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 tendentially lower infiltration of the kidney by leukocytes. Beneficial 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 intersect 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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P56 RHUPUS SYNDROME IN A TERTIARY HOSPITAL

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Background/Purpose Rhupus syndrome (RhS) is a rare combination of Rheumatoid Arthritis (RA) and Systemic Lupus Erythematosus (SLE). Different studies describe RhS cases that begin with erosive arthritis and the presence of rheumatoid factor (RF) and/or anti CCP and then the SLE symptoms.

Despite the fact that RhS shows a low prevalence, it would be useful to know clinical characteristics of RhS patients since their therapy and outcome differ from those having RA or SLE alone.

Methods Retrospective study with systematic revision of electronic clinical records of RhS patients was performed. Demographic, clinical and immunological data were collected.

Results Eight RhS patients were included (all fulfilled SLICC 2012 criteria for SLE and ACR 2010 for RA). Mean age was 67.3 (45–84) years (7 were female).

In 3 cases RA was the first diagnosis with a mean evolution of 4.5 years until SLE diagnosis. In contrast, in 5 cases SLE was the first diagnosis with a mean evolution of 7.2 years until RA diagnosis. Photosensitivity and arthritis were the predominant clinical manifestations. One patient presents pericarditis and other case showed rheumatoid nodules in elbows. Renal, pulmonary or neurological affection was no reported.

4 patients were under biological/JAK inhibitors therapies (2 abatacept, 1 rituximab and 1 baricitinib) with favorable response of treatment.

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 haematological 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.

P57 SMOKING AND PRIMARY CHRONIC CUTANEOUS LUPUS: WHO ARE THE MOST VULNERABLE?

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Background/Purpose Chronic Cutaneous Lupus Erythematosus (CCLE), including discoid lupus, often leads to scarring and disproportionately afflicts 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, <100 lifetime cigarettes), former smokers (FS, ≥100 lifetime cigarettes and not currently smoking), and current smokers (CS, ≥100 lifetime cigarettes and currently smoking). We created a Disadvantage 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

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

Disadvantage score [^]	CS vs NS OR (95% CI)	P-value	CS vs FS OR (95% CI)	P-value
0–1	(Ref)	(Ref)	(Ref)	(Ref)
2–3	3.9 (1.1–13.3)	0.03	6.9 (1.5–31.7)	0.01
4–6	9.3 (2.5–34.6)	0.003	7.6 (1.6–35.6)	0.004

*Multivariate logistic regression adjusted for significant confounders (age, gender, and dermatology visits). [^]Disadvantage score represents the sum of 1 point for each of the following characteristics: living below the federal poverty level, ≤ high school, African American race, unemployed/disabled, self-perceived discrimination, moderate to severe depressive symptoms.

Abbreviations: NS=Never Smoker; FS=Former Smoker; CS=Current Smoker; OR=Odds Ratio; CI=Confidence Interval; ref=Reference Group.