Abstract P178 Table 3  Treatment differences among JSLE patients

<table>
<thead>
<tr>
<th></th>
<th>Lupus nephritis</th>
<th>Without Lupus nephritis</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients, n (%)</td>
<td>45 (36%)</td>
<td>89 (66.4%)</td>
<td></td>
</tr>
<tr>
<td>Hydroxychloroquine, n (%)</td>
<td>43 (95.6%)</td>
<td>88 (98.9%)</td>
<td>0.295</td>
</tr>
<tr>
<td>Steroid treatment duration, (months)</td>
<td>31 (1.5-8.45)</td>
<td>29.5 (9-54.8)</td>
<td>0.834</td>
</tr>
<tr>
<td>MMF, n (%)</td>
<td>39 (86.7%)</td>
<td>43 (84.3%)</td>
<td></td>
</tr>
<tr>
<td>MMF, months</td>
<td>42 (18.75-94.5)</td>
<td>0 (0-44)</td>
<td>0.000*</td>
</tr>
<tr>
<td>Cyclophosphamide, n (%)</td>
<td>22 (48.9%)</td>
<td>17 (19.1%)</td>
<td>0.001*</td>
</tr>
<tr>
<td>Cyclophosphamide, number of courses</td>
<td>0 (0-3)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Rituximab, n (%)</td>
<td>27 (60%)</td>
<td>29 (22.6%)</td>
<td>0.003*</td>
</tr>
<tr>
<td>Rituximab, number of courses</td>
<td>2 (0-2)</td>
<td>0 (0-1)</td>
<td>0.000*</td>
</tr>
<tr>
<td>Azathioprine, months</td>
<td>2.5 (0-4.85)</td>
<td>10 (0-41)</td>
<td>0.868</td>
</tr>
<tr>
<td>Methotrexate, months</td>
<td>0</td>
<td>0 (0.75)</td>
<td>0.529</td>
</tr>
<tr>
<td>Tacrolimus, months</td>
<td>0</td>
<td>0</td>
<td>0.219</td>
</tr>
<tr>
<td>Belimumab, months</td>
<td>0</td>
<td>0</td>
<td>0.310</td>
</tr>
</tbody>
</table>

Numbers are medians (interquartile ranges) unless otherwise stated. MMF = mycophenolate mofetil. *p<0.05 is significant.

Methods

Factors associated with low bone mineral density in a univariate logistic regression analysis were: the use of mycophenolate mofetil (p=0.021) and the presence of LN (p=0.007), while LN also associated with low bone density (p=0.008) in a multivariate analysis. The skin involvement was the most common manifestation in both JSLE patients. The treatment was more aggressive in patients with LN, including the use of cyclophosphamide, mycophenolate and rituximab, but there was no difference regarding the length of the steroid treatment (table 3). The majority of the patients (67%) had one flare of nephritis and the number of flares ranged from 2 (13%) to 12 (22%) for the rest of the patients in this cohort with disease duration ranging from 8–12 years. The class of nephritis was reported in 34 out of 45 patients, and focal lupus nephritis (class III) was the most common type (44%). There were no statistical significant differences in the baseline characteristics or treatments among the different classes of LN.

Conclusion

Low bone mineral density is common in patients with JSLE, but this is the first study highlighting the association of low bone density with LN and the lack of association with the total duration of steroid treatment or other clinical manifestations.

REFERENCES


Background

SLE complexity and unpredictability challenge assessment of disease activity. Current scoring instruments are limited in ability to detect changes in activity over time and too cumbersome for daily practice. We constructed a new disease activity score, including physician and patient assessment, aiming to simplify and improve assessment in daily practice, and possibly serve as a tool for clinical studies.

Methods

The new instrument is comprised of 6 visual analogue scales, separately addressing the physician’s global assessment and 5 organ systems: musculoskeletal, cardiorespiratory, renal and neuropsychiatric systems, and 5 visual analogue scales addressing patients’ assessment of disease activity and adherence to therapy. Laboratory values and medications are recorded. Aiming to assess the reliability and validity of the new score, as well as its sensitivity to changes in disease activity, 4 paper cases, including 2 visits per case, were constructed. Each visit was scored by 5 experienced rheumatologists, using BILAG, SLEDAI, LFA-REAL and our proposed score.

Results

The inter-rater reliability of the new score was good for all systems, both for single visit scores and for change in disease activity between 2 consecutive visits (ICC [2,1] range 0.75–0.95), except for changes in activity in the renal system (0.59). The inter-rater reliability values of the new score were comparable with those of the BILAG and the LFA-REAL instruments. The construct validity of the new score was good for single visit scores (Spearman correlation coefficients range 0.48–0.94). Correlation of our proposed score with the BILAG, was good when scoring the mucocutaneous, musculoskeletal and cardiorespiratory systems (0.66, 0.75, 0.83, respectively) but poor when scoring the renal system (0.11).

Conclusions

This paper case evaluation of the new disease activity score suggests a promising and simple tool, with overall good reliability and construct validity.

P179  SYSTEMIC LUPUS ERYTHEMATOSUS, A PILOT STUDY OF A NEW DISEASE ACTIVITY SCORE

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10.1136/lupus-2020-eurolupus.221

Background

We aimed to measure the PRO-QL in SLE patients and correlate them with the clinical activity of the disease.

Methods

A cross-sectional observational study with SLE patients diagnosed according to SLICC 2012 criteria was performed. SLEDAI score was carried out, and patients full-filled

P180  CORRELATION BETWEEN PATIENT REPORTED OUTCOMES OF HEALTH-RELATED QUALITY OF LIFE AND CLINICAL ACTIVITY IN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS

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10.1136/lupus-2020-eurolupus.222

Background/Purpose

Patient-Reported Outcomes (PROs) allow us to know how the disease could affect patients, and maybe could not be detected by clinical measures. Among these, PROs of health-related quality of life (PRO-QL) represents patient evaluation of its health status. In systemic lupus erythematosus (SLE) patients, the heterogeneous inflammatory symptoms can affect the health-related quality of life in different ways.

We aimed to measure the PRO-QL in SLE patients and correlate them with the clinical activity of the disease.

Methods

A cross-sectional observational study with SLE patients diagnosed according to SLICC 2012 criteria was performed. SLEDAI score was carried out, and patients full-filled...
questionnaires of fatigue (FACIT-FATIGUE), quality of life (EQ-5D-5L), disability (HAQ) and a Global Health Status Scale (GHS) (0–100). Biostatistical analysis was performed using the multivariate analysis of variance by Pillai test.

**Results** 54 SLE patients (91.84% female) with a mean age at diagnosis of 27.55±13.21 years and a mean time of disease evolution of 20.45±9.7 years were included. Mean SLEDAI score was 6.63±6.89, with a 37.04% of patients with SLEDAI>6. The 64.66% of patients were under glucocorticoid treatment, 38.77% under immunosuppressants (methotrexate, azathioprine or mycophenolate) and 51.02% under antimalarials.

Patients showed a mean score of 34.02±12.38 in FACIT-FATIGUE, 0.72±0.26 in EQ-5D-5L, 0.62±0.71 in HAQ and 64.02±25.93 in GHS.

Statistical analysis showed correlation among high SLEDAI scores and low scores of EQ-5D-5L, FACIT-FATIGUE and GHS, and an increment in HAQ, considering as correcting factors the age, years of disease evolution, glucocorticoid treatment, antimalarials and immunosuppressants (P=0.0107).

**Conclusions** We observed a correlation between PROs-QL full-filled by SLE patients with the clinical activity of the disease, independently of glucocorticoid treatment, antimalarials and immunosuppressants, the age and the disease evolution.

**P181** COMPARISON OF SLEDAI-2K AND SLEDAI-2KG (GLUCOCORTICOID) INDEXES IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)

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**Background** Disease activity measurement in SLE can be performed with SLEDAI based on clinical and laboratory findings. The new SLEDAI-2K-glucocorticoid index (SLEDAI-2KG) developed from SLEDAI-2K calculates disease activity by taking into account the amount of glucocorticoids used. In this cross-sectional prospective study, two indexes were compared in consecutive SLE patients.

**Methods** Seventy-nine SLE patients were included into the study. Disease activity was evaluated using SLEDAI-2K and SLEDAI-2KG. Patients were grouped as SLEDAI = 0 (group 1), lupus low disease activity status (LLDAS) (group 2) and active disease (group 3). LLDAS was defined as: SLEDAI-2K ≤ 4, with no activity in major organ systems and no haemolytic anaemia or gastrointestinal activity; no new lupus disease activity; PGA (scale 0–3) ≤1; a current prednisolone dose ≤7.5 mg daily; and stable maintenance doses of immunosuppressive drugs and approved biological agents.

**Results** Table 1 shows clinical features of SLE patients. Eighty-six percent of the patients were female. Median age 34 (range 18–74), median disease duration 36 (0–436) months. Thirty-five percent of the patients had renal activity, 7% had malar rash, 12% had alopecia, 2 (2.5%) had thrombocytopenia, 8% had leucopenia, 3.8% had fever. Sixty-one percent of the patients had hypocomplementemia and 29% had anti-dsDNA positivity. Glucocorticoids were used by 63 patients and the median prednisone dose was 16 (0–75) mg. The median of SLEDAI-2K score of 79 patients was 4 (range 0–24) and the median of SLEDAI-2KG score was 7 (range 0–25). Significant positive correlation was found between SLEDAI-2K and SLEDAI-2KG scores (r=0.93, p<0.01). When SLEDAI-2K and SLEDAI-2KG were compared, the proportion of patients with disease activity 0 was 24% and 9%, LLDAS 20% and 27%, and active patients 56% and 64%, respectively.

**Conclusion** Although there was a significant correlation between SLEDAI-2K and SLEDAI-2KG, more patients were defined as active with SLEDAI-2KG. Considering the importance of reducing glucocorticoid dose in clinical trials in the assessment of treatment response, SLEDAI-2KG may provide a more precise treatment response. Prospective studies are required to investigate the importance of SLEDAI-2KG in long-term prognosis of SLE patients.

**P182** ORGAN DAMAGE IN CROATIAN COHORT OF PATIENTS WITH CHILDHOOD ONSET SYSTEMIC LUPUS ERYTHEMATOSUS

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**Background** Our aim was to explore the correlation between the Systemic Lupus Erythematosus Disease Activity Index (SLEDAI 2K) at the time of diagnosis and the SLICC/ACR damage index (SDI) of patients at their last follow up, to examine organ damage and to predict the risk of organ damage occurrence in time.

**Methods** The retrospective study included children with childhood onset systemic lupus erythematosus (cSLE) treated from 1991 to 2017 at University Hospital Centre Zagreb.