Abstract CS-30 Table 1 Significant independent predictors of sleep disturbances

	Obstructive Sleep Apnea (OSA)* diagnosis	Restless Leg Syndrome (RLS)* symptoms	Sleep Problems Index I (SPI-I)†
Age, years	1.04 (1.01, 1.07)	(ns)	−0.2 (0.01)
White race	(ns)	(ns)	−6.4 (0.02)
Low education (<high school)	(ns)	(ns)	6.4 (0.004)
Smoking, ever	(ns)	(ns)	4.6 (0.03)
Obesity	4.6 (2.4, 8.8)	(ns)	(ns)
Asthma	2.5 (1.1, 5.7)	(ns)	(ns)
RDCI (0–9)	1.3 (1.1, 1.5)	1.3 (1.1, 1.5)	1.3 (0.02)
Pain rating (0–10)	(ns)	(ns)	1.5 (0.002)
Disease activity (SLAQ)	1.07 (1.01, 1.13)	1.1 (1.03, 1.13)	0.9 (<0.0001)

* Tabled values are odds ratio (95% CI) from multiple logistic regression analyses
† Tabled values are beta (p-value) from multiple linear regression analysis. Higher scores reflect greater sleep problems
All regression models include age, race, education, ever smoking, obesity (BMI ≥30), concurrent asthma, Rheumatic Disease Comorbidity Index (RDCI), prednisone dose, pain rating, disease damage (BILD), and disease activity (SLAQ)

Research in SLE has linked SDs to worse outcomes. Previous research in other conditions suggests that SDs might also be a cause of increased disease activity through heighted inflammation. Further research is needed to tease out disease-specific causes and effects of SD in SLE.

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CS-31 SAFETY OF HYDROXYCHLOROQUINE WITHDRAWAL IN OLDER ADULTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Background Although hydroxychloroquine (HCQ) is a mainstay of treatment for patients with Systemic Lupus Erythematosus (SLE), ocular toxicity can result from accumulated exposure. The introduction of highly sensitive tools has engendered even more concern. As the longevity of patients with SLE improves, additional data will help physicians accurately balance the risk of ocular toxicity and the risk of disease flare, especially in older patients who have stable/quiescent disease. Accordingly, this study was initiated to examine the safety of HCQ withdrawal in older SLE patients.

Methods Data were obtained by retrospective chart review at three lupus centers. Twenty-seven patients met the following inclusion criteria: ≥4 ACR criteria, disease duration ≥5 years, HCQ use of 200–400 mg per day ≥5 years, and discontinuation of hydroxychloroquine at ≥age 55 years. The comparator group comprised 39 age, gender and racial/ethnic matched patients who remained on HCQ. The primary outcome was a clinically meaningful flare within one year of HCQ withdrawal, defined as moderate or severe, using a revised version of the SELENA-SLEDAI Flare composite that separates mild from moderate flares, evaluates each organ system separately, and incorporates increases in corticosteroid dose and/or addition of immunosuppressive agents. Mild flares were considered secondary outcomes.

Results Demographics are provided in table 1. There was a trend toward longer disease duration in the HCQ withdrawal group but no difference in prevalence of prior lupus nephritis between the groups. The reasons for HCQ withdrawal were maculopathy (n=13), presumed/biopsy proven cardiomyopathy (n=2), patient request (n=4), and miscellaneous other reasons (n=8). There was no difference in the primary or secondary outcomes between the groups (table 1). Two patients had a moderate flare after discontinuing HCQ, of whom one had arthritis treated with methotrexate and one had thrombocytopenia (>30K) and proteinuria of 2 grams/d (baseline 700 mg). Three patients had severe flares while continuing HCQ, of whom two were hospitalized, one for seizures and one for pericarditis; the third had worsening nephritis (urinary protein >4 g/d, requiring treatment). Two patients had moderate flares while remaining on HCQ, one of whom had a rash and arthritis treated with tofacitinib and one a rash treated with prednisone.

Conclusions In this retrospective study of older patients with SLE on long-term HCQ, withdrawal did not increase the risk of moderate or severe flares. These data provide reassurance regarding the safety of withdrawing HCQ in stable older SLE patients.

Abstract CS-31 Table 1

	HCQ Withdrawal (n=27)	HCQ Continuation (n=39)	P value
Age	59.9	60.6	0.52
Gender (% Female)	92.6%	97.4%	0.56
Race/Ethnicity			0.78
White	33.3%	35.9%	
Black	29.6%	25.6%	
Hispanic	18.5%	20.5%	
Asian	18.5%	17.9%	
Duration of SLE (years) (n=61)	26.7	21.1	0.088
Duration of HCQ Use (years) (n=52)	19.3	17.6	
Prior Renal Disease (N,%)	12 (44.4%)	13 (33.3%)	0.44
Moderate/Severe Flares (N,%)	2 (7.4%)	5 (12.8)	0.69
Moderate Flare	2 (7.4%)	2 (5.1%)	
Severe Flare	0 (0%)	3 (7.7%)	
Mild Flare	5 (18.5%)	3 (7.7%)	0.26
All Flares	7 (25.9%)	8 (20.5%)	0.77

CS-32 SLE-YPLL (YEARS OF POTENTIAL LIFE LOST) AS A MEASURE OF RELATIVE BURDEN OF PREMATURE MORTALITY

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Background Disease burden is the impact of a health problem on a given area, which can be used to prioritize actions in health, assess performance of healthcare and disease management, identify high-risk populations, and set research