incident CV event and death. Event-free survival rates were compared using Kaplan-Meier curves. Relative hazard ratios (HRs, 95%CI) were used to estimate the risk of the outcome.

Results The patients, n=99, 87% females, were mean (SD) 47 (13) years old, had disease duration of 12 (9) years. The controls, n=109, 91% females, were mean 49 (12) years old. Baseline carotid intima-media thickness (cIMT) did not differ between the groups. During 9.6 (1.5) years, 12 patients and 4 controls were documented with the outcome, p=0.022. Compared with the controls, the risk of the outcome in the patients was 3–4-fold increased at the same level of traditional CV risk factors and carotid measures. SLE-patients with poor outcomes had higher cIMT, SLICC, APS diagnosis and used prednisolone longer time than those without. Higher SLICC and APS diagnosis were associated with increased risk of the poor outcome, respective HRs 1.66 (1.20–2.28) and 9.08 (2.71–30.5), as well as with cIMT, HR 1.006 (1.002–1.01), independent of age and sex. The combination of SLICC and APS with cIMT significantly improved outcome prediction, p<0.001.

Conclusions Patients with SLE compared with controls at the same level of CV risk factors and cIMT had increased long-term risk of clinical events. Applying accumulated disease-damage, APS and cIMT may improve risk stratification in SLE.

P161

CASE REPORT OF A SYSTEMIC LUPUS ERYTHEMATOSUS AND ANTIPHOSPHOLIPID SYNDROME PATIENT WITH AN INFILTRATIVE TUBERCULOSIS AND MELANOMA: FEATURES OF THERAPEUTIC APPROACHES

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Background Systemic lupus erythematosus (SLE) is an autoimmune disease characterized by multiorgan tissue damage, including skin, that is frequently treated with high doses of immunosuppressive drugs. Thus, patients with SLE are at increased risk for infections (for example, tuberculosis) and malignancy. SLE and tuberculosis may have similar presentations and mimic each other; also, prior tuberculous infection may precipitate SLE in genetically predisposed individual. An increased standardized incidence ratio for non-melanoma skin cancer has been reported, however, there is no evidence of correlation between SLE and melanoma.

Methods We report a case of a patient with SLE and antiphospholipid syndrome (APS) with a moderate disease activity index (SLEDAI = 7) with infiltrative tuberculosis and melanoma.

Abstract P161 Table 1 Clinical and laboratory manifestations of the disease and treatment tactics

Age	1996 (18 years old)	2000-2001 (22-23 years old)	2009-2010 (31-23 years old)	2011-2012 (33-34 years old)	2017 (39 years old)	July 2018 (40 years old)	September 2018 (40 years old)	2019 (41 years old)
Manifestations								
Photosensitivity	■							
Skin lesion			■ erythema	■ erythema	■ erythema	■ cutaneous neoplasm of the lumbar region		■ erythema and subacute LE, herpes zoster
Oral ulcers			■		■			■
Alopecia					■			■
Arthritis								■
Pericarditis				■				■
Leukopenia		■		■	■			■
Hemolytic anemia				■	■			
Highly positive anticardiolipin antibodies	■			■				
Highly positive anti-beta-2-glycoprotein 1 antibodies				■				
Highly positive antibodies to dsDNA				■	■			■
Smith antigen				■	■			■
Hypocomplementemia				■	■			■
ANF hep-2 positivity				■	■			■
Additional information	■ False positive serological test for syphilis	■ Chest X-ray: detection of focal changes in the right lung	■ 1st Pregnancy and childbirth	■ 2nd Pregnancy and childbirth ■ Portal hypertension as a manifestation of microangiopathy of APS			■ PET-CT: infiltrative changes in the upper lobe of the right lung	
Diagnosis	No reliable data was obtained for antiphospholipid syndrome (APS)	Focal pulmonary tuberculosis	-	SLE (Hematologic diseases were excluded). APS	SLE. APS.	Melanoma IB T2N0M0. SLE. APS.	Infiltrative tuberculosis in the upper lobe of the right lung. Melanoma IB T2N0M0. SLE. APS.	SLE. APS. Infiltrative tuberculosis in the upper lobe of the right lung. Melanoma IB T2N0M0.
Treatment tactics	-	Antibacterial therapy (drugs and doses unknown)	-	Methylprednisolone 12–8 mg/day, Hydroxychloroquine 400 mg/day, Nadroparin calcium 0.6/day (6 months)	Methylprednisolone 16 mg/day, Hydroxychloroquine 400 mg/day, Mycophenolate mofetil 2 g/day, intravenous pulse methylprednisolone 1500 g №2 (in May and August), Rivaroxaban 15 mg/day	Melanoma excision surgery. Methylprednisolone 8 mg/day, Hydroxychloroquine 400 mg/day, Mycophenolate mofetil was canceled, Rivaroxaban 15 mg/day	Methylprednisolone 8 mg/day, Hydroxychloroquine 400 mg/day, Rivaroxaban 15 mg/day, Antibacterial therapy: (*Pyrazinamide 1500 mg/day, Cycloserine 0.5 g/day, Sparfloxacin 0.2 g/day, Linezolid 0.6 g/day, Ppotionamide 0.75 g/day)	Methylprednisolone 8 mg/day, Hydroxychloroquine 400 mg/day, Rivaroxaban 15 mg/day, intravenous pulse methylprednisolone 1500 g №2 (in May and December), intravenous immunoglobulin 20g (in December), Antibacterial therapy: (*), Acyclovir 4 g/day 10 days

Results A 41-year-old female patient with SLE for 22 years, was diagnosed on the basis of skin lesion, alopecia, photosensitivity, oral ulcers, arthritis, pericarditis, hemolytic anemia, leukopenia, highly positive antibodies to dsDNA, hypocomplementemia, ANF hep-2 positivity. An anamnesis of the disease and treatment tactics are presented in table 1.

Conclusions There are no established guidelines available for treatment of tuberculosis or melanoma in SLE patients due to lack of relevant studies and management based more on physician expertise. The use of genetically engineered biological drugs can be limited due to the high risk of infection, the onset of cancer in the anamnesis, and also not fully studied in patients with comorbidity.

P162 PROGRESSION OF SUBCLINICAL CARDIOVASCULAR DISEASE IN SLE: A FIVE YEAR FOLLOW UP STUDY

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Background SLE patients have 5–10-fold increased risk of developing CVD compared to controls.^{1,2} In this study we aimed to describe the rate and determinants of carotid plaque progression in a cohort of SLE patients who were asymptomatic of CVD at baseline.

Methods Vascular ultrasound studies of 100 patients with SLE asymptomatic of CVD was carried out at baseline. Sixty-nine patients were rescanned (94% female, mean overall age 46 years (SD 11)) over a median of 5 years of follow up. Clinical and CVD risk was assessed at baseline and follow up. B-mode Doppler ultrasound was used to measure intimal media thickness and plaque to assess progression. Total plaque area (TPA), a more sensitive measure of plaque, and echolucency expressed as gray scale median (GSM), linked to plaque lipid content were assessed.

Results Of the 100 patients with a baseline scan, 69 patients had a second scan at a median of 5 years follow up. New plaque developed in 9% and 26% had an increase in plaque number. The mean overall IMT (0.111 vs 0.064, $p<0.01$) and common carotid IMT (0.065 vs 0.055, $p<0.01$) were significantly raised in plaque vs non-plaque patients. In a multi-variable analysis CIMT at follow-up was independently associated with age (beta 0.415, $p<0.001$) and diastolic blood pressure (beta 0.285, $p<0.021$). Independent predictors of plaque at follow-up scan on multi-variable analysis were age at scan >52 years (OR 10.41, CI 2.66–40.80) and systolic BP >133 (OR 5.26, CI 1.396 – 19.862). In contrast, total cholesterol was negatively correlated with TPA (beta = -1.167, $p=0.002$) and with GSM (beta = -0.513, $p=0.012$).

Conclusions Amongst these 69 patients, 26% had progression and none had decreased plaque over a median of five years follow-up. Measurement of novel ultrasound variables such as TPA and echolucency may identify more modifiable risk factors that can be used to improve CVD outcomes in patients with SLE.

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P163 IMPROVING A SLE-QUALITY INDICATOR TOOL IN AN OUTPATIENT TERTIARY CARE SETTING

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Background The care for patients with lupus is complex as they may exhibit multiple concomitant medical and socioeconomic issues. To address all their needs according to the current guidelines is a daunting task in busy outpatient practices. However, incorporating quality indicators in patient care has been found to decrease mortality and morbidity, improve patient satisfaction, and reduce costs. To improve the quality of care following recommendations from published guidelines, ACR, and EULAR, we embarked on a comprehensive quality improvement project by developing a checklist tool that incorporates the major SLE-Quality indicators (SLE-QI).

Method The project was launched in October 2017. A SLE-QI checklist detailing quality indicators was created based on published recommendations for standard of care. The checklist included a set of 20 SLE-QIs that address several important aspects of SLE care including diagnosis and disease monitoring, general prevention strategies, screening for comorbidities, drug toxicity monitoring, assessment of renal disease, reproductive health, and quality of life in daily practice. A standardized document template for clinic visits was developed that incorporated these quality indicators. Clinic progress notes were reviewed weekly to determine if these indicators were used and addressed. If SLE-QIs were missing, efforts were made to reach out to providers to address the missing QIs.

Results At the beginning of the assessment, documentation of SLE-QIs was generally poor and inconsistent. For example, vaccinations was only at 60% compliance while screening for cardiovascular risk was only at 3% compliance. Since documentation was not standardized, it was difficult to assess if SLE-QIs were being done. Implementing SLE-QI in standardized notes resolved these concerns, bringing compliance close to 100% compliance for the 20 identified SLE quality indicators.

Conclusion Standardized progress notes incorporating QI indicators is a feasible strategy that helps streamline data extraction for future clinical research. Additionally, incorporating patient outcome tools improves the ability to perform treat-to-target strategies for SLE. This ongoing QI project may potentially improve overall patient outcomes and lead to reduce health care costs.