

**P144 POTENTIAL REVERSIBLE CAUSES FOR FATIGUE IN SLE PATIENTS – DIFFERENCES BETWEEN MILD AND SEVERE FATIGUE**

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**Background/Purpose** Fatigue is the most common symptom in SLE patients with a strong impact on patients' reported quality of life. Previous studies identified possible associations with fatigue with some contradictory results. The aim of this study was to identify additional potentially reversible associations with fatigue to generate targets for future interventions.

**Methods** Our study population consisted of 234 consecutively recruited SLE (1997 ACR criteria) outpatients from our university hospital based lupus reference centre. We analyzed clinical and demographic data from routine visits, laboratory variables, as well as sleeping disorders, disease perception, coping, social activities and health locus of control using validated questionnaires. We captured fatigue using the Fatigue Severity Scale (FSS). A score of  $\geq 4$  points is considered pathological. To assess depression, we used the German CES-D depression scale (values  $\geq 23/60$  points are considered pathological).

**Results** Our predominantly Caucasian cohort (99.1%) was mostly female (87.6%), with a mean age of 45.3 years ( $\pm 13.4$  [SD]) and a mean disease duration of 16.2 years ( $\pm 9.5$ ). In our cohort, 50.9% of patients reached a pathological result in the FSS. Depression was significantly associated with fatigue ( $p < 0.001$ ). Patients with poor health conditions (including sleeping disorders, pain, disease activity and damage) showed significantly more fatigue ( $p < 0.01$ ). Overall, in 71.4% of our SLE patients, we could identify at least one potentially reversible association for fatigue (shown in table 1).

**Abstract P144 Table 1** Potential reversible associations in our cohort

Variable	N (%)	No Fatigue	Mild Fatigue	Severe Fatigue
		FSS <4 points	FSS 4.0–5.5 points	FSS =5.6–7.0 points
Obesity (BMI >30 kg/m <sup>2</sup> )	27/234 (11.5)	11/115 (9.6)	5/48 (10.4)	11/71 (15.5)
Signs for depression (CES-D $\geq 23$ points)	59/209 (28.2)	18/99 (18.2)	14/48 (29.2)	27/71 (38.0)
Vitamin D deficiency (25-hydroxyvitamin D <30 ng/ml)	73/213 (34.3)	39/106 (34.0)	14/48 (29.2)	20/71 (28.2)
Anemia (Hb <11.9 g/dl)	41/234 (17.5)	17/115 (14.8)	13/48 (27.1)	11/71 (15.5)
Hypothyroidism (TSH >4.2 $\mu$ UI/ml)	6/225 (2.6)	2/112 (1.7)	2/48 (4.2)	2/71 (2.8)

**Conclusion** We observed a high prevalence of depressive disorders in our cohort and a significant correlation of depressive status with fatigue. Therefore, we suggest that psychological wellbeing is assessed in everyday clinical practice and treating physicians should react to patients' needs accordingly. Additionally, obesity, anaemia, hypothyroidism and vitamin D deficiency can easily be assessed. Optimizing these factors represent possible targets in order to improve fatigue in SLE patients.

**P145 MEMBRANOUS AND PROLIFERATIVE LUPUS NEPHRITIS – ANALYSIS OF A NATIONWIDE MULTICENTRE COHORT**

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**Background** Lupus Nephritis (LN) is one of the most severe manifestations of Systemic Lupus Erythematosus (SLE). We aimed to compare proliferative (PLN), membranous (MLN) and mixed LN regarding clinical and laboratory presentation, and serologic profiles. Previous work suggested that these groups differ in autoantibody profile and complement levels, but those reports mainly originate from single-centres.

**Methods** Multicentre observational study, with retrospective analysis of a prospective cohort, using data from the Portuguese registry of rheumatic diseases–Reuma.pt. Patients with biopsy-proven PLN, MLN and mixed LN were included. The first renal biopsy showing one of these classes was considered, for each patient. Groups were compared using Pearson's Chi-Square for categorical variables and One-Way ANOVA or Kruskal-Wallis for numerical variables.

**Results** 232 patients were included (87% females; 88.5% White Europeans). Median follow-up was 7 years (IQR 10.75; maximum 35 years). As seen in table1, the level of proteinuria did not differ between groups; however, MLN patients presented with significantly lower creatinine. Levels of complement were reduced in PLN and mixed LN but were normal in MLN patients, and this difference was statistically significant. Groups also differed regarding the proportion of positivity for anti-dsDNA (higher in PLN) and anti-RNP antibodies (higher in MLN). There was a lower SLEDAI in MLN, probably linked with the lower prevalence of anti-dsDNA antibodies and complement consumption in this group.

**Conclusions** Our results support previous findings from single-centre studies suggesting that MLN has a different serological profile than PLN, possibly reflecting different pathogenesis.