cases, only 34.3% of patients' medication regimens were changed following skin biopsy. These changes involved increasing the number or dosage of immunosuppressive medications such as hydroxychloroquine and dapsone.

Conclusion Most patients presenting with a rash concerning for SLE are diagnosed clinically, and data on skin biopsy is limited. Of patients who underwent skin biopsy, biopsy results often supported the clinical diagnosis, but a different diagnosis was suggested on biopsy in 27% of cases, thus impacting management. Skin biopsy should be integrated in cases of clinical ambiguity.

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P110 IMPACT OF NEUROPSYCHIATRIC INVOLVEMENT ON HEALTH-RELATED QUALITY OF LIFE IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Objective Substantial proportions of systemic lupus erythematosus (SLE) patients report severe fatigue and adverse Health-related Quality of Life (HRQoL). Particularly neuropsychiatric manifestations have been associated with reduced HRQoL. Our objective was to investigate patient-reported outcomes in patients with neuropsychiatric SLE (NPSLE) in comparison to SLE patients without neuropsychiatric involvement.

Methods We analysed baseline data from four phase III trials (BLISS-52, BLISS-76, BLISS-SC, EMBRACE; N=2968). The NPSLE group comprised individuals with NP BILAG scores A/B/C/D (N=350). The active NPSLE group was defined as individuals with NP BILAG scores A/B or active neuropsychiatric involvement based on NP SLEDAI-2K domains (n=71). The non-NPSLE group consisted of patients with NP BILAG score E (N=2621). HRQoL was assessed utilising the generic instruments Medical Outcomes Study Questionnaire Short Form 36 (SF-36) health survey, the three-level version of EQ-5D (EQ-5D-3L), and the Functional Assessment of Chronic Illness Therapy (FACIT) Fatigue (FACIT-F) scale. Full health state (FHS) was defined as an experience of 'no problems' in all five EQ-5D dimensions. Impaired HRQoL by EQ-5D was defined as level 2 or 3 responses in the different dimension.

Results We observed clinically momentous reduced HRQoL in SLE patients with neuropsychiatric manifestations. NPSLE patients had significantly lower scores of SF-36 physical component summary (PCS) and mental component summary (MCS) compared to the non-NPSLE population [mean (s.d.): 35.7 (9.1) vs. 39.6 (9.6); $p<0.001$ and 37.3 (12.1) vs. 41.4 (11.0); $p<0.001$, respectively]. NPSLE patients also exhibited impaired HRQoL in all five EQ-5D dimensions compared to non-NPSLE patients ($p<0.05$ for all). A substantially lower proportion among NPSLE patients experienced FHS in comparison to the non-NPSLE group (3.3% vs. 14.5%; $p<0.001$). Neuropsychiatric involvement in SLE was associated with more severe fatigue as measured by FACIT-F [23.8 (12.2) vs. 31.5 (11.6); $p<0.001$]. Similar associations were detected between active NPSLE patients and the non-NPSLE group with regards to SF-36 PCS/MSC domains, FHS, and FACIT-F scores. However, our findings revealed no discernible distinctions between NPSLE and active NPSLE patients, indicating that impaired HRQoL in patients with NPSLE persists regardless of the disease activity state in the neuropsychiatric domain.

Conclusions Neuropsychiatric involvement in patients with SLE has a detrimental effect on HRQoL experience and is associated with more severe fatigue. Impaired HRQoL scores remain steady in NPSLE patients regardless of the degree of neuropsychiatric activity. Early intervention strategies are warranted in this specific group of SLE patients to enhance long-term patient-reported outcomes.

P111 ASSESSLE, A NEW DISEASE ACTIVITY SCORE FOR THE ASSESSMENT OF SYSTEMIC LUPUS ERYTHEMATOSUS

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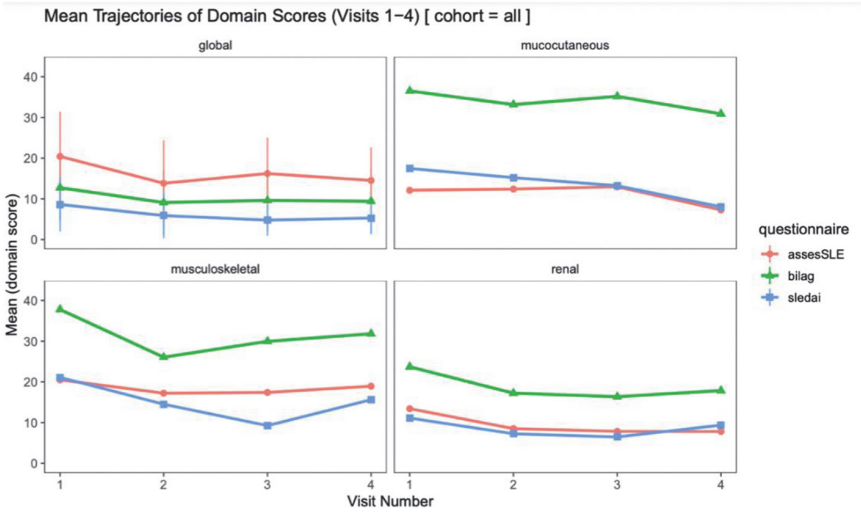
Objective The heterogeneous manifestations and clinical course of systemic lupus erythematosus (SLE) challenge disease activity assessment in everyday clinical practice. Multiple clinical disease monitoring instruments have been developed however, they are limited in the ability to detect changes in disease activity or too cumbersome to be utilized in daily practice. In a previous paper case pilot study, we compared the newly constructed ASSESSLE score, with the BILAG and SLEDAI scores and reported good reliability and construct validity. We aimed to apply the ASSESSLE disease activity score in clinical practice and evaluate its validity, and its ability to capture change in disease activity between visits, compared to the BILAG and SLEDAI scores.

Methods The new instrument for assessing SLE activity is comprised of 7 visual analog scales (VAS), which separately address the physician's global assessment and 6 organ systems including mucocutaneous, musculoskeletal, cardiorespiratory, renal, neuropsychiatric systems, and others. Changes in blood count, serology, and medications are recorded and incorporated into the final score. The study was performed in 2 tertiary medical centers in Israel and included consecutive patients with SLE attending the SLE clinics. Repeated follow-up visits were scored, aiming to assess the score's ability to detect changes in disease activity between visits.

Results Forty-five SLE patients were scored, 32 of whom had repeated visits (a total of 127 visits). When comparing the 3 scoring tools, the mean trajectories of the first 4 visits (121 of 127 visits) followed a similar trajectory for all 3 scores when looking at global disease activity, as well as activity in the domains most frequently active (mucocutaneous, musculoskeletal and renal domains) (figure 1). The ASSESSLE score correlated well with the BILAG score and with the SLEDAI score (Spearman correlation - 0.71 and 0.69 respectively).



Abstract P111 figure 1 Mean trajectories of the 3 scores of the first 4 visits

Conclusions The ASSESSLE score shows a good correlation with both the BILAG and the SLEDAI scores and a similar ability to capture change in disease activity over time. The ASSESSLE tool shares the simplicity and ease of interpretation of the SLEDAI and correlates well with the BILAG, allowing its use in everyday practice.

P112 ASSOCIATION OF LUPUS LOW DISEASE ACTIVITY WITH HEALTH-RELATED QUALITY OF LIFE

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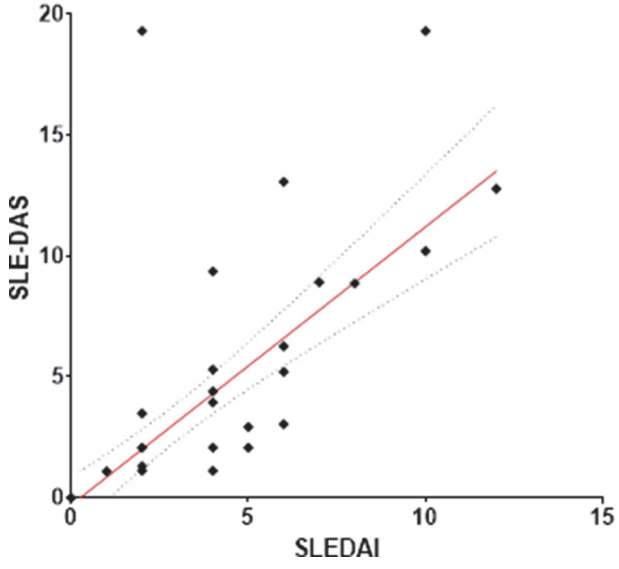
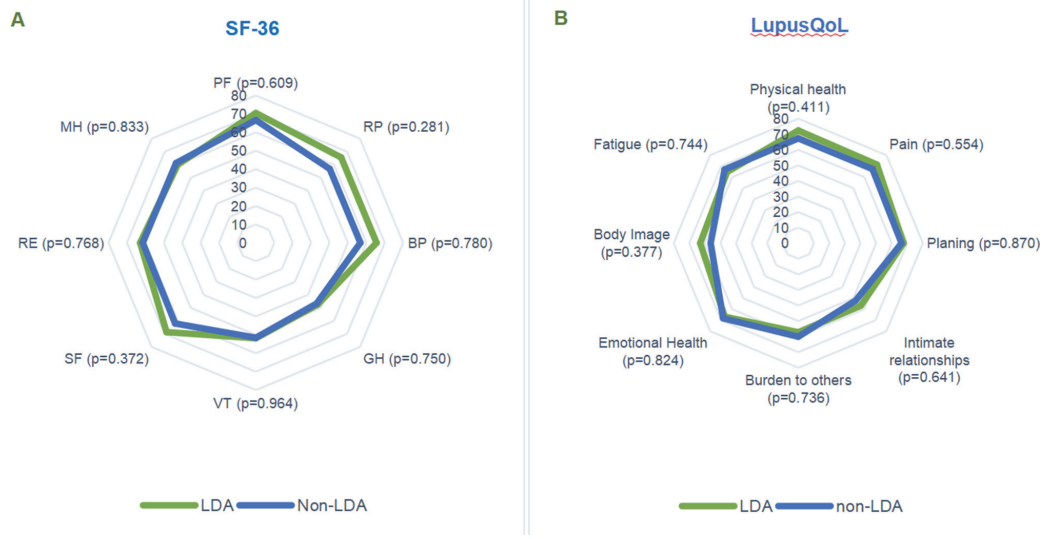
Objective Accurate disease assessment remains challenging in complex and heterogeneous diseases such as systemic lupus erythematosus (SLE). Systemic Lupus Erythematosus Disease Activity Score (SLE-DAS) is a recently developed disease activity score for SLE patients, followed by a successful definition



Abstract P112 Figure 1 Correlation between SLEDAI-2K and SLE-DAS



Abstract P112 Figure 2 Association of SF-36 and LupusQoL domains with LDA