b>				
PGA, median (IQR) (N=235)	0.1 (0-0.2)	0.1 (0-0.9)	0.1 (0-0.2)	0.65
SLEPDAI, median (IQR) (N=212)	2 (0-3)	2 (0-4)	2 (0-2)	0.06
SLICC-Damage Index, median (IQR) (N=236)	0 (0-0)	0 (0-0)	0 (0-0)	0.87
Clinical SLEPDAI=0	206 (86.6)	28 (80.0)	178 (87.7)	0.28
Remission (DORIA/Zen definition)	154 (64.7)	21 (60.0)	133 (65.5)	0.53
Remission (DORIS definition)	147 (61.8)	20 (57.1)	127 (62.6)	0.54
LLDAS (N=219)	157 (71.7)	25 (71.4)	132 (71.7)	0.97
<b>Current treatment</b>				
Prednisone	119 (50.0)	21 (60.0)	98 (48.3)	0.20
Prednisone mg/d, median (IQR) (N=119)	7 (5-10)	7 (5-10)	7 (5-10)	0.71
Immunosuppressive drugs*	56 (23.5)	12 (34.3)	44 (21.7)	0.10
Hydroxychloroquine**	234 (98.3)	34 (97.1)	200 (98.5)	0.47
Low-dose aspirin***	165 (69.3)	24 (68.6)	141 (69.5)	0.92
Low molecular weight heparin	61 (25.6)	8 (22.9)	53 (26.1)	0.68
Antihypertensive agents	5 (2.1)	1 (2.9)	4 (2.0)	0.55

SD: standard deviation; BMI: body mass index; IUFD: intrauterine fetal death (>10 weeks); APS: antiphospholipid syndrome; SLE: systemic lupus erythematosus; IQR: interquartile range; g/d: grams per day; anti-dsDNA: anti-double stranded DNA; aPL: antiphospholipid; aCL: anti-cardiolipin; anti- $\beta$ 2GPI: anti-

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3 beta2 Glycoprotein I; LAC: lupus anticoagulant; PGA: physician global assessment; SLEPDAI: Systemic  
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5 Lupus Erythematosus Pregnancy Disease Activity Index; SLICC: Systemic Lupus International  
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7 Collaborating Clinics; LLDAS: lupus low disease activity state.  
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10 §: at least 10 units per week.

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12 \*: Immunosuppressive drugs: azathioprine (n=53, 22.3%) and tacrolimus (n=5, 2.1%); two women received  
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14 both.  
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17 \*\*: All but four women (98.3%) took hydroxychloroquine; among those four, intolerance accounted for the  
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19 lack of hydroxychloroquine treatment for two, retinopathy for one, and non-adherence for the fourth.  
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26 were treated with low-dose aspirin.  
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29 More details on geographical origins are available in Supplementary Table S1. Bold text highlights  
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31 significance.  
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**Table 2. Baseline patient characteristics associated with APOs in the second and third trimesters**

<b>Maternal characteristics</b>	<b>Total (N=238)</b>	<b>APO (N=34)</b>	<b>No APO (N=204)</b>	<b>P value</b>
Age at pregnancy, mean (SD)	31.6 (4.5)	30.7 (4.8)	31.7 (4.4)	0.22
Nulliparity	88 (37.0)	11 (32.4)	77 (37.8)	0.55
Family geographical origins (N=235)				
- European descent	166 (70.6)	21 (61.8)	145 (72.1)	
- African descent	29 (12.3)	7 (20.6)	22 (11.0)	
- Asian descent	17 (7.2)	2 (5.9)	15 (7.5)	0.40
- Others	23 (9.8)	4 (11.8)	19 (9.5)	
Overweight (BMI $\geq$ 25 kg/m <sup>2</sup> ) (N=234)	71 (30.3)	14 (41.2)	57 (28.5)	0.14
Active smokers (N=233)	21 (9.0)	5 (15.2)	16 (8.0)	0.19
Alcohol consumption (N=226) <sup>§</sup>	6 (2.7)	2 (6.3)	4 (2.1)	0.20
Previous IUFD (N=237)	16 (6.8)	5 (14.7)	11 (5.4)	0.06
Previous thrombosis	41 (17.2)	10 (29.4)	31 (15.2)	<b>0.04</b>
Associated APS	34 (14.3)	10 (29.4)	24 (11.8)	<b>0.01</b>
SLE duration, years, median (IQR)	7.2 (3.6-12.4)	10.0 (3.7-15.3)	7.0 (3.5-11.9)	0.13
Previous renal involvement	67 (28.2)	13 (38.2)	54 (26.5)	0.16
<b>Laboratory characteristics</b>				
Low platelets (<100 $\times$ 10 <sup>9</sup> /l)	3 (1.3)	0 (0.0)	3 (1.5)	>0.99
24 h proteinuria>0.5 g/d (or >0.5 g/g)	9 (3.8)	3 (8.8)	6 (2.9)	0.12
Positive anti-dsDNA (N=222)	104 (46.9)	21 (67.7)	83 (43.5)	<b>0.01</b>
Hypocomplementemia (N=216)	57 (26.4)	13 (40.6)	44 (23.9)	0.05
At least one positive aPL (N=232)	61 (26.3)	18 (52.9)	43 (21.7)	<b>&lt;0.001</b>
IgG/IgM aCL (N=232)	37 (16.0)	9 (26.5)	28 (14.1)	0.08
IgG/IgM anti- $\beta$ 2GPI (N=232)	26 (11.2)	6 (17.7)	20 (10.1)	0.24
LAC (N=232)	41 (17.7)	15 (44.1)	26 (13.1)	<b>&lt;0.001</b>
Triple positive aPL (N=232)	17 (7.3)	5 (14.7)	12 (6.1)	0.08
<b>Disease activity and damage</b>				
PGA, median (IQR) (N=235)	0.1 (0-0.2)	0.1 (0.0-0.4)	0.1 (0.0-0.2)	0.06
SLEPDAI, median (IQR) (N=212)	2 (0-3)	2 (2-4)	2 (0-2)	<b>0.01</b>
SLICC-Damage Index, median (IQR) (N=236)	0 (0-0)	0 (0-1)	0 (0-0)	<b>0.01</b>
Clinical SLEPDAI=0	206 (86.6)	28 (82.4)	178 (87.3)	0.42
Remission (DORIA/Zen definition)	154 (64.7)	17 (50.0)	137 (67.2)	0.05
Remission (DORIS definition)	147 (61.8)	17 (50.0)	130 (63.7)	0.13
LLDAS (N=219)	157 (71.7)	19 (57.6)	138 (74.2)	0.05
<b>Current treatment</b>				
Prednisone	119 (50.0)	23 (67.7)	96 (47.1)	<b>0.03</b>
Prednisone mg/d, median (IQR) (N=119)	7 (5-10)	7.5 (5-10)	7 (5-10)	0.13
Immunosuppressive drugs*	56 (23.5)	13 (38.2)	43 (21.1)	<b>0.03</b>
Hydroxychloroquine**	234 (98.3)	34 (100.0)	200 (98.0)	>0.99
Low-dose aspirin***	165 (69.3)	29 (85.3)	136 (66.7)	<b>0.03</b>
Low molecular weight heparin	61 (25.6)	15 (44.1)	46 (22.6)	<b>0.01</b>
Antihypertensive agents	5 (2.1)	2 (5.9)	3 (1.5)	0.15

APO: adverse pregnancy outcome; SD: standard deviation; BMI: body mass index; IUFD: intrauterine fetal death (>10 weeks); APS: antiphospholipid syndrome; SLE: systemic lupus erythematosus; IQR: interquartile

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3 range; g/d: grams per day; anti-dsDNA: anti-double stranded DNA; aPL: antiphospholipid; aCL: anti-  
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5 cardiolipin; anti- $\beta$ 2GPI: anti-beta2 Glycoprotein I; LAC: lupus anticoagulant; PGA: physician global  
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7 assessment; SLEPDAI: Systemic Lupus Erythematosus Pregnancy Disease Activity Index; SLICC: Systemic  
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9 Lupus International Collaborating Clinics; LLDAS: lupus low disease activity state.  
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12 §: at least 10 units per week.  
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14 \*: Immunosuppressive drugs: azathioprine (n=53, 22.3%) and tacrolimus (n=5, 2.1%); two women received  
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16 both.  
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18 \*\*: All but four women (98.3%) took hydroxychloroquine; among those four, intolerance accounted for the  
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20 lack of hydroxychloroquine treatment for two, retinopathy for one, and non-adherence for the fourth.  
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23 \*\*\*: Low-dose aspirin was given to 165 women (69.3%). In particular, 52 of 67 patients (71.6%) with  
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**Table 3. Risk factors for APO: multivariate analysis**

Variables	Model 1 <sup>§</sup>		
	Crude OR (95%CI)	aOR (95%CI)	P value
Age at pregnancy	0.9 (0.9-1.0)	1.0 (0.9-1.1)	0.45
DORIA/Zen remission	0.5 (0.2-1.1)	0.5 (0.2-1.2)	0.11
SLICC-Damage Index (per 1-unit increase)	1.9 (1.2-3.0)	1.8 (1.1-2.9)	<b>0.02</b>
Positive LAC in the 1 <sup>st</sup> trimester	5.2 (2.4-11.5)	4.2 (1.8-9.7)	<b>0.001</b>

<sup>§</sup>: multivariate analysis performed on complete cases for the tested variables: N=230. OR: odds ratio; aOR: adjusted odds ratio; CI: confidence interval; LAC: lupus anticoagulant; SLICC: Systemic Lupus International Collaborating Clinics. Age at pregnancy was also forced into the analysis, as a known risk factor for APO. We included LAC, and because of high collinearity, we excluded associated APS, at least one positive aPL test, and treatments such as low-dose aspirin and LMWH (as most women with APS or carrying aPL were treated with these drugs) from our regression models. Finally, we excluded prednisone dose, immunosuppressants, SLEPDAI, hypocomplementemia, and anti-dsDNA from both models, since both the DORIA/Zen definition of remission and LLDAS are composite scores that already include these factors (see Supplementary Material). Bold text highlights significance.

**Table 4: Risk factors for APO: multivariate analysis**

Variables	Model 2 <sup>§</sup>		
	Crude OR (95%CI)	aOR (95%CI)	P value
Age at pregnancy	0.9 (0.9-1.0)	1.0 (0.9-1.1)	0.45
LLDAS	0.5 (0.2-1.1)	0.5 (0.2-1.1)	0.07
SLICC-Damage Index (per 1-unit increase)	1.9 (1.2-3.0)	1.7 (1.1-2.8)	<b>0.03</b>
Positive LAC in the 1 <sup>st</sup> trimester	5.2 (2.4-11.5)	3.7 (1.6-8.7)	<b>0.002</b>

<sup>§</sup>: multivariate analysis performed on complete cases for tested variables: N=212. OR: odds ratio; aOR: adjusted odds ratio; CI: confidence interval; LLDAS: lupus low disease activity state; LAC: lupus anticoagulant; SLICC: Systemic Lupus International Collaborating Clinics. Age at pregnancy was also forced into the analysis, as a known risk factor for APO. We included LAC, and because of high collinearity, we excluded associated APS, at least one positive aPL test, and treatments such as low-dose aspirin and LMWH (as most women with APS or carrying aPL were treated with these drugs) from our regression models. Finally, we excluded prednisone dose, immunosuppressants, SLEPDAI, hypocomplementemia, and anti-dsDNA from both models, since both the DORIA/Zen definition of remission and LLDAS are composite scores that already include these factors (see Supplementary Material). Bold text highlights significance.

**Table 5. Major differences between GR2 and PROMISSE [9] studies**

	<b>GR2</b>	<b>PROMISSE [9]</b>
<b>Time frame</b>	2014-2019	2003-2012
<b>Exclusion criteria</b>	Twin pregnancy	Twin pregnancy UPCR >1000 mg/g Creatinine level > 1.2 mg/dl Prednisone > 20 mg/d
<b>Ethnicity (African descent/Black)</b>	12.3%	20.3%
<b>History of thrombosis</b>	17.2%	8.1%
<b>Positive LAC</b>	17.7%	8.8%
<b>At least one positive aPL</b>	26.3%	12.5%
<b>Previous renal involvement</b>	28.2%	20.5%
<b>Hydroxychloroquine exposure</b>	98.3%	64.7%
<b>Mean SLEPDAI at 1<sup>st</sup> trimester</b>	1.96	2.79

UPCR: urinary protein creatinine ratio; LAC: lupus anticoagulant; aPL: anti-phospholipid; SLEPDAI: Systemic Lupus Erythematosus Pregnancy Disease Activity Index.