depression and anxiety (HADS), health-related QoL (SF36) and sexual function (Female Sexual Function Index [FSFI] - a 19-item patient-report outcome that assesses female sexual function) were collected. Data on clinical features (disease activity according to the SELENA-SLEDAI, organ involvement and evaluation of comorbidity [Charlson Comorbidity Index]) and on treatment status were collected from medical records. The main outcome was sexual dysfunction, defined as FSFI<26.5 (validated cut-off). A multivariable logistic regression was performed to test the association of clinical and demographic characteristics with sexual dysfunction (present vs absent).

Results In total, 194 female patients with SLE were included (mean age 44 years-old [SD 11]). The mean SELENA-SLEDAI score was 1.7 (SD 2.2), corresponding to low disease activity, and 94% of patients were on cDMARD's. The mean value of HADS was 9 (0–21), for both depression and anxiety scores. Regarding SF36, the mental component had a mean value of 61 (0–100) and the physical one of 70 (0–100). Sexual dysfunction was present in 128 (66%) patients.

In the multivariable analysis (table 1), older age (OR: 1.04; 95%CI: 1.01; 1.07), higher SELENA-SLEDAI (OR: 1.18; 95% CI: 1.01; 1.40), higher HADS depression score (OR: 1.20; 95%CI: 1.01; 1.43), as well as a lower (that is, worse) SF36 mental component score (OR: 0.97; 95%CI: 0.95; 0.98) were independently associated with sexual dysfunction.

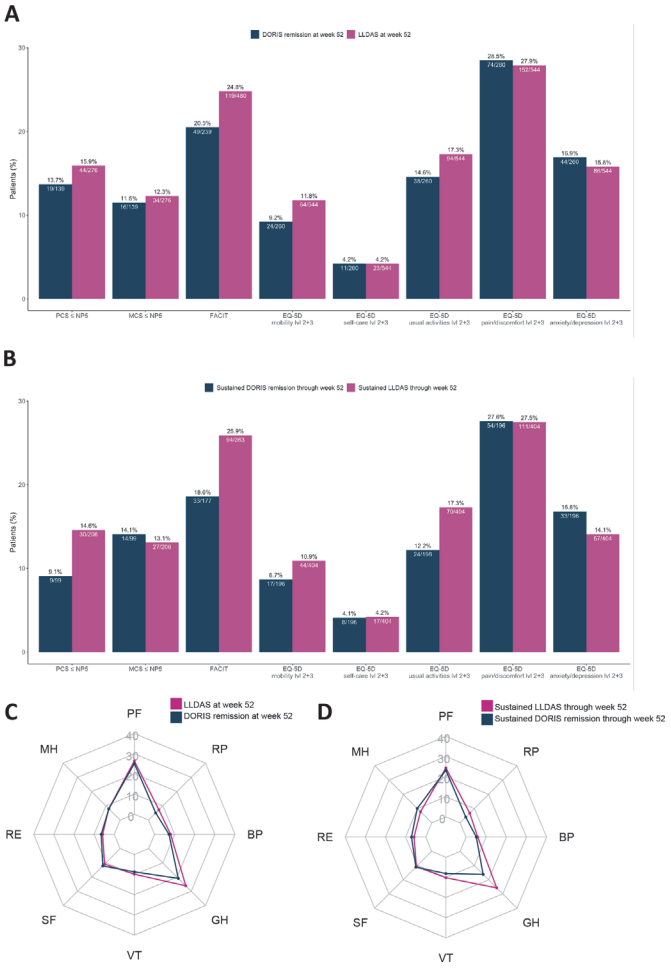
Conclusion Sexual dysfunction is common in women with SLE and is influenced by both physical and mental health components. Clinicians should consider both for the optimal management of their patients in order to improve their sexual QoL.

042 PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS EXPERIENCE POOR HEALTH-RELATED QUALITY OF LIFE DESPITE A LOW DISEASE ACTIVITY STATE OR REMISSION

[1,2]Ioannis Parodis, [1]Julius Lindblom, [1]Nursen Cetrez, [1]Leonardo Palazzo, [1]Henri Ala, [3]Mandana Nikpour*, [1]Adrian Levitsky*, [4]Vibeke Strand*. *Authors contributed equally; [1]Division of Rheumatology, Dept. of Medicine Solna, Karolinska Institutet and Karolinska University Hospital, Stockholm, Sweden; [2]Dept. of Rheumatology, Faculty of Medicine and Health, Örebro University, Örebro, Sweden; [3]University of Sydney School of Public Health, Sydney, New South Wales, Australia; [4]Division of Immunology/Rheumatology, Stanford University School of Medicine, Palo Alto CA, USA

10.1136/lupus-2024-el.51

Objective Patients with systemic lupus erythematosus (SLE) experience poor health-related quality of life (HRQoL), despite attaining responses by the SLE Responder Index (SRI)-4.[1] We



Abstract O42 Figure 1 Poor HRQoL despite (sustained) LLDAS or DORIS remission. Bars (A–B) and radar charts (C–D) depicting proportions of patients who reported poor HRQoL among patients who attained LLDAS (in dark pink), DORIS remission (in dark blue), sustained LLDAS (in dark pink), and sustained DORIS remission (in dark blue).

aimed to determine the prevalence of poor HRQoL in SLE patients who had attained low disease activity (LDA) or remission and sustained LDA or remission after a 52-week therapeutic intervention in a clinical trial setting.

Methods A post-hoc analysis was conducted using data from four trials: BLISS-52, BLISS-76, BLISS-SC, and EMBRACE. We defined LDA according to the Lupus LDA State (LLDAS) criteria, i.e., SLEDAI-2K ≤4 excluding major organ activity or fever or new activity since the previous assessment, Physician Global Assessment (PGA) ≤1 (scale 0–3), and prednisone ≤7.5 mg/day. We defined remission according to the Definitions of Remission in SLE (DORIS) criteria i.e., clinical (c)SLEDAI-2K=0, PGA <0.5, and prednisone ≤5 mg/day. Sustained LLDAS/remission were defined as persistent LLDAS/remission for at least two visits, four weeks apart, maintained through week 52. Poor HRQoL was defined as Short Form-36 (SF-36) physical/mental component summary (PCS/MCS) and domain scores ≤ the normative fifth percentile, i.e., the worst 5% of scores reported from US population-based age- and sex-matched individuals, Functional Assessment of Chronic Illness Therapy – Fatigue (FACIT-F) scores <30, and responses of 'some/moderate problems' or 'extreme/major problems' in each one of the five EQ-5D dimensions of the three-level version of EQ-5D (EQ-5D-3L).

Results Of 480, 239, 363, and 177 patients who attained LLDAS, DORIS remission, sustained LLDAS, and sustained DORIS remission at week 52, respectively, 16%, 14%, 15%, and 9% reported poor SF-36 PCS and 12%, 12%, 13%, and 14% reported poor MCS scores, respectively. The greatest percentages were reported in the physical functioning domain (23–26%), followed by the general health domain (16–26%), while 19–26% reported FACIT-F scores ≤30. Lastly, pain/discomfort was the EQ-5D dimension that yielded the greatest frequencies of poor experience (28–29%) (figure 1).

Conclusion Despite attainment of LLDAS or remission, substantial proportions of SLE patients experience poor HRQoL, indicating that current LDA and remission definitions fail to capture important aspects of patients' well-being.

REFERENCE

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Conflicts of Interest IP has received research funding and/or honoraria from Amgen, AstraZeneca, Aurinia, Bristol Myers Squibb (BMS), Elli Lilly, Gilead, GlaxoSmithKline (GSK), Janssen, Novartis, Otsuka, and Roche. MN has received research grant support from Janssen and Boehringer Ingelheim; received honoraria from Janssen, GSK, AstraZeneca, Pfizer, and Boehringer Ingelheim. AL reports employment with BMS outside the submitted work. VS has received consulting fees from AbbVie, Alpine, Alumis, Amgen, Aria, AstraZeneca, Bayer, BMS, Boehringer Ingelheim, Celltrion, Ermium, Genentech/Roche, GSK, Horizon, Inmedix, Janssen, Kiniksa, Lilly, Merck, MiMedx, Novartis, Omeros, Pfizer, RAPT, Regeneron, R-Pharm, Samsung, Sandoz, Sanofi, Scipher, Setpoint, Sorrento, Spherix, Tonix, and Urica. The other authors declare that they have no conflicts of interest related to this work. The funders had no role in the design of the study, the analyses or interpretation of data, or the writing of the manuscript.

043 THREE YEARS IS THE MINIMAL EFFECTIVE DURATION OF SUSTAINED CLINICAL REMISSION ASSOCIATED WITH REDUCED RISK OF IMPAIRED KIDNEY FUNCTION AND OF DAMAGE ACCRUAL IN LUPUS NEPHRITIS

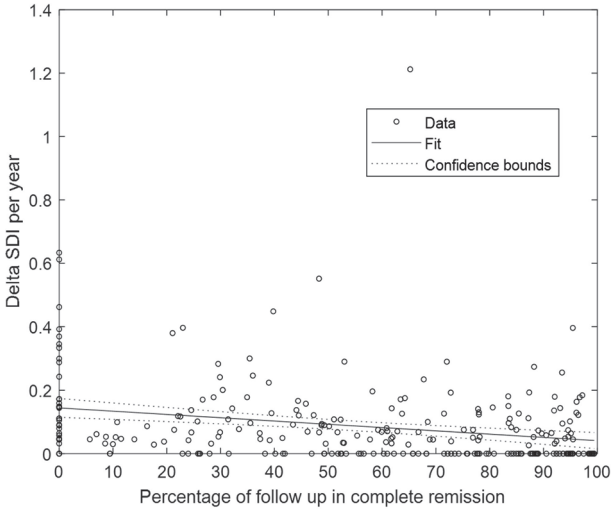
[1,2]Mariele Gatto, [3]Giulia Frontini, [4,5]Marta Calatroni, [2]Claudio Cruciani, [2]Luca Iaccarino, [4,5]Francesco Reggiani, [4]Renato Alberto Sinico, [4,5]Gabriella Moroni, [2]Andrea Doria. *[1]Academic Rheumatology Centre, Dept. of Clinical and Biological Sciences, University of Turin, AO Mauriziano, Turin, Italy; [2]Unit of Rheumatology, Dept. of Medicine, University of Padova, Padova, Italy; [3]Nephrology and Dialysis Unit, San Paolo Hospital, Milan, Italy; [4]Nephrology and Dialysis Division IRCCS Humanitas Research Hospital, Rozzano, Milan, Italy; [5]Dept. of Biomedical Sciences Humanitas University, Milan, Italy*

10.1136/lupus-2024-el.52

Objectives To assess the minimum effective duration of clinical remission capable of protecting against damage accrual and development of impaired kidney function (IKF) in lupus nephritis (LN)

Methods Patients with biopsy-proven LN and at least 5 years follow-up were enrolled in this study. Sustained Clinical remission (sCR) (henceforth: remission) was defined as eGFR>60 ml/min/1.73m2, proteinuria <0.5g/24h and clinical SLE-disease activity index (cSLEDAI)=0 lasting for at least one year. The duration of remission to prevent IKF (eGFR <60 ml/min per 1.73 m^2 (32) for at least 3 months) was estimated through Kaplan-Meier curves and compared by log-rank. Spearman correlation analysis was performed to assess the potential correlation between the yearly increase in SLICC damage index (SD) and the percentage of follow-up spent in remission.

Results 303 LN patients were included (median follow-up: 14.8 (9.8–22) years) of whom 84.8% achieved sCR lasting 8.6±6.9 years. At the last observation, the increase in SDI from baseline was significantly higher in patients who never achieved vs. those who achieved remission (median: 2 (1–3) vs. 1 (0–1), p=0.003). Consistently, the higher the percentage



Abstract O43 Figure 1 Spearman correlation between yearly SDI values and the percent of follow-up in clinical remission for each patient