0.38–0.85). Other variables significantly associated with TEs are depicted in Table 1.

Conclusions After adjusting for possible confounding factors related to AMs use, a clear protective effect of AMs in the development of TEs in SLE patients from this Latin American cohort was observed.

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CE-29 DO PATIENTS WITH SYSTEMIC LUPUS GET BETTER QUALITY OF CARE IN LUPUS CLINICS THAN IN GENERAL RHEUMATOLOGY CLINICS?

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Background Patients with SLE receive care from several physicians in varied health care settings worldwide. Herein, we compared the quality of care received by SLE patients at two settings within the same academic institution (lupus clinic or general rheumatology clinic) using validated SLE quality indicators (QI).

Methods 100 consenting, consecutive patients fulfilling the American College of Rheumatology (ACR) classification criteria for SLE who were receiving longitudinal care at Rush University Rheumatology outpatient clinic and at subspecialty Lupus clinic were recruited. A validated QI survey was updated, modified for self-report and administered during participants' routine SLE care visit. Retrospective rheumatology medical chart reviews were done in addition for complete evaluation of performance on each QI. The overall performance rate and performance rates on 20 QIs were calculated for the two groups and compared using non-parametric tests. P-value <0.05 was considered significant.

Results 60 patients from sub-specialty lupus clinic and 40 patients from general rheumatology clinic participated. Patients receiving care at lupus clinic had longer disease duration [10 ± 6.6 vs 6.5 ± 6.9 years; P = 0.01] and met more number of ACR criteria [5.4 ± 1.7 vs 4.7 ± 1.0; P = 0.01] compared to patients from general rheumatology clinics. The overall performance rate was significantly greater among lupus clinic as compared to rheumatology clinic SLE patients [87.5% (IQR: 16%) vs.71.1% (IQR: 19%), P = 0.001]. Differences noted among the two groups were in counselling for use of sunscreen (98% vs 87%, p < 0.036), testing for antiphospholipid antibodies within 6 months of diagnosis (70% vs 30%, p < 0.001), recommendation for pneumococcal vaccine if on immunosuppressive medication/s (86% vs 50%, p < 0.003), bone mineral density test performance if on chronic steroids (95% vs 48%, p < 0.001) and prescribing a steroid sparing agent (100% vs 82%, p < 0.007) (Table 1).

Conclusions SLE patients seen in the dedicated lupus clinic had better overall and specific QI performance relative to general rheumatology clinics. This may suggest greater recognition among lupus clinic physicians of the importance of preventive care and disease monitoring among SLE patients. Of particular importance were the findings regarding vaccination and preventive use of sunscreen, as these may substantially affect morbidity in this patient population.

Abstract CE-29 TABLE 1 Performance on Quality Indicatore (QI)

		Lupus clinic			General Rheumatology clinic			P-value
QI No.	Description of QI	QI eligible (N)	Met QI (n)	PP (%)	QI eligible (N)	Met QI (n)	PP (%)	
1	ANA, CBC, Platelet, Creatinine, UA at diagnosis of lupus	60	60	100	40	39	97.5	0.4
2	AntidsDNA, C3/4, APL within 6 months of diagnosis	60	42	**70.0**	40	12	30.0	**<0.001**
3	Counselling for use of sunscreen	60	59	**98.3**	40	35	87.5	**0.036**
4	Influenza vaccine in last year if on ISM	37	36	97.3	24	20	83.3	0.07
5	Pneumococcal vaccine if on ISM	37	32	**86.5**	24	12	50.0	**0.003**
6	DEXA if have received ≥7.5 mg/day CS for ≥3 months	42	40	**95.2**	25	12	48.0	**< 0.001**
7	Calcium and Vitamin D if have received ≥7.5 mg/d CS for ≥3 months or is post-menopausal	45	38	84.4	31	22	71.0	0.25
8	Antiresorptive agent if have received ≥7.5 mg/d CS for ≥1 month & central T score ≤ 2.5 or h/o fragility fracture	10	10	100	3	3	100	N\A
9	Counselling about drugs at initiation	60	54	90.0	40	36	90.0	1.00
10	Baseline tests at initiation of drugs	59	58	98.3	40	38	95.0	0.56
11	Tests for drug monitoring	59	53	89.8	38	33	86.8	0.74
12	Steroid sparing agent if have taken ≥10 mg/day CS for ≥3 months	38	38	**100**	22	18	81.8	**0.007**
13	Follow up tests (UA, CBC, Creatinine) done for LN at every 3 months	17	12	70.6	7	5	71.4	1.00
14	Treatment with ISM & CS within 1 month of diagnosis of Class 3/4 LN	13	13	100	7	7	100	N\A
15	Antihypertensive if have proteinuria ≥ 300 mg/d or GFR < 60 ml/min & ≥ 2 BP readings > 130/80	14	13	92.9	9	9	100	1.00
16	ACE inhibitor or ARB if have proteinuria ≥300 mg/d	15	14	93.3	7	4	57.1	0.07
17	Assessment of CVD risk & counselling	60	19	31.7	40	7	17.5	0.16
18	Tests in pregnancy (AntiSSA/SSB, APL)	9	6	66.7	5	2	40.0	0.58
19	Treatment of APS in future pregnancies	1	1	100	1	1	100	N\A
20	Reproductive health counselling	23	20	87.0	13	10	76.9	0.64

Abbreviations: PP – Performance percentage, ANA – Antinuclear antibody, CBC – Complete Blood Count, UA – Urinalysis, APL – Anti- phospholipid antibodies, ISM – Immunosuppressive medications, CS – Corticosteroids, HCQ – Hydroxychloroquine, MTX – Methotrexate, MMF – Mycophenolate mofetil,LN – Lupus Nephritis, ARB – Angiotensin receptor blocker, CVD – Cardiovascular Disease, APS – Antiphospholipid antibody syndrome