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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10.1136/lupus-2020-eurolupus.204

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.

Acknowledgements Rosetrees Trust

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

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10.1136/lupus-2020-eurolupus.205

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.