Abstract 61 Table 1 SLICC Damage index (SDI) by race/ethnicity

	Total (n=323)		Asian (n=125)		Non-Hispanic Black (n=34)		Hispanic (n=69)		Non-Hispanic White (n=95)		p-value
SDI, mean (sd)	1.8 (0.4)		1.8 (0.2)		2.2 (0.3)		2.0 (0.2)		1.6 (0.2)		0.394
	%	rank	%	rank	%	rank	%	rank	%	rank	
Musculoskeletal	24%	1	21%	2	24%	2	24%	2	29%	1	0.648
Ocular	21%	2	23%	1	19%	3	27%	1	17%	3	0.398
Neuropsychiatric	19%	3	16%	3	18%	4	13%	6	25%	2	0.265
Skin	14%	4	11%	6	31%	1	14%	4	10%	5	0.021
Renal	14%	5	16%	4	17%	5	21%	3	7%	6	0.087
Vascular	10%	6	12%	5	11%	8	14%	5	6%	7	0.415
Malignancy	8%	7	3%	11	8%	9	7%	8	14%	4	0.060
Glucocorticoid-related damage	28%		30%		37%		30%		22%		0.195

Ranks are based on prevalence of organ system damage in each group. The remaining organ systems that were not among the top 5 in any group included cardiovascular, pulmonary gastrointestinal, reproductive, and diabetes.
Glucocorticoid damage includes avascular necrosis, diabetes, cataracts, and osteoporosis.
All results are adjusted for age at study visit. P-value is based on comparison across all racial/ethnic groups.

Results Among 323 participants, 89% were female, 39% Asian, 11% African American, 22% Hispanic of any race, and 29% White. Mean age was 45±14; mean age at diagnosis 29±12. SDI ranged from 0 to 10 points, mean 1.8±2.0; 70% of the cohort had SDI>0. There were no differences in mean SDI by race/ethnicity (p=0.4; see Table). Musculoskeletal and ocular damage were among the five most common systems for all groups. African Americans were significantly (p=0.02) more likely to have skin damage than the other racial/ethnic groups. Non-Hispanic whites were the only group that had malignancy in their top five systems of SDI damage. Renal damage was most prevalent among Hispanics and least prevalent among whites. Glucocorticoid-related damage was more prevalent among African Americans in comparison to whites, although this difference was not statistically significant.

Conclusions There are differences in prevalence of damage by organ system among racial/ethnic groups, with blacks significantly more likely to have skin manifestations and whites more likely to have a history of cancer. There is also evidence of higher glucocorticoid-related damage among blacks. Further research is required to explain what leads to these differences; they could be related to quality and access to care and treatment, or to differential disease biology or environmental exposures.

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62 RACIAL DIFFERENCES IN SELF-EFFICACY AND PATIENT-PROVIDER INTERACTIONS AMONG PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Background Significant racial disparities exist in the prevalence and outcomes of systemic lupus erythematosus (SLE). Few studies have examined modifiable factors intrinsic to a patient encounter that may contribute to such disparities. We aimed to explore potential areas for intervention to reduce racial disparities with a focus on patient self-efficacy and the quality of patient-provider interactions.

Methods Cross-sectional data were collected from consecutive SLE patients actively treated and followed at a tertiary lupus clinic. Patient-provider interaction was measured using the Interpersonal Processes of Care survey (IPC-29), which has 7 domains on a 5-point Likert scale including Hurried communication, Elicited concerns, Explained results, Patient-centered decision making, Compassionate respectful, Discrimination, and Disrespectful office staff. General self-efficacy, self-efficacy for managing medications and treatments, and patient-reported health status were measured using Patient-Reported Outcomes Measurement Information System (PROMIS) short forms. Additional demographic and clinical information were gathered by survey and chart review. SLE Disease Activity Index (SLEDAI), Systemic Lupus International Collaborating Clinics (SLICC) Damage scores, and Medication Regimen Complexity Index were calculated. Bivariate analyses compared patient characteristics of Caucasians and non-Caucasians.

Results 84 enrolled (37% Caucasians, 59% African American, 1% Native American, and 4% Hispanic). Non-Caucasians compared to Caucasians are younger, more likely to be single/unmarried, on disability, and less likely to have college education. Non-Caucasians tend to report less fatigue, better social health, carry a more recent SLE diagnosis but take a more complex rheumatic medication regimen, have higher SLEDAI, lower fibromyalgia symptom severity, and a trend for higher damage scores (table 1). In terms of modifiable factors intrinsic to the patient encounter, there were no significant differences in patient-provider interactions except that non-Caucasians rated providers to have more Hurried communication. Non-Caucasians also had a trend for lower general self-efficacy.

Conclusions Non-Caucasians come from more disadvantaged sociodemographic backgrounds and have worse SLE disease outcomes. Overall, scores for patient-rated interactions with physicians in this selective sample were better than in other studies. However, non-Caucasians reported more Hurried communication with their providers and lower general self-efficacy. These may be modifiable factors within a patient encounter to reduce healthcare disparities in SLE. Whether quality of patient-provider communication and patient self-efficacy predict higher disease activity and damage scores longitudinally should be investigated.

Abstract 62 Table 1 Comparing patient characteristics between Caucasians and non-Caucasians

	Caucasian (n=30)	Non-Caucasians (n=53)	p-value
Socio-demographics			
Age, years, median [IQR]	**48 [41-62]**	**39 [31-49]**	**0.002**
≥College education,%	**68**	**38**	**0.008**
Disability,%	**23**	**50**	**0.02**
Marital status,%			
Single	**10**	**42**	**0.002**
Married	**63**	**39**	
Divorced	**17**	**19**	
Widowed	**10**	**0**	
Live with partner/spouse	70	48	0.05
Medicaid,%	10	25	0.09
Interpersonal Process of Care			
Hurried communication*, median [IQR]	**1 [1–1.3]**	**1.3 [1–1.8]**	**0.001**
Elicit concerns†, median [IQR]	5 [4.7–5]	5 [4.7–5]	0.6
Explained results†, median [IQR]	4.6 [3.6–5]	4.8 [4 - 5]	1
Patient-centered decision making†, median [IQR]	4.8 [3.8–5]	4.5 [3.8–5]	0.5
Compassionate respectful†, median [IQR]	5 [4.4–5]	5 [4.4–5]	0.7
Discrimination*, median [IQR]	1 [1 - 1]	1 [1 - 1]	0.2
Disrespectful office staff*, median [IQR]	1 [1 - 1]	1 [1 - 1]	0.8
Patient-reported Outcomes			
General Self-efficacy§, median [IQR]	60 [49 - 65]	51 [42 - 62]	0.06
Self-efficacy in taking medications§, median [IQR]	52 [43 - 61]	50 [42 - 54]	0.3
Fatigue§, mean (SD)	58 (10)	54 (11)	0.06
Social health§, mean (SD)	48 (10)	52 (10)	0.06
Clinical factors			
Years of diagnosis, median [IQR]	20 [7 - 26]	14 [8 - 17]	0.08
Rheumatic medication regimen complexity score, median [IQR]	**5 [3 - 8]**	**8 [5 - 11]**	**0.004**
SLICC damage score, median [IQR]	1 [0–2]	2 [1 - 3]	0.06
SLEDAI, median [IQR]	**1 [0–4]**	**4 [1 - 8]**	**0.03**
SLAQ, median [IQR]	11 [6 - 14]	9 [6 - 13]	0.7
Fibromyalgia symptom severity score, median [IQR]	**4 (2)**	**3 (2)**	**0.04**

IQR=interquartile range; SD=standard deviation; SLAQ=systemic lupus activity questionnaire; SLEDAI=systemic lupus erythematosus disease activity index; SLICC=systemic lupus international collaborating clinics
*Scores range from 1–5, with lower being better
†Scores range from 1–5, with higher being better
§A score of 50 represents the US population mean, a difference in 5 is clinically significant. Higher scores are better for self-efficacy and social health, but lower scores are better for fatigue.

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63 METABOLIC SYNDROME IN LUPUS AND RELATIONSHIP WITH THE NEUTROPHIL TO LYMPHOCYTE RATIO

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Background In SLE there is five times more risk of cardiovascular events (CV) compared to the general population. In Argentina, a prevalence of metabolic syndrome (MetS) was reported in 28%. The SLICC cohort found 36.5% of MS in the first 2 years of diagnosis.

The neutrophil to lymphocyte ratio (NLR) is a marker of inflammation that relates the absolute count of neutrophils and lymphocytes, is a tool in the assessment of CV risk and systemic endothelial dysfunction. The NLR values reported in healthy is 1.65 (±1.47). Studies in SLE show that NLR is a marker of activity and nephritis.

We aimed to determine the association of MetS with and without renal involvement, the relationship between NLR and MetS and relationship between NLR and disease activity.

Methods Descriptive, cross-sectional study.

Patients with SLE (SLICC 2012) of <5 years of evolution and >18 years followed at the Güemes Hospital were included, between 06/2013 to 07/2018.

Acute CV events, infections, pregnancy, diabetes and chronic kidney disease were excluded.

Risk factors nontraditional were determined: antiphospholipid (aPL), GC, SLEDAI.

MetS (NCEP ATP III criteria): Weight, height, abdominal perimeter (AP) and blood pressure.

PCR, neutrophil and lymphocyte count, glucose, CT, TG, LDL, urea, creatinine, proteinuria/24hs, Anti DNA, C3, C4, aPL: LA, Anti B2GP and Anti aCL antibody.

Statistical Analysis: Epi Info 7.2.0.

Results A total of 42 patients were reviewed, 12 were excluded (incomplete data).

Of 30 patients: 23 women (77%), mean age 39.3 (±SD 14.3), evolution of disease: 35 months (±SD 18.9), tobacco exposure: 11 (37%). Nephritis in 17 patients (51%).

MetS: 13 (43.3%), components: AP increased 15 (50%), HDL low 11 (37%), hypertension 11 (37%), high TG 8 (27%), hyperglycemia 3 (10%). Overweight: 17 (57%).

Mean BMI 27.4 (±DS 6.2).

Characteristics of patients with and without MetS and relationship MetS and SLE with NLR. (Table).

Conclusions In our series, a greater frequency of MetS was found than literature. No relationship was found between MetS with renal involvement; however patients with MetS had higher proteinuria and elevated CRP.

No relationship was found between the NLR with MetS and nephritis. The NLR was higher in patients with SLEDAI 4.

The high prevalence of MetS, proteinuria, elevated CRP and NLR in our population suggest persistent inflammatory activity and probable CV morbidity, so it is important to detect it from the onset of the disease.

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