**Results** As compared to German nationals, non-Germans had a 81% higher chance of impairment despite treatment (adjusted odds ratio [aOR]=1.81; 95%-CI=1.17–2.78) (table 1). Also, patients who worked in a semi-skilled or unskilled position had a 40% higher chance of a poor outcome than those in skilled occupational positions (aOR=1.40; 95%-CI=1.02–1.92). Disparities did not significantly differ between the years in which services were utilized. There were also no difference between men and women, between different age or diagnostic groups.

**Conclusions** The study illustrates disparities in health care outcomes associated with different diversity characteristics, which likely result from different obstacles some disadvantaged population groups encounter in the health system. This heterogeneity must be taken into account through strategies of diversity-sensitive health care provision.

## LO-002 'SKIN-DEEP RESILIENCE' IN THE BLACK WOMEN'S EXPERIENCES LIVING WITH LUPUS (BEWELL) STUDY

[1]Kara W Chung*, [2]Connor D Martz, [3]Brendan Lutz, [4]Natalie Slopen, [5]Bridget J Goosby, [6]Tamika Webb-Detiege, [1]David H Chae. *[1]Social, Behavioral, and Population Sciences, Tulane School of Public Health and Tropical Medicine, New Orleans, LA, USA; [2]Population Research Center, University of Texas at Austin, Austin, TX, USA; [3]Edward Via College of Osteopathic Medicine, Auburn Campus, Auburn, AL, USA; [4]Department of Social and Behavioral Sciences, Harvard T. H. Chan School of Public Health, Boston, MA, USA; [5]Department of Sociology, University of Texas at Austin, Austin, TX, USA; [6]Department of Rheumatology, Ochsner Health, New Orleans, LA, USA*

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**Background** The 'skin-deep resilience' hypothesis suggests that Black Americans from disadvantaged backgrounds who persevere and attain academic or professional success despite various social obstacles may nevertheless suffer from poorer underlying physical health. This study examined the 'skin-deep resilience' phenomenon among Black American women with systemic lupus erythematosus (SLE).

**Methods** Data were from the Black Women's Experiences Living with Lupus (BeWELL) Study, which recruited largely from a population-based sample of Black women living with SLE in metropolitan Atlanta, GA, USA (n=438). Multivariable linear regression models were specified examining SLE disease activity measured using the patient-reported Systemic Lupus Activity Questionnaire (SLAQ), in relation to educational attainment, adverse childhood experiences (ACEs), and experiences of racial discrimination in adulthood. We examined whether associations between racial discrimination and disease activity differed by educational attainment and ACEs, particularly for those who achieved high levels of education despite greater childhood adversity—an indicator of resilience.

**Results** We found a significant three-way interaction between educational attainment, ACEs, and racial discrimination, consistent with the skin-deep resilience hypothesis ($F(26,399)=2.92$, $p=.02$). As expected, racial discrimination was positively associated with disease activity (b=1.89, 95% Confidence Interval [CI] [1.19, 2.59], $p<.001$). However, this relationship was strongest among those who experienced greater childhood adversity and attained a graduate degree, in other words, those who were highly resilient. There was no interaction between education attainment and racial discrimination among those who experienced low childhood adversity.

**Conclusions** Findings suggest that 'highly resilient' Black women living with SLE (those who achieved a graduate degree despite high childhood adversity), were the most physically impacted by experiences of high racial discrimination. This study challenges traditional conceptualizations of resilience by demonstrating the unintended physical health tolls of 'building resilience' without addressing other social and structural inequities stemming from racism.

## LO-003 PREVALENCE OF REMISSION ACCORDING TO PHYSICIAN AND PATIENT AND LEVEL OF AGREEMENT IN A REAL-WORLD MULTICENTER LUPUS REGISTRY

[1]Julia Martínez-Barrio, [2]José María Pego Reigosa*, [1]Isabel Castrejón, [3]María Galindo-Izquierdo, [4]Esther Uriarte-Isacelaya, [5]Elena Aurrecoechea Aguinaga, [6]Natalia Mena Vazquez, [2]Irene Altabas, [7]José Carlos Rosas Gómez de Salazar, [8]Silvia Gómez Sabater, [9]Mónica Ibáñez Barcelo, [10]Vicente Torrente Segarra, [11]F Javier Narváez García, [12]Clara Sangüesa Gómez, [13]Joan Calvet Fontova, [14]Mercedes Freire González, [15]Clara Moriano Morales, [16]Carlota Iñiguez, [17]Eva Gloria Tomero Muriel, [18]Ana Pérez Gómez, [19]José Luis Andreu Sánchez, [20]M Jesús García-Villanueva, [21]Tatiana Cobo, [22]Gema Bonilla Hernán, [23]Nuria Lozano Rivas, [24]Loreto Horcada, [25]Carlos Montilla Morales, [26]Francisco Javier Toyos Sáenz de Miera, [27]Lorena Expósito, [28]María Esther Ruiz Lucea, [29]José Eloy Oller, [30]Ángela Pecondón Español, [31]Ricardo Blanco Alonso, [32]Sergio Machín, [33]Eva Salgado, [34]Irene Carrión Bárbera, [35]Raúl Menor Almagro, [36]Jaime Calvo Alen, [37]Alejandro Muñoz Jiménez, [38]Jorge Fragio Gil, [39]Iñigo Rúa-Figueroa Fdez de Larrinoa. *[1]Rheumatology, Hospital General Universitario Gregorio Marañón, Spain; [2]Rheumatology, Hospital Meixoeiro, Spain; [3]Rheumatology, Hospital 12 de Octubre, Spain; [4]Rheumatology, Hospital Universitario Donostia, Spain; [5]Rheumatology, Hospital de Sierrallana, Spain; [6]Rheumatology, Carlos Haya (Málaga), Spain; [7]Rheumatology, Hospital Marina Baixa, Spain; [8]Rheumatology, Hospital General Universitario de Alicante, Spain; [9]Rheumatology, Hospital Universitari Son Llàtzer, Spain; [10]Rheumatology, Hospital de Sant Joan Despí Moisès Broggi/Consorci Sanitari Integral (CSI), Spain; [11]Rheumatology, Hospital Universitario de Bellvitge, Spain; [12]Rheumatology, Hospital Universitario Germans Trias i Pujol, Spain; [13]Rheumatology, Consorci Corporació Sanitària Parc Taulí, Spain; [14]Rheumatology, Complejo Hospitalario Universitario de A Coruña (CHUAC), Spain; [15]Rheumatology, Complejo Asistencial Universitario de León, Spain; [16]Rheumatology, Hospital Lucus Augusti (Anterior Xeral-Calde), Spain; [17]Rheumatology, Hospital Universitario La Princesa, Spain; [18]Rheumatology, Hospital Universitario Principe de Asturias, Spain; [19]Rheumatology, Hospital Universitario Puerta de Hierro, Spain; [20]Rheumatology, Hospital Universitario Ramón y Cajal, Spain; [21]Rheumatology, Hospital Infanta Sofía, Spain; [22]Rheumatology, Hospital Universitario La Paz, Spain; [23]Rheumatology, Hospital Clínico Universitario Virgen de la Arrixaca, Spain; [24]Rheumatology, Complejo Hospitalario de Navarra, Spain; [25]Rheumatology, Hospital Cínico Universitario de Salamanca, Spain; [26]Rheumatology, Hospital Virgen de la Macarena, Spain; [27]Rheumatology, Hospital Universitario de Canarias, Spain; [28]Rheumatology, Hospital Universitario de Basurto, Spain; [29]Rheumatology, Hospital Universitario Dr. Peset, Spain; [30]Rheumatology, Hospital Universitario Miguel Servet, Spain; [31]Rheumatology, Hospital Universitario Marqués de Valdecilla, Spain; [32]Rheumatology, Complejo Hospitalario Universitario Insular de Gran Canarias, Spain; [33]Rheumatology, Complejo Hospitalario De Orense, Spain; [34]Rheumatology, Hospital del Mar, Spain; [35]Rheumatology, Hospital Jerez de la Frontera, Spain; [36]Rheumatology, Hospital Universitario de Araba, Spain; [37]Rheumatology, Hospital Universitario Virgen del Rocío, Spain; [38]Rheumatology, Hospital La Fe, Spain; [39]Rheumatology, Hospital Universitario de Gran Canaria Doctor Negrín, Spain*

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**Background** To investigate the prevalence and level of agreement between remission according to physician and patient criteria and to evaluate the impact of remission on HRQoL in patients with SLE.

**Methods** Prospective study of patients included in RELESSER-PROS, a multicenter register of SLE patients, protocol previously described.[1] Remission according to physician was defined in agreement with DORIS 2021 criteria.[2] Remission according to patient was defined as SLAQ (Systemic Lupus Activity Questionnaire) question 1 with no flare in the last 3 months (score 0).

Patients were classified in three groups according to remission status (DORIS, SLAQ, both). Level of agreement was

assessed using kappa statistics, considered acceptable if kappa>0.60.

**Results** 1102 patients, with a follow-up of at least 2 years (data from 3 visits available) were included. Patient characteristics according remission status at baseline are presented in the table 1. At baseline, remission by DORIS was present in 16.1%, by SLAQ 16.7% and 2.45% by both. Remission by DORIS was more frequent among patients with higher education, on immunosuppressant/biological therapy and patients with history of hospitalization; remission by SLAQ was more frequent among women, obese patients, and those on antimalarials (p<0.05). Symptoms reported in patients who considered themselves in remission were mainly cutaneous and articular (53.3%). Mean SLEDAI in patients on remission by SLAQ was 3.28 (3.78). Patients in remission by DORIS had significantly better results in patient reported outcomes measured by EQ-5D and LIT (p<0.05). Level of agreement in remission according to physician and patient was 78.04% (K=0.061) at baseline, 63.39% (K=0.039), and 62.73% (K=0.099) in year 2 and 5. Kappa level of agreement was low.

**Conclusions** Our results reflect low level of agreement between physician and patients in terms of remission status with increasing disagreement in the follow-up. Patients in remission by DORIS shows better results in EQ-5D and LIT.

## REFERENCES

1. Rúa-Figueroa I, *et al. Reumatol Clin.* 2014;**10**(1):17–24.
2. van Vollenhoven RF, *et al. Lupus Sci Med.* 2021;**8**(1):e000538.

**Abstract LO-003 Table 1** Patient characteristics according remission status at baseline

| | Remission by DORIS (n=177) | Remission by SLAQ (n=184) | Remission by both criteria (n=27) | *p-value* |
|---|---|---|---|---|
| Age at diagnosis (years), mean (SD) | 34.6 (14.87) | 36.64 (13.74) | 33.77 (13.12) | 0.181 |
| Female sex, n (%) | 160/176 (90.9%) | 166/182 (91.2%) | 27/27 (100%) | 0.004 |
| Disease duration (yrs), mean (SD) | 15.26 (8.18) | 13.71 (7.7) | 19.8 (7.66) | 0.069 |
| Highest education | 57/172 (33.1%) | 40/180 (22.2%) | 13/26 (50%) | <0.001 |
| Medication, n (%) | | | | |
| Off-therapy | 0/177 (0%) | 36/182 (19.8%) | 0/27 (0%) | 1 |
| Antimalarials | 79/176 (44.9%) | 100/182 (54.9%) | 14/27 (51.9%) | <0.001 |
| Immunosuppressants (AZA, MTX, MMF) | 63/175 (36%) | 36/180 (20%) | 12/27 (44.4%) | <0.001 |
| Biological therapy (rituximab, belimumab) | 14/176 (8%) | 8/178 (4.5%) | 4/27 (14.8%) | <0.001 |
| Obesity (BMI>30), n (%) | 18/162 (11.1%) | 44/176 (25%) | 3/24 (12.5%) | 0.003 |
| Hospital admission, n (%) | 57/176 (32.4%) | 40/182 (22%) | 7/26 (26.9%) | <0.001 |
| SLEDAI, mean (SD) | 1.66 (1.66) | 3.28 (3.78) | 1.78 (1.5) | <0.001 |
| SLAQ, mean (SD) | 26.15 (2.55) | 27.98 (1.81) | 27.63 (1.96) | <0.001 |
| EQ-5D | 67.53 (19.31) | 63.22 (20.12) | 64.54 (17.7) | 0.041 |
| LIT | 26.68 (21.76) | 34.37 (20.34) | 31.3 (18.34) | 0.0007 |
| SLICC/ACR Damage Index | 1.57 (1.74) | 1.42 (1.84) | 1.37 (1.9) | 0.437 |
| Mortality | 0/177 (0%) | 0/184 (0%) | 0/27 (0%) | 1 |