**Long title: Do classical blood biomarkers of JSLE identify active Lupus Nephritis? Evidence from the UK JSLE Cohort Study**

**Short title: Classical Lupus blood biomarker and active LN identification**

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**Abstract**

**Background:** Lupus nephritis (LN) affects up to 80% of Juvenile-onset Systemic Lupus Erythematosus (JSLE) patients. The value of commonly available biomarkers, such as anti-dsDNA-antibodies, complement (C3/C4), erythrocyte sedimentation rate (ESR) and full blood count parameters in identification of active-LN remains uncertain.

**Methods:** Participants from the UK JSLE Cohort Study, aged <16 years at diagnosis, were categorised as having active or in-active LN according to the renal domain of the British Isles Lupus Assessment Group score. Classical biomarkers: anti-dsDNA, C3, C4, ESR, CRP, haemoglobin, total white cells, neutrophils, lymphocytes, platelets and immunoglobulins were assessed for their ability to identify active LN using binary logistic regression modeling, with stepAIC function applied to select a final model. Receiver-operating curve analysis was used to assess diagnostic accuracy.

**Results:** 370 patients were recruited; 191 (52%) had active LN and 179 (48%) had inactive LN. Binary logistic regression modelling demonstrated a combination of ESR, C3, WCC, neutrophils, lymphocytes and IgG to be best for identification of active LN identification (AUC 0.724).

**Conclusions:** At best, combining common classical blood biomarkers of Lupus activity using multivariate analysis provides a ‘fair’ ability to identify active LN. Urine biomarkers were not included in these analyses. These results add to the concern that classical blood biomarkers are limited in monitoring discrete JSLE manifestations such as LN.

**Keywords**

Lupus Nephritis, classical biomarkers, ESR, anti-dsDNA, complement, C3, C4

**Introduction**

Juvenile-onset systemic lupus erythematosus (JSLE) is a heterogeneous life-threatening multi-system autoimmune disease, exhibiting a more aggressive course when onset is within childhood [[1](#_ENREF_1)]. The value of commonly available classical biomarkers of overall JSLE activity in identifying discrete aspects of JSLE, such as Lupus Nephritis (LN) remains uncertain. LN is more common in JSLE than in adult counterparts, with up to 80% of JSLE patients having some renal involvement within a 5-year period [[2](#_ENREF_2)]. Renal histology is the gold standard for LN identification, but is seldom repeated serially due to its invasive nature. Effective treatment of LN relies upon early recognition of the often-subtle presenting features, to prevent renal damage.

Clinicians rely heavily upon non-invasive markers such as proteinuria, serum creatinine and glomerular filtration rate (GFR) when monitoring JSLE patients. Following a LN flare, proteinuria has been shown to take a significant period of time to normalise, with 53% of adult LN patients requiring up to 2 years to recover and 74% recovering by 5 years [[3](#_ENREF_3)]. During this time, differentiating between proteinuria due to irreversible damage of the glomerular capillaries or a LN flare is problematic, limiting the reliability of proteinuria in on-going monitoring. Spot albumin or protein creatinine ratio measurements are largely used as an alternative to 24-hour urinary protein quantification, however the correlation between spot protein/creatinine ratio and 24-hour urine protein has recently been shown to be poor in those with a high or medium LN activity index scores [[4](#_ENREF_4)].

There have also been numerous reports of clinically silent LN in patients with biopsy defined LN but no proteinuria, normal urinalysis and normal renal function [[5](#_ENREF_5)]. The best calculation for GFR measurement in LN patients has been shown to be the Cockcroft Gault equation using ideal body weight in the calculation. Deviation from this approach as part of the standard protocols used in some institutions may also influence the reliability of GFR measurements in SLE patients [[6](#_ENREF_6)].

The above studies highlight uncertainties relating to conventional renal function measurements in SLE. Studies looking at the role of other routinely measured immunological, haematological and inflammatory biomarkers in active LN identification have mainly focused on adult patients. The aim of this study was therefore to use participants from the UK JSLE Cohort Study [[2](#_ENREF_2)] to assess the ability of classical biomarkers of JSLE for identification of active LN, both individually and in combination.

*Patients and methods*

*Patient Cohort.*Children participating in the UK JSLE Cohort Study [[2](#_ENREF_2)] between 2005-15, aged < 16 years at the time of diagnosis, meeting ≥4 of the American College of Rheumatology (ACR) SLE classification criteria were recruited. Disease activity and classical biomarker data were collected using the paediatric BILAG2004 (pBILAG2004) disease activity score [[7](#_ENREF_7)]. Written patient assent / consent and parental consent was obtained, and the study had full ethical approvals in place from the National Research Ethics Service North West, Liverpool East (REC reference 06/Q1502/77). The research was carried out in accordance with the declaration of Helsinki.

*Patient groups.*Patients were categorised according to the renal domain of pBILAG2004 disease activity score, defined as follows; pBILAG2004 grade A/B: severe, moderate renal disease respectively, grade C: mild renal disease, grade D: in-active disease but previous renal system involvement, grade E: renal system has never been involved. The composite renal domain of the BILAG score consists of six items including renal function (deterioration based on serum creatinine and GFR), proteinuria (defined by urine dipstick, or urine protein / albumin creatinine ratio (UPCR / UACR), or 24 hour protein levels), nephrotic syndrome, active urinary sediment, hypertension, and histological evidence of active nephritis in the previous three months. Different cut-offs for the above clinical investigations correspond to the different renal BILAG disease activity categories [[7](#_ENREF_7)]. Patients were then grouped as follows:

* Active LN – if they had a renal pBILAG2004 of A or B.
* In-active LN - if they had a renal pBILAG2004 of D or E.

Patients who were graded ‘C’ were excluded from analysis. The study was undertaken on a cross-sectional basis. Individual patient visits were selected where the clinical data was most complete.

*Classical blood biomarkers investigated.* Anti-dsDNA, C3, C4, ESR, c-reactive protein (CRP), haemoglobin, total white cell count (WCC), neutrophils, lymphocytes, platelets and immunoglobulin (IgG, IgA, IgM) levels were compared between patients with active and in-active LN. As our definition of active LN was based on the composite renal BILAG score, calculated from proteinuria, GFR, blood pressure, active urine sediment, plasma creatinine and recent biopsy findings, we could not investigate the performance of these classical biomarkers.

*Statistical analysis.* Demographic and classical biomarker data were not normally distributed and therefore expressed as median values and interquartile ranges (IQR). Mann Whitney U tests were used to compare the distribution of the classical biomarker levels between active and in-active LN patients (Bonferroni correction method applied to account for multiple testing, 17 comparisons). A binary logistic multiple regression model was fitted to assess for association between a combination of classical biomarkers and LN status (outcome: LN active=1; non-LN JSLE=0). All classical biomarkers (log-transformed) excluding those contributing to the renal BILAG score (UACR, UPCR, GFR, plasma creatinine) were included in an initial model and the ‘stepAIC’ function in R [[8](#_ENREF_8)] applied to select a final model. This function compares different models based on all possible combinations of biomarkers and chooses the model with the minimum AIC (Akaike Information Criterion) value. The AIC is a measure of the relative quality of a model relative to each of the other models, with a lower value representing better quality. The AUC for the final model was calculated. AUC values of 1.0**–**0.9, 0.9**–**0.8, 0.8**–**0.7, 0.7**–**0.6, 0.6**–**0.5 were considered “excellent, good, fair, poor and fail” respectively. Data analysis and was undertaken using R version 3.1.1 [[8](#_ENREF_8)]. Where Bonferroni adjustment was made to account for multiple testing, the Bonferroni corrected p-value, pc is reported.

**Results**

*Patient demographics*

The study cohort consisted of 370 JSLE patients, 191 active LN patients and 179 in-active, with a median age of 12.7 and 12.8 years respectively at diagnosis (Table 1). All patients fulfilled at least four ACR classification criteria at diagnosis. At the time of analysis, disease duration for active and in-active LN patients was 0.5 and 0.6 years respectively. The female to male gender ratio was 5.0:1 for active LN patients and 4.8:1 for in-active LN patients. The most commonly self-reported patient ethnicity in both groups was Caucasian (54% active group and 51% inactive group), followed by Indian, Pakistani or Bangaldeshi (21% active group and 21% inactive group). No statistically significant differences were observed on comparing any of the reported demographics between the active and inactive groups (*pc>0.05 for all*, see Table 1).

*Individual classical biomarkers*

Table 2 summarises the median and interquartile ranges for renal and non-renal classical biomarker concentrations in the active and in-active LN patient groups separately. Univariate analysis of the association between each classical biomarker and LN status revealed a statistically significant difference in concentration of C3, C4, ESR, Hb, UACR and UPCR between patients with active LN and those with in-active LN (all *pc<0.05*). Concentration of serum creatinine, anti-dsDNA, neutrophils, eGFR, CRP, WCC, lymphocyte / platelet counts and IgG, IgA, IgM did not differ between patient groups (all *pc>0.05*).

*Strength of non-renal classical biomarkers in combination for identifying active LN*

A binary multiple logistic regression model was fitted including all classical biomarkers which do not contribute to the renal BILAG score, and then applying the R ‘StepAIC’ function [[8](#_ENREF_8)]. The final selected model included six classical biomarkers including ESR, C3, WCC, neutrophils, lymphocytes and IgG (see Table 3). The AUC corresponding to this final model was 0.724, demonstrating this optimal combination of classical non-renal biomarkers to have ‘fair’ ability for active LN identification.

**Discussion**

Using a cross-sectional national cohort of paediatric patients recruited to the UK JSLE Cohort Study, the aim of this study was to assess the ability of classical immunological and haematological biomarkers of JSLE to identify active LN compared to in-active LN, both individually and in combination. Previous studies have largely focused on individual biomarkers and adult-onset SLE populations.

This study univariately showed ESR, C3, C4, haemoglobin, UACR and UPCR to differ significantly between active and inactive LN patients (all *pc<0.05*). When all classical biomarkers which do not contribute to the renal BILAG score were considered within a binary multiple logistic regression model, ESR, C3, WCC, Neutrophils, Lymphocytes and IgG were shown to contribute significantly to the optimal model for identification of active LN. The accuracy of these tests for identifying active LN was assessed using area under the ROC curve analysis, with the area measuring discrimination, i.e. the ability of the test to correctly classify those with and without LN. AUC values of 1.0**–**0.9, 0.9**–**0.8, 0.8**–**0.7, 0.7**–**0.6, 0.6**–**0.5 correspond to a test being “excellent, good, fair, poor and failing”. Although ESR, C3, WCC, neutrophils, lymphocytes and IgG levels differed significantly, their accuracy as a test for active LN fell in the ‘fair’ range when considered in combination (AUC 0.724).

These results complement those of an adult-onset SLE study which showed decreases in C3 to be associated with renal disease activity, despite inconsistent performance for predicting global SLE activity [[9](#_ENREF_9)]. In a prospective study serially monitoring C3/C4 levels in adult SLE patients, C4 was demonstrated to deteriorate before C3, starting 25 and 20 weeks respectively before the LN flare becoming clinically detectable [[10](#_ENREF_10)]. Together with anti-dsDNA antibody levels, C3/C4 levels have been shown to have a good negative predictive value for active LN in a 6-year prospective study of 228 LN patients [[11](#_ENREF_11)]. Complement fragments C3d-CIC and C5a have previously been shown to be significantly higher in active compared to inactive JSLE patients [[12](#_ENREF_12)], but these data are not collected by the UK JSLE Cohort Study, and therefore could not be included in these analyses.

Our findings relating to ESR are also in-keeping with those of a recent adult SLE study that showed ESR to be correlated with renal involvement and fatigue according to the Lupus Activity Index visual analogue scales (VAS), the overall SELENA-SLEDAI score and Physician Global Assessment (PGA). ESR was also correlated with hematuria and proteinuria during the current visit. Over time, a change in ESR between two visits was highly correlated with a concurrent change in the PGA and renal VAS but not changes in overall disease activity [[13](#_ENREF_13)]. ESR is clearly an easily accessible and inexpensive test, which has some utility in monitoring renal and global disease activity but is very non-specific in separating renal and global disease activity.

Anti-dsDNA antibody levels did not feature in the final multiple logistic regression model. Similar results have previously been reported in a study assessing anti-dsDNA antibody and C3/C4 levels, in 53 adult SLE patients 3-9 months preceding a flare. For all three tests, sensitivity and specificity for predicting renal and non-renal flares was in the region of 50% and 75% respectively, with positive and negative likelihood ratios being close to 1.0, suggesting little clinical value as a routine test [[14](#_ENREF_14)]. In contrast, high titres of anti-dsDNA have been shown to differentiate proliferative from non-proliferative LN at the time of renal biopsy [[15](#_ENREF_15)], with some studies concluding that increased anti-dsDNA antibody levels should prompt preemptive treatment due to anti-dsDNA’s strong ability to predict SLE flares [[16](#_ENREF_16)]. These conflicting results may be due to differences in sample size, disease activity measures and the frequency of biomarker testing.

This study is the largest to date in children and young people with JSLE looking at the performance of classical biomarkers for LN identification. We recognise that there are certain limitations to this work, which should be addressed in future studies. In this study we were interested in the performance of biomarkers not considered of classical renal origin (e.g. anti-dsDNA antibodies, C3/C4, ESR, full blood count parameters etc) as our definition of active LN was based on the composite renal BILAG score (calculated from proteinuria, blood pressure, serum creatinine, GFR, active urine sediment, and recent biopsy findings). To look more closely at all classical biomarkers available to the clinician, including those involved in calculation of the composite renal BILAG score, further large prospective longitudinal studies are warranted using different outcome measures (e.g. renal biopsy defined LN). Such future analysis would indicate the diagnostic value of the full range of urine and blood tests which are available to the clinician. It would also be of interest to explore the effect of combining classical blood and urine biomarkers with novel urine biomarkers, as such novel biomarker have been shown to be extremely useful in the identification of active LN [[17](#_ENREF_17)].

Patient episodes where a renal BILAG of C was scored were not included in this current study. Renal BILAG C patient can be a rather heterogeneous group of patients with mild LN (scoring a C on the basis of a urine dipstick value of ≥ 1+) or with slowly improving renal disease where the urine protein-creatinine ratio can still in fact be very high, but have improved by ≥ 25% in the previous 4 weeks. The renal BILAG score has been shown to be most sensitive for detection of new-onset LN and significant improvement of renal disease activity [[18](#_ENREF_18)], therefore, this current study included a more dichotomous group of patients with clearly defined active v.s. inactive LN (renal BILAG A/B v.s. D/E). Such a renal BILAG score definition of active LN has previously been utilised within a large number of studies looking at the ability of urine and serum biomarkers to differentiate active and inactive LN [[19-23](#_ENREF_19)]. Further analysis of the role of classical biomarkers in renal BILAG C patients would be of interest.

**Conclusions**

JSLE patients have significant renal involvement and the potential to develop irreversible renal damage as the result of unrecognised LN relapses. At best, combining ESR, C3, WCC, neutrophils, lymphocytes and IgG provided a ‘fair’ ability to identify active LN. In contrast, novel urine biomarkers have been shown to be ‘excellent’ for identifying active LN (AUC up to 0.92), in the UK JSLE Study Cohort [[17](#_ENREF_17)]. In the future, to optimise effective management of LN, easily measured novel biomarkers are anticipated to add to the information gained from classical biomarkers.

**Acknowledgements**

The authors would like to acknowledge all patients and their families for participating in this Study, as well as all the support given by the entire multi-disciplinary team within each of the paediatric centres. The study was supported by the National Institute of Health Research (NIHR) Clinical Research Network (CRN): Children and CRN Research Nurses and staff in all centres. Special acknowledgement is given to the principle investigators in each of the participating centres and lead nurse(s) for the Study, and all those who have supported the work of the UK JSLE Study Group to date. We acknowledge the important work of NIHR and other funded Clinical Research Facilities that have supported this Study, including specifically the NIHR Alder Hey Clinical Research Facility. Specific acknowledgement goes to Duncan Appleby for database and information technology support and Carla Roberts for co-ordination of the Cohort study.

**Conflicting interests**

There has not been any financial support or other benefits from commercial sources for the work reported on in this manuscript. The authors declare that there is no conflict of interest.

**Funding**

This work was supported by the Alder Hey Children’s Kidney Fund through a training fellowship [UOG10065 to ES]. Lupus UK also provides financial support for co-ordination of the UK JSLE Cohort Study.

**Authors’ contributions:**

ES and MWB participated in conception, design of the study, and acquisition of data. All authors participated in interpretation of the data. ES and AJ performed the statistical analysis. MWB is Chief Investigator of the UK JSLE Cohort Study. All authors were involved in drafting the manuscript and revising it critically for important intellectual content. They have also all read and given final approval of the version to be published.

**References**

1. Mina R, Brunner HI. Pediatric lupus-are there differences in presentation, genetics, response to therapy, and damage accrual compared with adult lupus? Rheum Dis Clin North Am 2010; 36: 53-80.

2. Watson L, Leone V, Pilkington C, Tullus K, Rangaraj S, McDonagh JE, et al. Disease activity, severity, and damage in the UK Juvenile-Onset Systemic Lupus Erythematosus Cohort. Arthritis Rheum 2012; 64: 2356-65.

3. Touma Z, Urowitz MB, Ibanez D, Gladman DD. Time to recovery from proteinuria in patients with lupus nephritis receiving standard treatment. J Rheumatol 2014; 41: 688-97.

4. Zhang Q, Sun L, Jin L. Spot urine protein/creatinine ratio is unreliable estimate of 24 h proteinuria in lupus nephritis when the histological scores of activity index are higher. Lupus 2015; 24: 943-7.

5. Ishizaki J, Saito K, Nawata M, Mizuno Y, Tokunaga M, Sawamukai N, et al. Low complements and high titre of anti-Sm antibody as predictors of histopathologically proven silent lupus nephritis without abnormal urinalysis in patients with systemic lupus erythematosus. Rheumatology (Oxford) 2015; 54: 405-12.

6. Martinez-Martinez MU, Borjas-Garcia JA, Magana-Aquino M, Cuevas-Orta E, Llamazares-Azuara L, Abud-Mendoza C. Renal function assessment in patients with systemic lupus erythematosus. Rheumatol Int 2012; 32: 2293-9.

7. Isenberg DA, Rahman A, Allen E, Farewell V, Akil M, Bruce IN, et al. BILAG 2004. Development and initial validation of an updated version of the British Isles Lupus Assessment Group's disease activity index for patients with systemic lupus erythematosus. Rheumatology (Oxford) 2005; 44: 902-6.

8. R Core Team. R: A language and environment for statistical computing R Foundation for Statistical Computing, Vienna, Austria2013 [Available from: [http://www.r-project.org/](http://www.R-project.org/).

9. Ho A, Barr SG, Magder LS, Petri M. A decrease in complement is associated with increased renal and hematologic activity in patients with systemic lupus erythematosus. Arthritis Rheum 2001; 44: 2350-7.

10. Swaak AJ, Groenwold J, Bronsveld W. Predictive value of complement profiles and anti-dsDNA in systemic lupus erythematosus. Ann Rheum Dis 1986; 45: 359-66.

11. Moroni G, Radice A, Giammarresi G, Quaglini S, Gallelli B, Leoni A, et al. Are laboratory tests useful for monitoring the activity of lupus nephritis? A 6-year prospective study in a cohort of 228 patients with lupus nephritis. Ann Rheum Dis 2009; 68: 234-7.

12. Edelbauer M, Kshirsagar S, Riedl M, Haffner D, Billing H, Tonshoff B, et al. Markers of childhood lupus nephritis indicating disease activity. Pediatr Nephrol 2011; 26: 401-10.

13. Stojan G, Fang H, Magder L, Petri M. Erythrocyte sedimentation rate is a predictor of renal and overall SLE disease activity. Lupus 2013; 22: 827-34.

14. Esdaile JM, Joseph L, Abrahamowicz M, Li Y, Danoff D, Clarke AE. Routine immunologic tests in systemic lupus erythematosus: is there a need for more studies? J Rheumatol 1996; 23: 1891-6.

15. Moroni G, Quaglini S, Radice A, Trezzi B, Raffiotta F, Messa P, et al. The value of a panel of autoantibodies for predicting the activity of lupus nephritis at time of renal biopsy. J Immunol Res 2015; 2015: 106904.

16. Spronk PE, Bootsma H, Kallenberg CG. Anti-DNA antibodies as early predictor for disease exacerbations in SLE. Guideline for treatment? Clin Rev Allergy Immunol 1998; 16: 211-8.

17. Smith EM, Jorgensen AL, Midgley A, Oni L, Goilav B, Putterman C, et al. International validation of a urinary biomarker panel for identification of active lupus nephritis in children. Pediatr Nephrol 2017; 32: 283-295.

18. Yee CS, Farewell V, Isenberg DA, Griffiths B, Teh LS, Bruce IN, et al. The BILAG-2004 index is sensitive to change for assessment of SLE disease activity. Rheumatology (Oxford) 2009; 48: 691-5.

19. Zickert A, Palmblad K, Sundelin B, Chavan S, Tracey KJ, Bruchfeld A, et al. Renal expression and serum levels of high mobility group box 1 protein in lupus nephritis. Arthritis Res Ther 2012; 14: R36.

20. Watson L, Midgley A, Ballantine L, Jones CA, Holt RC, Marks SD, et al. Monocyte chemoattractant protein 1 is expressed from kidney epithelial cells in response to activated macrophages in juvenile-onset systemic lupus erythematosis (JSLE). Annals of Rheumatic Disease 2012; 41: 72.

21. Rubinstein T, Pitashny M, Levine B, Schwartz N, Schwartzman J, Weinstein E, et al. Urinary neutrophil gelatinase-associated lipocalin as a novel biomarker for disease activity in lupus nephritis. Rheumatology (Oxford) 2010; 49: 960-71.

22. Marks SD, Shah V, Pilkington C, Tullus K. Urinary monocyte chemoattractant protein-1 correlates with disease activity in lupus nephritis. Pediatr Nephrol 2010; 25: 2283-8.

23. Hinze CH, Suzuki M, Klein-Gitelman M, Passo MH, Olson J, Singer NG, et al. Neutrophil gelatinase-associated lipocalin is a predictor of the course of global and renal childhood-onset systemic lupus erythematosus disease activity. Arthritis Rheum 2009; 60: 2772-81.

**Table 1. Key demographic data for the JSLE patients studied.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **In-active LN (n=179)a** | **Active LN (n=191)a** | ***pcb*** |
| **Age at diagnosis (years)** | 12.7 [10.1-14.3] | 12.8 [10.8-14.5] | *1.000* |
| **Disease duration (years)** | 0.6 [0-1.7] | 0.5 [0-2.6] | *1.000* |
| **Gender (F: M ratio)c** | 4.8:1 | 5:1 | *1.000* |
| **ACR criteria at diagnosisd** | 4 [4-5] | 5 [4-5] | *1.000* |
| **Patient ethnicity (n, %)e**   * Caucasian * African * Caribbean * Mixed race * Indian / Pakistani / Bangladeshi * Chinese * Other Asian | 95 (54%)  12 (6%)  6 (3%)  14 (8%)  38 (21%)  3 (2%)  11 (6%) | 95 (51%)  12 (6%)  10 (5%)  14 (7%)  40 (21%)  8 (4%)  12 (6%) | *0.717* |

aResults expressed as median values and interquartile ranges. Chi Squared and Mann Whitney U tests used to assess for differences in demographic / clinical factors between different patient groups as appropriate. b*pc*: Bonferroni-corrected p-values, cF:female, M:male, dACR:American College of Rheumatology, eethnicity data is patient reported.

**Table 2. Classical biomarker measurements in active versus in-active LN patients.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **na** | **Inactive LNb** | **Active LNb** | ***pcc*** |
| **Anti-dsDNA (IU/L)d** | 308 | 29 [7-154] | 77 [13-261] | *0.068* |
| **C3 (g/L)e** | 339 | 0.99 [0.75-1.23] | 0.78 [0.43-1.08] | *<0.001* |
| **C4 (g/L)f** | 338 | 0.15 [0.08-0.20] | 0.10 [0.05-0.19] | *0.017* |
| **ESR (mm/h)g** | 327 | 18 [6-40] | 40 [11-80] | *<0.001* |
| **CRP (mg/L)h** | 306 | 5 [3-7] | 5 [3-7] | *1.000* |
| **Haemoglobin (g/dl)** | 367 | 12.1 [10.8-13.2] | 11.5 [9.9-12.8] | *0.014* |
| **White cells (x109/L)** | 365 | 5.4 [4.2-7.1] | 5.7 [4.0-8.8] | *1.000* |
| **Neutrophils (x109/L)** | 365 | 3.2 [2.1-4.3] | 3.6 [2.4-6.4] | *0.053* |
| **Lymphocytes (x109/L)** | 365 | 1.3 [0.9-1.9] | 1.3 [0.9-1.9] | *1.000* |
| **Platelets (x109/L)** | 364 | 270 [207-325] | 261 [196-335] | *1.000* |
| **IgG (g/L)i** | 291 | 13.7 [10.9-18.6] | 12.0 [9.2-18.1] | *1.000* |
| **IgA (g/L)j** | 289 | 1.8 [1.2-2.4] | 1.9 [1.2-2.8] | *1.000* |
| **IgM (g/L)k** | 287 | 1.2 [0.8-1.7] | 1.0 [0.6-1.6] | *1.000* |
| **UACR (mg/mmol Cr)l** | 130 | 0.9 [0.5-2.2] | 23.9 [2.5-109.7] | *<0.001* |
| **UPCR (mg/mmol Cr)m** | 141 | 11 [5-15] | 102 [60-325] | *<0.001* |
| **eGFR (ml/min/m2)n** | 267 | 116 [99-130] | 108 [87-108] | *1.000* |
| **S creatinine (μmol/L)o** | 318 | 54 [46-54] | 61 [48-57] | *1.000* |

aNumber of patients contributing to analysis for each laboratory parameter. bExpressed as median values and interquartile ranges. c*pc*: Bonferroni-corrected p-values. danti-dsDNA: anti-double stranded DNA antibody, eC3: complement factor 3, fC4: complement factor 4, gESR: erythrocyte sedimentation rate, hCRP: C-reactive protein, iIgG: immunoglobulin G, jIgA: immunoglobulin A, kIgM: immunoglobulin M, lUACR: urinary albumin to creatinine ratio, mUPCR: urinaryprotein creatinine ratio, neGFR: estimated glomerular filtration rate, oS creatinine: serum creatinine.

**Table 3. Binary logistic regression model for identification of active LN using classical biomarkers.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Biomarkers** | **Final model fitted by including all biomarkers in a multiple logistic regression model and applying ‘StepAIC’ functiona** | | | |
| Co-efficient | Std. Error | *p-value* | *AUCb* |
| **ESRc** | 0.019 | 0.007 | *0.003* | *0.724* |
| **C3d** | -1.035 | 0.488 | *0.034* |
| **White cells** | -0.699 | 0.423 | *0.098* |
| **Neutrophils** | 0.795 | 0.427 | *0.06* |
| **Lymphocytes** | 0.735 | 0.503 | *0.144* |
| **IgGe** | -0.061 | 0.026 | *0.017* |

aStepAIC function:step Akaike Information Criterion function,185 patients (88 active LN and 97 in-active LN) included in this model as patients excluded when classical biomarker measurements were missing. bAUC: area under the curve, cESR: erythrocyte sedimentation rate, dC3: complement factor 3, eIgG: immunoglobulin G.