in SLE patients, even among those with mild or inactive disease. This preliminary study examines the relationship between disease activity scores and HRQoL changes in SLE patients and will then be followed by another study to evaluate whether a multidisciplinary approach (based on yoga, mindfulness and Chinese medicine), in addition to conventional medical therapy, could improve quality of life.

Methods This is a cross-sectional observational study of SLE patients in a tertiary disease-specific outpatient clinic. During clinical evaluation, for each enrolled patient, demographics, drugs, organ damage (Systemic Lupus International Collaborating Clinics Damage Index), active disease manifestations, and Systemic Lupus Disease Activity Index scores are recorded. At the same time, patients complete two questionnaires, the Short Form-36 (SF-36) and the Functional Assessment Chronic Illness Therapy-Fatigue (FACIT-F), considered as patient reported outcome scores (PRO scores).

Results Although the study is still ongoing, we are presenting preliminary data. 17 outpatients have been enrolled since January 2022 (mean age 41.7±16.4 years, median duration of the disease 7.5 years). The median scores of SLEDAI-2K, SLICC-DI, SLEDAs, FACIT-F, and SF-36 (physical and mental component) are, respectively, 2 (IQR 0.5–4), 0 (IQR 0–0), 1.12 (IQR 0.28–6.88), 38.5 (28.75–46.25), 43 (IQR 36.5–51), 36 (IQR 19–50). Of the patients in our cohort, 10/17 (58.8%) met the definition of Lupus Law Disease Activity State (LLDAS), while 4/17 (23.5%) manifested an active disease.

In preliminary data analysis, there is no evidence of correlation between lower disease activity and better PRO score. The study is expected to be completed in May 2022 and the final data will be available from June 2022.

Conclusions While research has recently begun, there seems to be a discordance between physician's and patient's disease perception. SLE patients often feel misunderstood and complain that doctors do not take care of all aspects of the disease. We are sure that the multidisciplinary approach proposed at the end of the study will overcome this gap in healthcare.

PO.7.152 COMPARISON OF EDUCATIONAL NEEDS AMONG PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS AND ANCA ASSOCIATED VASCULITIS – A PILOT STUDY USING THE EDUCATIONAL NEEDS ASSESSMENT TOOL

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Purpose The aim of the study was to compare educational needs among the systemic inflammatory diseases, Systemic lupus erythematosus (SLE) and ANCA associated vasculitis (AAV) using the Educational Needs Assessment Tool (ENAT).

Method This pilot study included cross-sectional data from two separate cohorts, SLE and AVV, from the Karolinska University Hospital, Sweden. Inclusion criteria were minimum age of 18 years and literate in Swedish. Exclusion criterion was cognitive impairment interfering with literate capabilities. Participants with SLE and AAV respectively were individually matched for disease duration, sex, and education.

Educational needs were captured by patients' answers to the questionnaire ENAT. The ENAT consists of 39 questions, presented as total ENAT and seven domains ('Managing pain', 'Movement', 'Feelings', 'Disease process', 'Treatment', 'Self-management' and, 'Support systems') each containing 4–7 items (from 'not at all important' = 0, to 'extremely important' = 3). The participants responses are presented as 'mean % of the domain score' (from 0 = no to 100 = highest). For comparisons paired samples t-test were used.

Abstract PO.7.152 Table 1 Comparison of ENAT scores (mean% of max) (SD) between patient with SLE and AAV

ENAT domain	All *n=52*	SLE *n=26*	AAV *n=26*	p
Managing pain	49.7 (29.7)	48.9 (28.4)	50.4 (32.0)	0.846
Movement	47.7 (33.3)	42.8 (32.1)	49.7 (34.4)	0.469
Feelings	63.5 (31.2)	54.2 (31.2)	71.9 (29.5)	**0.050**
Disease process	77.3 (22.0)	71.2 (22.7)	84.0 (20.0)	**0.037**
Treatments	60.4 (34.8)	45.8 (36.0)	74.3 (28.6)	**0.010**
Self-management	76.4 (20.8)	76.1 (19.6)	76.6 (22.9)	0.945
Support systems	52.9 (29.5)	46.3 (30.5)	59.7 (28.0)	0.122
Total ENAT	59.9 (23.7)	54.0 (23.1)	65.7 (23.3)	0.096

Results Twenty-six matched pairs (89% female), mean (SD) disease duration 6.1 (8.4) years, were included. The mean age was 44 (13.1) years for SLE and 58.5 (16.2) years for AAV (p=0.003). Educational length was reported as mean 14.9 (3.3) years among SLE patients and 12.8 (2.7) years among AAV patients (p=0.1).

Among all patients, the mean total ENAT was generally high 59.9% (range 12.8–100%) and did not differ between the two diseases (p = 0.1) (Table 1). The highest education need in SLE, were 'Self-management' (76.1%) and the 'Disease process' (71.2%), and lowest educational need in SLE were found in the domains 'Movement' (mean 42.8%) and 'Treatments' (mean 45.8%). Patients with SLE reported a lower educational need compared to AAV, statistically significantly in three of the domains, 'Treatments' (74.3% vs. 45.8%, p = 0.01), 'Disease process' (84.0% vs. 71.2%, p = 0.04) and 'Feelings' (71.9% vs. 54.2%, p = 0.05).

Conclusions In this pilot study with SLE and AAV, educational needs regarding 'Treatments', 'Disease process' and 'Feelings' were lower in SLE compared to AAV, despite that the participants were matched for disease duration and sex, two variables previously found to be indicators of increased educational needs. Although, this study indicated lower needs in SLE compared to AAV, significant patient educational needs were identified among SLE especially concerning self-management and disease process. If other factors such as age play a role in the educational need must be explored in a larger sample with more variations in age among the participants. However, the results indicates that healthcare providers must further develop their support activities to help patients manage life with SLE based on these expressed needs.

PO.7.153 SYSTEMIC LUPUS-DERMATOMYOSITIS OVERLAPPING SYNDROME: A CASE REPORT

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Introduction About 10 to 20% of myositis are associated with other connectivitis as cleroderma, Sjogren's syndrome and systemic lupus erythematosus (SLE). Nearly 10 to 15% - with specific immunological markers are associated with cancers.

Purpose To review a case report to illustrate this clinical situation

Observation A 53 years old woman, without medical history, who presented with arthromyalgia associated with a skin rash, all of which had been progressively evolving for 3 months. On clinical examination, a typical clinical myogenic syndrome was noted Skin involvement was also noted. erythematous macular lesions poorly limited, partly erosive, periorbital, erythema in shawl and V neckline on the upper limbs and neck with the presence of erosive pulpal lesions on the anterior surfaces of the fingers. There was also diffuse alopecia and butterfly-wing erythema of the face. In addition, a notion of intermittent fever at 38.5 with a progressive deterioration in general condition was reported. Severe signs such as dysphagia and dyspnea on the slightest exertion justified his admission to hospital. The physical examination found a BMI at 25, HR at 88 beats/min, respiratory rate at 20 cycles/min, TA at 110/70 mm Hg and saturation at rest and ambient air at 97%. Apart from the muscle damage, the examination of the various devices (lung, heart, vessels) was unremarkable. The biological explorations revealed leukopenia at 2000 with neutropenia and a lymphopenia at 600. The inflammatory syndrome was attested by an ESR of 59 mm and CRP of 12 mg/l. An elevation of muscle enzymes was noted (X8 N). The ANA and anti-DNA antibodies were positive but without other antigenic specificity. In addition, the blood ionogram, the renal assessment, the assessment of hemostasis were normal. Viral hepatitis (B and C) and covid 19 serologies were negative. The EMNG showed muscle damage. Cardiac evaluation objectified increase in troponins which remained stable over time with no noticeable alteration on the electrical tracing, but nevertheless apical hypokinesia without alteration of systolic function was found on cardiac echography-Doppler. At the end of these explorations, the diagnosis of overlap myositis was retained in front of the signs of dermatomyositis and SLE (the latter accumulated 19 points of the EULAR/ACR 2019 classification criteria). Therapeutically and in view of the severe motor deficit and cardiac involvement, the patient was put on a bolus of corticosteroids and immunoglobulin infusions. The evolution was favorable. The search for cancer (ovaries, lungs, breast, genitals) by the appropriate examinations (thoraco-abdominopelvic CT scan, mammography, cervico-vaginal smear) was negative, as were the anti-TIF1Y antibodies.

Conclusion The association SLE and inflammatory myopathy is rare and all types of myopathy can be found. There is a strong female predominance in so-called overlapping myositis. On the evolutionary level, the presence of another connective tissue does not seem to modify the response of myositis to treatment. The fear of cancer in its forms remains a low probability but nevertheless justifies clinical monitoring.

PO.7.154 JACCOUD'S RHEUMATISM DURING SYSTEMIC LUPUS: A CASE REPORT

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Introduction Jaccoud's rheumatism (JR) is a chronic, deforming and non-erosive arthropathy which preferentially affects the hands giving an aspect close to rheumatoid arthritis (RA). It' is distinguished from this connective tissue by the initially reducible character of the deformations and the absence of erosions on standard radiography.

Observation BR, 34 years old, who with inflammatory arthralgia and a dry syndrome. The immunological assessment showed positive AAN 1/320, anti-SSA, anti-SSB and proteinuria for 24 hours at 4 g/24 hours. The accessory salivary gland biopsy showed Chisholm grade 4. The diagnosis of systemic lupus erythematosus (SLE) associated with secondary Sjogren's syndrome (SSj) was retained. The nephropathy had benefited boluses of cyclophosphamide presuming an active and severe lesion. The corticosteroids and immunosuppressants had been continued for 2 years and for the joint damage which appeared 2years ago and a rhulupus had been diagnosed and benefited from treatment with hydroxychloroquine and methotrexate. The physical examination found a deformation of the hands type deviation in ulnar wind. The joint deformity was reducible, painless and the radiographs did not show any erosions allowing the diagnosis of JR be retained. The biological assessment found an accelerated ESR at 94 mm and a CRP at 67 mg/l, and the immunological assessment of AAN 1/320, SSA + and SSB suggesting a lupus inflammatory flare-up. Anti-CCP rheumatoid serology was negative. The patient also presented with autoimmune thyroiditis and heterozygous β-thalassemia.

Discussion The physiopathological mechanism of JR remains imperfectly elucidated. Its diagnostic criteria are not validated and its therapeutic management poorly codified. There are different severity scores for the evaluation of RJ. The most commonly used is the Jaccoud arthropathy (JA) index, used by Spronk and Al, which takes into account the number of fingers affected and the type of deformities visualized (ulnar deviation sup 20°, swan neck deformities, limitation of Metacarpophalangeal extension, buttonhole deformation, Z deformation.). The pathologies most frequently associated with JR are mainly SLE with a prevalence of 10–35%, more rarely SSj 2%. The clinical and serological factors correlated to JR are a longer duration of evolution of SLE, the presence of arthritis of the hands and wrists (rhulupus) and biologically, a higher CRP and the presence of anti-DNA antibodies. native or antiphospholipid antibodies. RJ deformities tend to worsen over time, causing functional disability and impaired quality of life, and no treatment has been proven to be effective. Rehabilitation and the wearing of orthoses remain the usual modest techniques.

Conclusion JR is classically associated with SLE. A JR that has been evolving for several years can lead to degenerative damage and lead to irreducible deformities whose pathophysiology deserves to be better elucidate in order to determine the optimal therapeutic strategy. Therefore, it is important not to ignore this complication, which is the cause of a functional and unsightly disability that alters the quality of life.