

management. Herein, we explored patient and physician descriptions of lupus flares.

**Methods** We conducted a qualitative descriptive study using in-depth interviews with a purposeful sample of SLE patients (1997 ACR or SLICC criteria) selected for age, race, sex and nephritis; we also interviewed a range of rheumatologists. Interviews were audio-recorded and transcribed. The data were analyzed using applied thematic analysis by a team of qualitative analysts and rheumatologists.

**Results** We interviewed 42 SLE patients (mean age 45, 93% female, 52% Black, 52% college educated, 15 mean years of disease, 33% historical nephritis). The majority of patients described flare symptoms as joint pain, fatigue, and rashes. Other common symptoms included swelling, myalgias, mood disturbance and flu-like symptoms. Several patients noted brain fog and weakness as flare symptoms. One patient included nephritis and one noted lab abnormalities as signs of flare. According to patients, the majority of flares lasted a matter of days although some quantified flare length as weeks or months. Patients considered stress as the most common trigger.

Thirteen rheumatologists (mean age 54, 53% Female, 61% non-Hispanic White, mean 25 practice years) from 10 academic and 3 community centers were interviewed. All rheumatologists cared for SLE patients; half had a SLE clinical focus and 75% conducted SLE research. The majority of rheumatologists defined flare as an increase in disease activity, with more than half requiring objective findings while a few incorporated a change in therapy. Around half of rheumatologists included fatigue, pain or patient reported symptoms as part of a lupus flare; however, another 2 specifically excluded patient-reported symptoms. A few rheumatologists acknowledged patient and physician discordant views.

**Conclusion** Together, these data suggest that patients and physicians have different views of flares. Patients view flares as short-lived periods of fatigue, myalgia and arthralgia often prompted by stress. Providers view flares as an objective increase in lupus inflammation requiring immunosuppression. Appreciating this discrepancy is important since patients could misinterpret their rheumatologist's assessment. Moreover, discounting the patient experience could impair the patient-physician relationship with implications for adherence and outcomes. Further study is needed to understand the immunologic basis of patient flares and determine the best approach to incorporate the patient perspective into clinical assessments and management.

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#### TRAJECTORY OF DAMAGE ACCRUAL IN SYSTEMIC LUPUS ERYTHEMATOSUS BASED ON ETHNICITY, SOCIOECONOMIC FACTORS AND COMORBIDITIES

<sup>1,2</sup>Romy Kallas, <sup>1</sup>Jessica Li, <sup>1</sup>Daniel W Goldman, <sup>1</sup>Michelle Petri\*. <sup>1</sup>Division of Rheumatology, Johns Hopkins University School of Medicine, Baltimore, MD USA; <sup>2</sup>Department of Internal Medicine, Lankenau Medical Center, Lankenau, PA USA

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**Background** The Systemic Lupus International Collaborating Clinics/American College of Rheumatology Damage Index (SLICC/ACR DI) is associated with increased healthcare cost and mortality. We compared the trajectory of total and individual damage items of the SLICC/ACR DI in African-American vs Caucasian ethnicities in a large prospective SLE cohort.

We calculated the attributable risk of comorbidities and socioeconomic factors.

**Methods** Poisson regression was used to calculate the rate of damage per year for each organ. Cox regression modeling was used to determine the association between time to the individual damage item and ethnicity. Pooled logistic regression models of prospective data were used to calculate the population attributable risk (PAR) for each damage organ.

**Results** We included 2,436 patients: 43% African-American, 57% Caucasian, and 92% female. There was a linear relationship between time since diagnosis and mean SLICC/ACR DI score, with no plateau. Compared to Caucasians, African-Americans had a faster total, renal, pulmonary, and skin damage accrual rate. Hypertension contributed to 30% of total damage, 70% of renal and 40% of cardiovascular damage. The three socioeconomic measures (education, income, and insurance) accounted for only about 10% of any organ damage and contributed approximately equally to total damage.

**Conclusions** The linear increase in damage in both ethnicities over time is of particular concern. Ethnicity and hypertension are both important contributors to organ damage in SLE, but socioeconomic factors play a lesser role.

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#### THE TYPE 1 & 2 SLE MODEL: THE PERSPECTIVE OF PATIENTS AND RHEUMATOLOGISTS

Megan EB Clowse\*, Jennifer Rogers, David Pisetsky, Lisa Criscione-Schreiber, Kai Sun, Jayanth Doss, Rebecca Sadun, Amanda Eudy. *Duke University, USA*

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**Background** We have proposed a new model that divides SLE manifestations into Type 1 (objective signs of inflammation) and Type 2 (generalized pain and fatigue not clearly due to inflammation). We sought the opinions of patients and rheumatologists to assess the model's face-validity based on their experience living with and/or managing SLE.

**Methods** Recorded interviews were conducted and analyzed with 42 adults with SLE and 13 rheumatologists. Patients were purposefully recruited to reflect a spectrum of active and inactive Type 1 and 2 SLE. Clinicians were intentionally selected to include leading experts in SLE and community rheumatologists.

**Results** Most patients approved of the Type 1 & 2 SLE model and several patients said it was 'spot on.' Almost all patients accurately characterized their experience with SLE as having more Type 1, 2, or Mixed symptoms based on their clinical history. One patient with predominantly Type 2 symptoms felt that she had only Type 1 disease as she believed inflammation caused her chronic pain and fatigue. Two patients had difficulty separating Type 1 and 2 symptoms, one having only experienced these together and the other feeling the categorization was 'limiting and binary.' Many patients discussed the connection between their Type 1 & 2 symptoms.

The majority of rheumatologists approved of the model. Many reported using a similar approach and found the addition of specific labels helpful. They felt it could be useful for counseling patients on symptom etiology and the expected impact of medications. Some felt applying the model in patient care could help them determine their therapeutic approach. Several rheumatologists emphasized that Type 2