

CS-08 EFFECT OF ANTIMALARIALS OVER THE DIFFERENT DOMAINS OF THE DAMAGE INDEX IN LATIN AMERICAN SLE PATIENTS

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Background We have previously shown that Latin American SLE patients treated with Antimalarials (AMs) have a 25% lower risk of damage accrual than patients not receiving them. The present study was conducted to assess the effects of AMs over the 12 items of the SLICC Damage Index, (SDI).

Methods Patients with a recent SLE diagnosis (≤ 2 years) from the GLADEL cohort were studied. End-point: Increase in the 12 items SDI since cohort entry. Independent (socio-

demographic, clinical laboratory and treatment) variables were included. The effect of AMs as a time dependent variable on items of the SDI (adjusting for potential confounders) was examined with a multivariable Cox regression model. Multivariate models were developed for the most common SDI items.

Results Of the 1466 patients included in this analysis 1049 (72%) received AMs during follow-up (as defined); median exposure time: 30 months (Q1-Q3: 11–57 months). Total damage accrual occurred in 665 (45%) patients during a median follow up time of 24 months (Q1-Q3: 8–55) months. Within the 12 items of the SDI there were 301 integument, 208 renal, 149 neuropsychiatric, 98 musculoskeletal, 88 cardiovascular, 65 ocular, 43 pulmonary, 42 peripheral vascular, 33 gastrointestinal, 22 premature gonadal failure, 16 diabetes and 9 malignancy. After adjusting for potential confounders, at any time during follow-up a patient on AMs had a 35% and 30% lower risk of renal and neuropsychiatric damage accrual respectively than a patient not on AMs (adjusted HR 0.65, 95% CI 0.47 to 0.90 and HR 0.70, 95% CI 0.48 to 1.02). Such protective effect was not evident for integument, musculoskeletal and cardiovascular damage. Table 1.

Conclusions After adjustment for possible confounding factors related to AMs use and damage accrual, AMs were independently associated with a reduced risk of renal and neuropsychiatric damage accrual in this cohort.

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CS-09 CONTRACEPTIVE DOCUMENTATION IN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS AT A SAFETY NET HOSPITAL

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Background Systemic Lupus Erythematosus (SLE) predominantly affects reproductive aged women. Contraceptive counseling is an important quality indicator in SLE patient care. Here we evaluate current practice in the documentation of contraceptive use amongst reproductive aged women with SLE cared for at a large safety net hospital.

Abstract CS-08 Table 1 Multivariable Cox proportional hazard model: time-to-items damage accrual

Endpoint	Unadjusted		Adjusted	
	HR ¹ (95% CI)	p-value	HR ¹ (95% CI)	p-value
Integument Damage	0.987 (0.763–1.277)	0.9223	0.971 (0.734–1.286) ²	0.8381
Renal Damage	0.516 (0.385–0.692)	<0.0001	0.652 (0.472–0.901) ³	0.0094
Neuropsychiatric Damage	0.651 (0.458–0.925)	0.0167	0.701 (0.481–1.024) ⁴	0.0660
Musculoskeletal Damage	0.838 (0.524–1.340)	0.4612	0.909 (0.561–1.473) ⁵	0.6977
Cardiovascular Damage	0.562 (0.357–0.886)	0.0130	0.690 (0.430–1.107) ⁶	0.1240

¹Hazard ratio for any antimalarial vs no antimalarial in the previous month.

²Adjusted for integument domain SDI at entry, hypertension, malar rash, discoid rash, proteinuria/cilindruria, hematologic disorder, glucocorticoid pulse and SLEDAI at cohort entry.

³Adjusted for renal domain SDI at entry, age at diagnosis, socio-economic level, hypertension, proteinuria/cilindruria, immunosuppressants and SLEDAI at cohort entry.

⁴Adjusted for neurologic domain SDI at entry, glucocorticoid pulse, NSAIDs and SLEDAI at cohort entry.

⁵Adjusted for musculoskeletal domain SDI at entry, gender, hypertension, discoid rash, oral/nasopharyngeal ulcerations, arthritis, neurologic disorder, glucocorticoids at cohort entry.

⁶Adjusted for cardiovascular domain SDI at entry, disease duration, hypertension and serositis at cohort entry.

Methods Using ICD 10 codes for SLE (M32, M320, M321, M328, M329), we identified reproductive aged (ages 16–50) female SLE patients, who presented to the outpatient rheumatology clinic at Parkland Hospital between 07/01/17 and 10/31/17. We performed a retrospective chart review of the documentation of contraception use. We also assessed medication use including potential teratogenic medications.

Results Among 112 clinic encounters, contraceptive use was documented in 60% of encounters. Amongst those women prescribed a potentially teratogenic medication, documentation of contraception was present in 68% of clinic notes. In our patient population, the most commonly prescribed potentially teratogenic medication was mycophenolate mofetil followed by methotrexate. The average age of women who were on potentially teratogenic medicine and had documented contraception was younger (mean 31, SD 7.2) than those in whom contraception was not documented (mean 38, SD 8.6). Greater than 50% of those patients on potentially teratogenic medicine used less reliable contraceptive methods: abstinence or condoms. Providers rarely documented other information in regard to reproductive health such as pregnancy planning and the desire to have children.

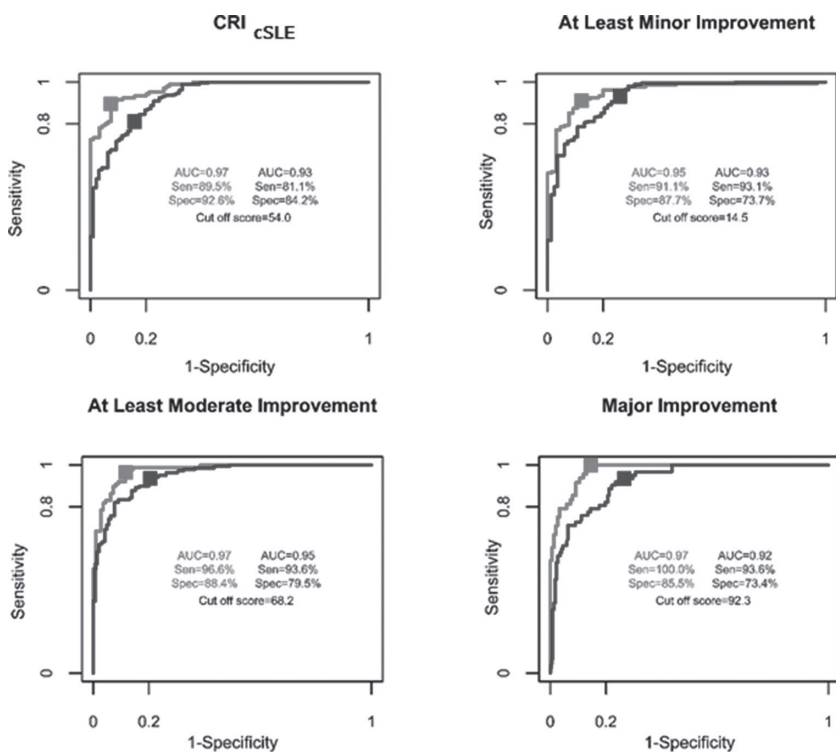
Conclusions Contraceptive use documentation amongst reproductive aged women with SLE in a safety net hospital is often lacking even amongst those on potentially teratogenic medication. Documentation of contraception is more common in younger women. Identifying barriers to contraceptive use documentation and implementing interventions to facilitate documentation is a future goal.

CS-10 CRITERIA FOR CLINICALLY RELEVANT IMPROVEMENT IN CHILDREN & ADOLESCENTS WITH CHILDHOOD-ONSET SYSTEMIC LUPUS ERYTHEMATOSUS

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Background There is international consensus around a core set of variables (cSLE-CRVs) to assess response to therapy with childhood-onset systemic lupus erythematosus (cSLE) [global assessment of patient well-being (Patient-global), physician



Abstract CS-10 Figure 1 CHILI scores were calculated from logit scores using multivariate logistic models considering either absolute differences between the baseline and follow-up time point at the time of follow-up relative of the baseline visit in the trainings-dataset. The range of the improvement score has been standardized to range from 0–100, the higher (lower) score indicates higher (lower) likelihood of improvement. The CHILI score =100 × raw score/(1+raw score). The raw score is calculated as follows: raw score =Exp (5.1+0.47xSLEDAI +0.7xMD-global +1.1xPC-ratio–0.32xpatient-global +0.002xCHQ-Phs)