function, 44% of the subjects had some degree of dysfunction. The rest of the variables are shown in table 1.

Conclusions Sexual function is affected in men with lupus (mostly young and with adequate functional capacity), regardless of comorbidities and treatment. Interestingly, lymphopenia is persistently associated with an impaired sexual function, which could be related to the role it plays in endothelial dysfunction and atherosclerosis. The patients disease perception, which is influenced by their academic level and physical role in their daily activities, seems to affect their sexual performance and quality of life. These findings reinforce the need of a multidisciplinary approach for male SLE patients with sexual dysfunction.

Funding Source(s): None

153 INCIDENCE AND RISK FACTORS FOR PROGRESSION OF CORONARY-ARTERY CALCIFICATION IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)

[1]Mario Cesar Ocampo-Torres, [1]Gabriela Hernandez-Molina, [2]Sergio Criales, [1]Juanita Romero-Diaz*. *[1]Instituto Nacional de Ciencias Médicas y Nutrición S.Z; [2]Instituto Nacional de Cardiologia Ignacio Chavez*

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Background Premature atherosclerosis has been recognized as a major cause of morbidity and mortality in SLE patients. Whether the effect of risk factors for cardiovascular disease in patients with lupus change over time is still unknown. We aimed to identify the incidence and risk factors for progression of coronary-artery calcification (CAC) in SLE patients.

Methods Design: Inception Cohort. Since enrollment into the cohort, all patients had a standardized medical history, physical examination, and laboratory tests, including lipid profile, apoB, homocystein, high-sensitivity C-reactive protein (hs-CRP), serum complement (C3 and C4), and autoantibodies. Every 3–6 months, patients have been seen at the lupus clinic for medical care, and assessments of disease activity using the SLE disease activity scores, and medications usage. Every year, information has been updated, including irreversible damage accrual, any co-morbidities, traditional cardiovascular risk-factors, and a blood sample has been drawn. In 2008, 104 lupus patients from the cohort (93% females) was screened for coronary-artery calcifications using Multidetector Computed Tomography, after 5.1 years of follow-up. In 2018 a follow-up screening for CAC was carried-up. CAC was considered as positive if i) patients without CAC in 2008 were found with CAC +in the second screening or ii) patients with CAC positive in 2008 were found with any increase of their Calcium Score. Correlates for calcifications were analyzed. Cumulative incidence of CAC was calculated and risk factors for CAC progression were identified by multivariate analysis.

Results At-enrollment into de cohort, lupus patients were 27.2 +9.1 years of age and disease duration 5.4+3.8 months. On 2008 during the first screening, coronary-artery calcification were detected in 7.2% patients, since age 23 years, and from three years of diagnosis. At follow-up screening, progression of CAC was identified in 16.3% (IC95% 10.4–24.6). Cumulative incidence of CAC was observed in 9%. Earlier Risk factors associated with CAC were disease activity (p=0.03) and disease duration (p=0.03) while risk factors for progression of CAC were postmenopausal status (p=0.01), apoB levels (p=0.01).

Conclusions Our findings suggest that in patients with SLE earlier CAC is associated with disease severity while in the progression of CAC, traditional risk factors for atherosclerosis were adding.

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154 IMPACT OF DIAGNOSIS AGE ON QUALITY OF LIFE AMONG PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

[1]Christina L Kearse*, [2]Robert Campbell, [3]Jim Oates, [3]Gary S Gilkeson, [3]Diane L Kamen. *[1]College of Medicine, Medical University of South Carolina; [2]Center for Health Analytics and Discovery, Eastern Virginia Medical School; [3]Division of Rheumatology and Immunology, Medical University of South Carolina*

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Abstract 154 Table 1 Health related quality of life scores for the physical health and mental health domains of the SF-36 v2 questionnaire in patients with aSLE and cSLE

Domain	aSLE (n=323) Mean ± SD	cSLE (n=9) Mean ± SD	P Value
Physical Health			
Physical Functioning	38.8 ± 12.4	52.1 ± 6.1	0.002*
Role Physical	38.5 ±12.5	50.1 ± 7.1	0.007*
Bodily Pain	41.8 ± 11.3	48.0 ± 11.3	0.103
General Health	37.7 ± 11.3	41.7 ± 7.9	0.289
Mental Health			
Vitality	43.1 ± 11.6	50.4 ± 8.6	0.064
Social Functioning	40.7 ± 12.7	46.5 ± 8.3	0.172
Role Emotional	41.0 ± 14.9	48.5 ± 8.1	0.133
Mental Health	45.3 ± 13.5	48.8 ± 12.5	0.442

Background While systemic lupus erythematosus (SLE) disproportionately affects minority women of child-bearing age, 1520% of all patients with SLE are diagnosed as children. Studies have shown that patients with SLE perceive their quality of life as poorer than the general public due to the impact of the disease on aspects of their physical, social, and psychological function. This study compares the health-related quality of life (HRQOL) in childhood-onset SLE (cSLE), defined as diagnosed prior to age 18, to HRQOL in adult-onset SLE (aSLE).

Methods Data was collected as part of an ongoing longitudinal SLE registry at MUSC, including demographics, clinical disease manifestations and patient-reported responses to the Short Form-36 (SF-36) v2 questionnaire. For this study, the initial SF-36 v2 questionnaire completed at time of registry enrollment after age 18 was utilized, excluding patients with less than 4 ACR Classification Criteria for SLE and patients missing SF-36 v2 data. Scores were analyzed across four physical health and four mental health domains. SF-36 v2 mean scores were compared between cSLE patients and aSLE patients.

Results The mean normalized scores for all four SF-36 v2 physical health domains were higher for cSLE patients compared to aSLE patients as seen in table 1. There was statistical significance found in two domains of physical health: physical functioning (52.1±6.1 cSLE vs 38.8±12.4 aSLE, p=0.002) and role physical (50.1±7.1 cSLE vs 38.5±12.5 aSLE, p=0.007). The mean normalized scores for all four SF-36 v2 mental health domains were also higher for cSLE patients compared to aSLE patients, but no statistical significance was found.

Conclusions Despite the association among patients with SLE between childhood-onset and a more severe disease course, our findings showed an overall higher health related quality of life within the cohort. These findings suggest that having been diagnosed at an earlier age and having lived most of their life with a systemic autoimmune disease may contribute to the higher quality of life reported by patients with cSLE.

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155 CHARACTERIZATION OF A SINGLE CENTER SYSTEMIC LUPUS ERYTHEMATOSUS COHORT ACCORDING TO COMPLEMENT LEVELS

[1]Sheyla Leal Castro*, [2]Luis O Roa Perez, [3]Yesid J Portilla, [2]Adriana Seewald, [3]Jaime A Betancourt, [4]Sandy Sapag Duran, [5]Diana Dubinsky. *[1]University of Buenes Aires; [2]Hospital de Clínicas Jose de San Martín; [3]University of Buenos Aires; [4]Hospital de Clínicas Jose de San Martpin; [5]Sanatorio Guemes*

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Background Systemic Lupus Erythematosus (SLE) is an autoimmune disease in which inflammation is mediated by complement activation by immune complex deposit, leading to damage. Consumption of C3 and C4 complement fragments is accepted as a disease activity marker.

Abstract 155 Table 1

	(G1) Normal C3 and C4	(G2) Low levels C3 and C4	(G3) Low levels C4	(G4) Variable levels C3 and/or C4	Total n 149	P (value)
Age at diagnosis /SD)	32,1 (13,9)	29,5 (10,9)	28,5 (15,4)	29,5 (13,6)	30,6 (13,3)	0004
Disease duration (mean yrs)	10,5	7,8	13,07	8,7	9,7	0002
Female (%)	98,5%	94,1%	92,9	90,9	95,3	0001
SLEDAI (mean/SD)	5,1 (4,5)	9.2 (4 ,75)	8,07 (4)	7,9 (5,4)	6,9 (5.0)	0001
SLICC (average)	1,01	0,5	1,3	0,6	0.8	0031
Leukopenia (%)	27,9	29,4	21,4	27,3	27,5	0.876
Lymphopenia (%)	27,9	32,9	21,4	30.3	28,9	0769
Hemolytic anemia (%)	17,6	5,9	28,6	6,1	13,4	0196
Hypergamma (%)	30,9	30,3	50	44.1	35,6	0.211
LN (%)	36,8	45,5	78,6	35,3	42.3	0,0002
Overlap (%)	11,8	15,2	14,3	11,8	12,8	0,55
DNAds (%)	26,3	39,4	50	26,5	42,3	0011
Sm (%)	14,5	30,3	14,3	38,2	35,4	0,0001
RNP (%)	22,1	33,3	7,1	44,1	42,4	0003
Ro (%)	35,3	48,5	35,7	50	55,9	0,32
La (%)	16,2	15,2	14,3	29,4	29,2	0,16
aPL (%)	12,5	30,4	25	26,3	20,4	0,1415