development of clinical disease and associated changes in immune status, gut and energy homeostasis.

Results Animals fed a HFD showed lower autoantibody titres going along with an improved overall survival and a tenden-
tiously lower infiltration of the kidney by leukocytes. Benefici-
ficial clinical effects were reflected in systemic immunologic
changes, as the distribution and differentiation of main
immune cell subsets in HFD animals more closely resembled
that of yet healthy animals. We assume that most probably a
complex interplay of different fiber-associated effects underlies
these favorable effects. This may involve intestinal leakage
and bacterial translocation that were increased in LFD animals.
Further, LFD animals showed a significant increase in body
weight and white adipose tissue expressing more leptin
and inflammatory cytokines. We are currently testing, if the
observed beneficial effects may also be attributed to an
increased fermentation of dietary fibre into SCFA. SCFA inter-
sect in various ways and at different sites with the immune
system and mostly have anti-inflammatory effects.

Conclusion Altogether, we think that intake of dietary fiber
affects immune status, gut and energy homeostasis. These may
be interlinked and affect each other, inflicting more or less
systemic chronic inflammation promoting lupus pathology.

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of Science, Research, and Arts Baden-Württemberg (Margarete
von Wrangell Programm).

Abstract P57 Table 1 Association of tobacco smoking status with disadvantage score among adults with Primary CCLE. Multivariate Analysis*

<table>
<thead>
<tr>
<th>Disadvantage score*</th>
<th>CS vs NS (OR 95% CI)</th>
<th>P-value</th>
<th>CS vs FS (OR 95% CI)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–1</td>
<td>(Ref)</td>
<td></td>
<td>(Ref)</td>
<td></td>
</tr>
<tr>
<td>2–3</td>
<td>3.9 (1.1–13.3)</td>
<td>0.03</td>
<td>6.9 (1.5–31.7)</td>
<td>0.01</td>
</tr>
<tr>
<td>4–6</td>
<td>9.3 (2.5–34.6)</td>
<td>0.003</td>
<td>7.6 (1.6–35.6)</td>
<td>0.004</td>
</tr>
</tbody>
</table>

*Multivariate logistic regression adjusted for significant confounders (age, gender, and der-
matology visits). **Disadvantage score represents the sum of 1 point for each of the follow-
ing characteristics: living below the federal poverty level, ≥ high school education, self-reported AA race, unemployed/disabled, self-perceived discrimination, and moderate/severe depression.

Conclusions In contrast to other series, only the 37.5% of our RhS cases begins with polyarticular seropositive arthritis. The 62.5% started with SLE symptoms as haemato logical alterations, cutaneous and serological manifestation, and showed longer progression to have polyarticular affection. Thus, RhS diagnosis is earlier in patients that begin with RA symptoms. 4 RhS patients were refractory to DMARD treatments, where biological/JAK inhibitors therapies are needed.

Background/Purpose Chronic Cutaneous Lupus Erythematosus
(CCLE), including discoid lupus, often leads to scarring
and disproportionately affects African American (AA) people.
Smoking worsens the severity of skin lupus and is highly
prevalent in those from disadvantaged groups. We examined
sociodemographic disparities in tobacco smoking among
patients with CCLE confined to the skin (primary CCLE
[pCCLE]).

Methods Cross-sectional study of adults with dermatologist-
diagnosed pCCLE consented into the Georgians Organized
Against Lupus (GOAL) Cohort. GOAL is a population-based
lupus cohort established in the Southeastern US, where there
is a large AA, socioeconomically disadvantaged population.
pCCLE were classified as never smokers (NS, 2.0 lifetime cigarettes), former smokers (FS, >100 lifetime cigarettes and
not currently smoking), and current smokers (CS, >100 life-
time cigarettes and currently smoking). We created a Disad-
vantage Score (DScore) by attributing 1 point to each of the
following: living below the federal poverty level, ≤ high
school education, self-reported AA race, unemployed/disabled,
self-perceived discrimination, and moderate/severe depression.
We examined the association of DScore with active smoking
(CS vs NS) and smoking cessation (CS vs FS).

Results Among 124 patients (86% females, 82% AA), the
prevalence of NS, FS, and CS was 53%, 16%, and 31%,
respectively. In multivariate models adjusting for age, sex and
dermatology visits (table 1), the odds of CS (vs NS) increased significantly as the Dscores increased (OR=3.9 and