reliability measures, including member checking and reflexivity, were embedded throughout the process.

Results Several barriers to equitable health outcomes in SLE were identified, including: a notable gap in access to rheumatologists and other specialists; socioeconomic factors influencing the quality of care; systemic biases in healthcare; and communication barriers between patients and providers. Proposed solutions to these included: enhancing access to specialists by addressing affordability, such as through telemedicine; implementing models of value-based care, such as accountable care organizations and patient-centered medical homes, that consider social determinants of health; and educating healthcare providers on communication barriers and other biases experienced by patients from diverse backgrounds. The panel acknowledged potential challenges of these solutions, including logistical difficulties and the need for significant shifts in attitudes and behaviors.

Conclusions The complex factors underlying health disparities in SLE necessitate multilayered strategies to promote health equity. Proposed solutions such as improved patient education, cultural tailoring of interventions, and policy changes to increase access may be promising, but require substantial resources and systemic reform. Our insights suggest that it is important to not generalize amongst minorities, and create solutions that address concerns specific to the population being considered. While the contributors here were US-based, the learnings are globally applicable, and emphasize the need for ongoing research and advocacy initiatives to address health inequities in SLE and ensure optimal outcomes for all patients. Further investigation into actionable and evidence-based recommendations is warranted.

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P107 SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) AND SUBCLINICAL MUSCULOSKELETAL INVOLVEMENT: A ROLE FOR OSTEOARTICULAR ULTRASOUND?

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Objective The purpose of the study is to evaluate the role of ultrasonography in the detection of musculoskeletal disease in subclinical form, and the possible association with different disease features.

Methods Sixty-four consecutive SLE patients followed at our Lupus Clinic were enrolled. Patients were divided into 3 groups according to the type of musculoskeletal involvement: GROUP 1: 22 patients with no previous or current musculoskeletal involvement; GROUP 2: 21 patients with arthralgias without objective signs of synovitis; GROUP 3: 21 patients with objectively detectable musculoskeletal involvement. All patients underwent osteoarticular ultrasound exploring 26 sites bilaterally: MCP II-V, PIP II-V, wrist, elbow, shoulder, knee, Achilles tendon. Images were grayscale (GS) and Power Doppler (PD) evaluated according to the OMERACT EULAR Score System definitions. The presence of ultrasound-evident arthritis was defined for each patient if there was at least 1 joint with GS score$\geq$1 and PD$\geq$1.

Results In 7 patients in GROUP 1+2 (16.3%), subclinical arthritis could be detected by ultrasound, particularly in 3 (6.9%) in Group 1 and in 4 (9.3%) in GROUP 2. In GROUP 1+2, a statistically significant difference in mean age at the time of ultrasound (50.92 ± 10.56 and 40.43 ± 10.40, respectively, p = 0.019) and mean age at diagnosis (38.50 ± 10.18 and 25.95 ± 9.71, p = 0.004) could be detected between patients with and without subclinical arthritis. Higher age at diagnosis (OR = 1.518, p = 0.049) and at the time of ultrasound (OR = 1.336, p = 0.018) were confirmed to be predictive factors for subclinical arthritis. The presence of subclinical arthritis was associated with normal C3 values (p = 0.015).

Conclusions The sensitivity of ultrasonography in detecting subclinical joint inflammation in patients with SLE is confirmed. The results should prompt consideration of the presence of arthritis even in patients without complement consumption. The correlation between age and subclinical arthritis suggests on the one hand that synovial inflammation may develop even in more advanced stages of disease, and on the other hand makes it imperative to exclude the possible bias of the presence of osteoarthritic pathology.

P108 A 6-YEAR PROSPECTIVE STUDY ON WORK PARTICIPATION AND ASSOCIATED FACTORS IN DUTCH PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)

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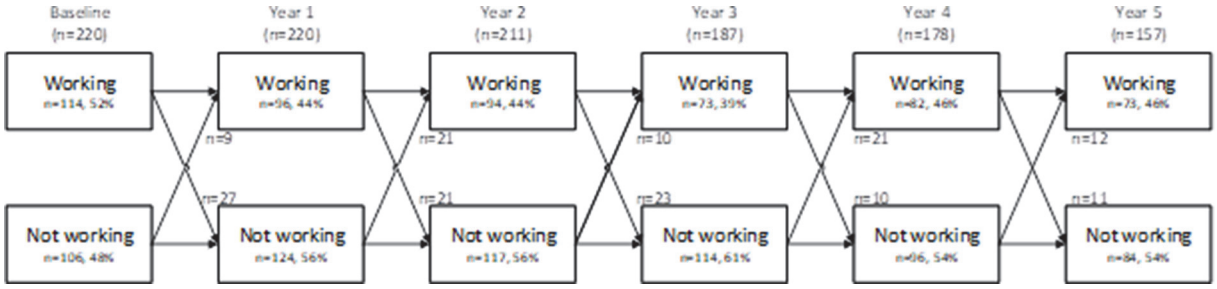
Objective To study transitions in work participation in patients with systemic lupus erythematosus (SLE) over a six year period. In addition, possible associations with having (and maintaining) paid work, and receiving work disability pension were studied, focusing on demographic, disease-related and work characteristics.

Methods Patients are participants of the Amsterdam SLE cohort. For this study, data from all patients with 5 yearly follow-up visits were used for the analyses. Logistic Generalized Estimating Equations were performed to identify associations between demographic, disease-related and work characteristics and having paid work. Logistic regression analyses were performed to study associations with maintaining paid work after 6 years and with work disability.

Results In total, 261 patients were included in the SLE cohort. A total of 220 SLE patients had at least 5 follow-up visits and were included in this study (table 1). Fifty-two percent had paid work at baseline, which decreased to 46% after six



Abstract P108 Figure 1 Transitions in employment status of patients with SLE. Figure showing transitions in employment status during follow-up of the study. At baseline, 114 patients are having paid work and 106 patients are not having paid work. The figure shows the transitions patients are making between having paid work and having no paid work

Abstract P108 Table 1 Baseline demographic, disease related and work characteristics

	Total (n=220)	Employed (n=114)	Unemployed (n=106)
Demographic characteristics			
Female	199 (90.5%)	104 (91.2%)	95 (89.6%)
Caucasian ethnicity	153 (69.5%)	80 (70.2%)	73 (68.9%)
Age (years), mean (SD)	41 (12.5)	36 (8.9)	47 (13.6)
Disease related characteristics			
Disease duration in years	5 [1–11]	4 [1–8]	7 [2–12]
SDI	1 [0–2]	0 [0–1]	1 [0–3]
SLEDAI-2K score[1]	4 [2–6]	4 [2–6]	2 [2–6]
Work characteristics			
Having work in the past[2]			98 (94.2%)
Having work at diagnosis[3]			48 (47.1%)
Reported reason to stop working[4]			
• SLE-related symptoms			58 (62.8%)
• Retirement			4 (4.3%)
• Employment contract not extended			4 (4.3%)
• Other			27 (28.7%)
Having evening and night shifts[5]		24 (21.6%)	
Having irregular working hours[6]		27 (24.1%)	
Job Content Questionnaire			
• Skill discretion[7]		36.6 (6.0)	
• Decision authority[8]		34.2 (8.6)	
• Decision latitude[9]		71.6 (12.6)	
• Psychological job demands[10]		32.6 (5.1)	
• Supervisor support[11]		11.4 (2.5)	
• Coworker support[12]		13.3 (1.8)	
Working during follow-up[13]			
• 1–4 years		52 (45.6%)	15 (88.2%)
• ≥5 years		62 (54.4%)	2 (11.8%)

Legend: Baseline demographic, disease related and work characteristics of the total population (n=220), employed patients (n=114) and unemployed patients (n=106). Data are presented as n (%), mean (SD) or median [interquartile range]
1. Employed: n=114, Unemployed: n=105. 2. Unemployed: n=104. 3. Unemployed: n=102. 4. Unemployed: n=93. 5. Employed: n=111. 6. Employed: n=112. 7. Employed: n=25. 8. Employed: n=26. 9. Employed: n=25. 10. Employed: n=25. 11. Employed: n=22. 12. Employed: n=24. 13. Employed: n=114, Unemployed: n=17.
SDI = Systemic Lupus International Collaborative Clinics/American College of Rheumatology Damage Index; SLEDAI = Systemic Lupus Erythematosus Disease Activity Index 2000

years (figure 1). Of the patients without paid work at baseline, 16% started working during follow-up of whom 29% maintained work. Maintaining work for ≥5 years during follow-up occurred in 29 percent. The majority (63%) of patients without work at baseline reported to have stopped working due to SLE-related symptoms. Having paid work was associated with younger age, higher level of education, shorter disease duration, lower organ damage index and supervisor support at work. Maintaining work for ≥5 years during follow-up was associated with regular working hours, skill discretion, decision authority and decision latitude. Work disability at baseline was associated with a longer disease duration.

Conclusion Having work is associated with various characteristics, but maintaining work is mainly associated with work characteristics. Work disability is only associated with longer disease duration. So, depending on the work situation of the patient as well as future whishes related to work participation, different types of interventions are needed to support work participation of patients with SLE.

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P109 UTILITY OF SKIN BIOPSY IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Objective The objective of this study was to determine the utility of skin biopsy in patients presenting with a rash concerning for systemic lupus erythematosus (SLE) to see if biopsy results are different from clinical diagnoses made by rheumatologists or dermatologists and changed management. The results of this study would help determine whether skin biopsy should be integrated into the workflow of patients undergoing workup for new presentation of SLE or in cases with known SLE but unclear if the rash is related.

Methods Patients with connective tissue diseases seen by rheumatology and dermatology who had a skin biopsy for a rash between 2015–2022 at a single institution were identified. Of these, 48 patients were assigned a clinical diagnosis of SLE and therefore selected for retrospective chart review. Collected data include skin biopsy results and changes in medical treatments.

Results In 27.1% of all cases in this study, biopsy results were discordant from clinical diagnosis; out of these cases, 69.7% of patients' medication regimens were changed following receipt of skin biopsy results. For instance, biopsy results showing psoriasiform findings led to addition of methotrexate or apremilast. Biopsy results were concordant with clinical diagnosis in 72.9% of all cases in this study; out of these