well as to define characteristics of the lymphoma and its evolution.

Methods Retrospective observational, longitudinal study conducted in a tertiary hospital. Medical records of 362 patients with ≥4 SLICC classification criteria of SLE were reviewed, including those with lymphoma diagnosis. Demographic and clinical data, comorbidities, SLE manifestations and therapy, data related to lymphoma and outcome were collected. Descriptive statistic analysis with measures of central tendency and measures of variability was performed.

Results Of the 362 SLE patients, 9 (2.5%) were diagnosed of lymphoma, of which 100% female. Mean age at SLE diagnosis was 34 y.o (SD 11) and average duration from SLE diagnosis to lymphoma was 17 years (SD 14). 7 patients were Caucasian and 2 Hispanic. Observed comorbidities were hypertension (67%), diabetes (22%), dyslipidemia (33%), HBV infection (11%) and active smoking (66%). No malignancy history was detected. Most frequent SLE features were haematological (100%), joint (56%) and skin (56%) involvement. The serious ones were: 3 patients with haemolytic anaemia (1 of them, platelets <200000), 2 epilepsy (1 with CNS vasculitis), 1 glomerulonephritis, 1 pulmonary hypertension and 1 hemophagocytic syndrome. Only 1 patient had overlap with Sjögren’s syndrome. At the time of lymphoma diagnosis, 7 patients were on steroids, 4 on immunosuppressants (2 mycophenolate, 1 azathioprine, 1 rituximab) and 3 on antimalarials (table 1). Mean age at lymphoma diagnosis was 51 y.o (SD 10). 5 patients (56%) had diffuse large B-cell lymphoma (DLBCL); 1, NHL; 1, Hodgkin’s lymphoma; 1, mantle B-cell lymphoma and; 1, MALT. Only 1 patient, of 4 with available data, had EBV positive in the tissue. 7 patients received chemotherapy and 2 patients completed treatment with autologous peripheral stem-cell transplantation. Three patients died, 2 due to lymphoma and one due to other causes (severe flaccid paralysis). Overall survival after lymphoma diagnosis was 8 years (SD 6).

Conclusion In our patients, unlike that reported in the literature, lymphoma diagnosis was in SLE with longer duration of the disease, and all cases were female. Most frequent subtype was NHL, and all patients had previous haematological manifestations. Regarding previous SLE treatments, 5 patients had been exposed to immunosuppressants.

Methods A cross-sectional sample of juvenile-onset SLE (JSL) patients, currently aged ≥16 years, completed a psychosocial assessment including the SF-36, HADS, SHS, BriefCope and MMSE questionnaires, between October 2018- May 2019. Local Ethics Committee approved the study. All patients fulfilled both 2012 and 2019 EULAR/ACR classification criteria for SLE. Juvenile-onset was defined as age at diagnosis <18 years. Demographics and clinical characteristics were collected. Statistical analysis was performed with SPSS®.

Results 30 JSL patients were included (90%female) in the study, with median age of 21 years, being the youngest 16 and the oldest 35, with mean (SD) age of diagnosis of 15.8 ± 2.1. Mean values (SD) of psychosocial assessment were: SHS 5.2 (1.02); MMSE of 27.7 (1.8); Physical health SF-36 of 66.8 (9.9) and Mental health SF-36 of 68.9 (17.5). 23.3% JSL showed mild cognitive impairment, 63.3% anxiety and 13.3% depression. From the 27 JSL treated with HCQ, those had better results in the SHS (p=0.030) and scored lower in scores in the Hospital Anxiety and Depression scale (p=0.023). Interestingly, this also occurs for emotion focused coping, with significantly better results in JSL taking HCQ (p=0.001).

Conclusions Young adults with SLE are at risk for depression and HCQ may have a role in preventing it. Longitudinal studies will permit to confirm present results and clarify the role of coping strategies in the occurrence of depression in JSL.