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%), 8% 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

Abstract P181 Table 1 Demographic and clinical characteristics of SLE patients

	SLE, n=79
Male/Female,	68/11
Age, years (median, range)	34 (18–74)
Disease duration, months (median, range)	36 (0–436)
Manifestations	
Vasculitis, n (%)	10 (12,7)
Arthritis, n (%)	5 (6,3)
Renal activity, n (%)	28
Proteinuria, n (%)	26
Hemolytic anemia, n (%)	6 (7,5)
Thrombocytopenia, n (%)	7 (8,9)
Autoantibodies	
ANA, n (%)	74 (93,7)
Anti-dsDNA, n (%)	23 (29,1)
C3 levels (mg/dl, median, range)	81 (34–185)
C4 levels (mg/dl, median, range)	2 (2–42)
SLEDAI score (median, range)	4 (0–24)
SLEDAI-2KG score (median, range)	7 (0–25)
Treatment	
Prednisone, n (%)	63 (79,7)
Azathioprine, n (%)	21 (26,6)
Antimalarial, n (%)	52 (62,8)
Mycophenolate, n (%)	21 (26,6)

(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.

Results 93 children (74 females and 19 males) with cSLE were examined with median (range) follow up time of 7 (0.5–24) years and the median (range) age at diagnosis of 13 (5–19) years. Mean (SD) SLEDAI-2K was 18.3 (9.0) at the disease onset. 38% had organ damage at the last follow up with the median (range) SDI 0 (0–7). The first organ systems damaged in affected patients were renal (28%), musculoskeletal (22%), ocular (19%), neuro-psychiatric (17%), cardiovascular (11%) and peripheral vascular (2.8%), but with no significant statistical difference regarding the type of organ damage. Kendall rank correlation coefficient determined a positive correlation between SLEDAI-2K at the disease onset and SDI ($\tau_b=0.252$, $p=0.003$). There was no significant difference of SDI in regard to gender (Asymptotic Wilcoxon-Mann-Whitney Test, $p=0.574$). Using Kaplan-Meier method we estimated with 95% confidence the damage is not happening in the first 9 or 10 years after diagnosis or the occurrence of the first symptoms.

Conclusions The high correlation between SLEDAI-2K and SDI indicated that the presentation of the cSLE at onset can be prognostic of the course and long-term prognosis of lupus. Our findings suggest it is unlikely that organ damage will occur in 50% of patients in the first nine years of the disease course.

P183 ARE QUALITY OF LIFE CONCERNS DIFFERENT BY SEX AMONG PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS?

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Background Not much is known about health outcomes among women, in comparison to men, in Systemic Lupus Erythematosus (SLE). Quality of life (QOL) is one of the core health outcome measures in SLE. This study compared health outcomes among SLE patients, stratified by sex, to facilitate better management strategies.

Methods Existent cross-sectional data from SLE patients from a multicenter health outcomes study was utilized. Demographic data, disease activity (SELENA-SLEDAI), damage (SLICC-SDI/ACR), QOL (SF-36, LupusQoL) were compared by sex. Multivariate analysis (adjusted for age, disease activity and damage) were undertaken for QOL, using sex as the independent variable.

Results Of the 325 participants, 33 were men. Mean age was 41.9 ± 13.0 years, and over 53% were Caucasians. Mean SELENA-SLEDAI scores were 4.8 ± 3.8 . There were no age, race or disease activity differences among the two groups. Damage was significantly greater among men than women. On univariate analysis, no differences in SF-36 QOL were observed by sex. However, women fared significantly worse than men in (Physical health, fatigue, Intimate relationship) LupusQoL domains. On multivariate analysis, female sex was an independent predictor of worse functioning on SF-36 (Physical function, vitality) and LupusQoL (Physical Health, Fatigue, Intimate Relationship) (table 1).

Conclusion SLE has differential effects on QOL among men and women. Use of disease specific QOL tool offers more comprehensive and disease pertinent evaluation of SLE impact. Women with SLE report worse impact on physical health, fatigue and intimate relationships. Further studies are required to better understand plausible reasons for these observations.

Abstract P183 Table 1

Tool	Domain	Multivariate*		
		Beta	95 % CI	P value
SF 36	Physical Functioning	-0.174	-10.4, -1.19	0.014
	Physical Role Functioning	-0.09	-7.47, 1.78	0.227
	Bodily Pain	-0.07	-6.79, 2.16	0.309
	General Health Perceptions	-0.09	-7.70, 1.77	0.219
	Vitality	-0.18	-10.30, -1.14	0.015
	Social Role Functioning	-0.09	-7.57, 1.69	0.212
	Emotional Role Functioning	-0.43	-6.85, 3.75	0.564
	Mental Health	0.04	-3.57, 6.28	0.588
LupusQoL	Physical Health	-0.18	-28.43, -2.72	0.016
	Emotional Health	-0.02	-12.64, 9.09	0.748
	Body Image	-0.13	-25.01, 1.85	0.09
	Pain	-0.09	-21.17, 5.14	0.231
	Planning	-0.11	-23.36, 3.32	0.14
	Fatigue	-0.18	-25.76, -2.82	0.015
	Intimate relationships	-0.17	-34.69, -2.9	0.021
	Burden	-0.09	-24.02, 5.25	0.207
* Adjusted for age, activity and damage				