

Abstract PO.7.149 Table 1

	BMI categories			
	Normal weight (N=854)	Underweight (N=76)	Pre-obese (N=427)	Obese (N=295)
EQ-5D mobility				
Level 2; Level 3	297; 5 (35.4%)	25; 1 (34.2%)	200; 1 (47.1%)	173; 1 (58.9%)
OR (95% CI)		0.95 (0.58–1.56)	1.63 (1.28–2.06)	2.63 (2.00–3.45)
P value		0.840	<0.001	<0.001
EQ-5D self-care				
Level 2; Level 3	123; 5 (15.0%)	16; 1 (22.1%)	87; 1 (20.7%)	72; 5 (26.2%)
OR (95% CI)		1.61 (0.91–2.84)	1.48 (1.09–1.99)	2.01 (1.46–2.77)
P value		0.100	0.011	<0.001
EQ-5D usual activities				
Level 2; Level 3	404; 22 (50.0%)	36; 2 (49.4%)	237; 16 (59.4%)	197; 18 (72.9%)
OR (95% CI)		0.97 (0.61–1.55)	1.46 (1.16–1.85)	2.69 (2.01–3.59)
P value		0.913	0.002	<0.001
EQ-5D pain or discomfort				
Level 2; Level 3	580; 60 (75.2%)	58; 3 (79.2%)	306; 50 (83.2%)	220; 46 (89.9%)
OR (95% CI)		1.26 (0.71–2.23)	1.63 (1.21–2.19)	2.92 (1.94–4.40)
P value		0.433	0.001	<0.001
EQ-5D anxiety or depression				
Level 2; Level 3	404; 47 (52.7%)	33; 4 (48.1%)	209; 27 (55.1%)	162; 17 (60.7%)
OR (95% CI)		0.83 (0.60–1.32)	1.10 (0.87–1.39)	1.38 (1.06–1.81)
P value		0.429	0.418	0.018

Abstract PO.7.149 Table 2

	BMI categories			
	Normal weight (N=838)	Underweight (N=72)	Pre-obese (N=432)	Obese (N=323)
EQ-5D mobility				
Level 2; Level 3	218; 5 (26.6%)	13; 2 (20.8%)	163; 5 (38.9%)	152; 0 (47.1%)
OR (95% CI)		0.75 (0.39–1.40)	1.63 (1.24–2.15)	1.82 (1.35–2.45)
P value		0.382	<0.001	<0.001
EQ-5D self-care				
Level 2; Level 3	100; 5 (12.5%)	10; 2 (16.7%)	82; 3 (19.7%)	69; 3 (22.3%)
OR (95% CI)		1.46 (0.67–2.97)	1.63 (1.14–2.33)	1.55 (1.05–2.27)
P value		0.317	0.007	0.026
EQ-5D usual activities				
Level 2; Level 3	306; 16 (38.4%)	24; 2 (36.1%)	191; 16 (47.9%)	175; 10 (57.3%)
OR (95% CI)		1.03 (0.59–1.78)	1.39 (1.07–1.80)	1.61 (1.21–2.14)
P value		0.913	0.013	0.001
EQ-5D pain or discomfort				
Level 2; Level 3	493; 46 (64.3%)	40; 4 (61.1%)	273; 29 (69.9%)	232; 34 (82.4%)
OR (95% CI)		0.80 (0.47–1.37)	1.12 (0.860–1.47)	2.07 (1.49–2.92)
P value		0.399	0.396	<0.001
EQ-5D anxiety or depression				
Level 2; Level 3	332; 40 (44.4%)	30; 4 (47.2%)	189; 17 (47.7%)	144; 25 (52.3%)
OR (95% CI)		1.34 (0.77–2.32)	1.11 (0.86–1.45)	1.29 (0.97–1.73)
P value		0.296	0.426	0.084

confidence interval (CI): 1.28–2.06; $P < 0.001$) and pain or discomfort (PD) (83.2% versus 75.2%; OR: 1.63; 95% CI: 1.21–2.19; $P = 0.001$). Proportions of patients reporting problems were greater among obese versus normal-weighted patients regarding all EQ-5D dimensions (table 1). Post-intervention, similar results were seen for both the pre-obese patients and the obese patients, in comparison with normal-weighted patients (table 2). In multivariable logistic regression analysis, obesity was associated with unfavourable HRQoL in all EQ-5D-3L dimensions at baseline ($P < 0.05$ for all), showing the strongest association with mobility (OR: 2.09; 95% CI: 1.57–2.79; $P < 0.001$), and pre-obesity with problems regarding mobility (OR: 1.42; 95% CI: 1.11–1.82; $P = 0.005$). Post-intervention, obesity was associated with problems in mobility and pain/discomfort, and pre-obesity with problems in mobility and self-care ($P < 0.05$ for all).

Conclusions Our study corroborates known associations between high BMI and HRQoL impairments. Obesity appears to negatively impact on mobility and contribute to pain despite therapy. Investigation of whether weight control can improve HRQoL in a prospective setting is warranted.

PO.7.150 EXPERIENCE OF DAILY ACTIVITIES AMONG PERSONS WITH SYSTEMIC LUPUS ERYTHEMATOSUS WITH COGNITIVE SYMPTOM

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Purpose/Objective Systemic Lupus Erythematosus (SLE) is an inflammatory systemic disease that can affect patients' ability to perform and take part in daily activities. Symptoms from the nervous system is common and include problems with cognitive functions. There is a lack of knowledge about how cognitive problems in SLE influence daily activities. The aim of this study was to investigate how persons with SLE experiencing cognitive problems perceived that these affected their daily activities and how they handled these difficulties.

Methods The study had a qualitative method approach, was an interview study and has been analyzed according to Graneheim and Lundmans method of content analysis. The method has been inductive and the analysis has been manifest.

Results Four categories could be discerned from the analysis: 1) Memory-, concentration- and learning problems affected my activities on leisure time, at work, at home and household activities for example impaired ability to read a book or to limit the amount of activities. 2) The body was experienced differently for example difficulty moving to music. 3) Emotions, fatigue and stress were affected when cognitive problems manifested in daily activities. This category describes emotions in participants, including irritation from their surroundings and participants experienced that fatigue and stress had a negative effect on cognitive problems and everyday activities. 4) Participants had made adjustments needed to be able to do what they wanted, for example they used everyday technology and performed activities in different ways than before, made changes at work, and used support from the environment, but also that they sometimes had to stop doing certain activities.

Conclusion Cognitive problems manifested themselves in the everyday life in persons with SLE. It is important that the rehabilitation recognizes the difficulties of this patient group and meets their needs. From an occupational therapy perspective, it could include improving activity ability and preventing activity loss.

PO.7.151 THE RELATIONSHIP BETWEEN HEALTH-RELATED QUALITY OF LIFE AND DISEASE ACTIVITY IN SLE PATIENTS

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Purpose Systemic lupus erythematosus (SLE) treatment has two objectives: disease activity control and damage progression prevention. These clinical aspects should be regularly measured by validated scores.

Unfortunately, these instruments do not take into account the health-related quality of life (HRQoL), often compromised

in SLE patients, even among those with mild or inactive disease. This preliminary study examines the relationship between disease activity scores and HRQoL changes in SLE patients and will then be followed by another study to evaluate whether a multidisciplinary approach (based on yoga, mindfulness and Chinese medicine), in addition to conventional medical therapy, could improve quality of life.

Methods This is a cross-sectional observational study of SLE patients in a tertiary disease-specific outpatient clinic. During clinical evaluation, for each enrolled patient, demographics, drugs, organ damage (Systemic Lupus International Collaborating Clinics Damage Index), active disease manifestations, and Systemic Lupus Disease Activity Index scores are recorded. At the same time, patients complete two questionnaires, the Short Form-36 (SF-36) and the Functional Assessment Chronic Illness Therapy-Fatigue (FACIT-F), considered as patient reported outcome scores (PRO scores).

Results Although the study is still ongoing, we are presenting preliminary data. 17 outpatients have been enrolled since January 2022 (mean age 41.7 ± 16.4 years, median duration of the disease 7.5 years). The median scores of SLEDAI-2K, SLICC-DI, SLEDAs, FACIT-F, and SF-36 (physical and mental component) are, respectively, 2 (IQR 0.5–4), 0 (IQR 0–0), 1.12 (IQR 0.28–6.88), 38.5 (28.75–46.25), 43 (IQR 36.5–51), 36 (IQR 19–50). Of the patients in our cohort, 10/17 (58.8%) met the definition of Lupus Law Disease Activity State (LLDAS), while 4/17 (23.5%) manifested an active disease.

In preliminary data analysis, there is no evidence of correlation between lower disease activity and better PRO score. The study is expected to be completed in May 2022 and the final data will be available from June 2022.

Conclusions While research has recently begun, there seems to be a discordance between physician's and patient's disease perception. SLE patients often feel misunderstood and complain that doctors do not take care of all aspects of the disease. We are sure that the multidisciplinary approach proposed at the end of the study will overcome this gap in healthcare.

PO.7.152 COMPARISON OF EDUCATIONAL NEEDS AMONG PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS AND ANCA ASSOCIATED VASCULITIS – A PILOT STUDY USING THE EDUCATIONAL NEEDS ASSESSMENT TOOL

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Purpose The aim of the study was to compare educational needs among the systemic inflammatory diseases, Systemic lupus erythematosus (SLE) and ANCA associated vasculitis (AAV) using the Educational Needs Assessment Tool (ENAT).

Method This pilot study included cross-sectional data from two separate cohorts, SLE and AAV, from the Karolinska University Hospital, Sweden. Inclusion criteria were minimum age of 18 years and literate in Swedish. Exclusion criterion was cognitive impairment interfering with literate capabilities. Participants with SLE and AAV respectively were individually matched for disease duration, sex, and education.

Educational needs were captured by patients' answers to the questionnaire ENAT. The ENAT consists of 39 questions, presented as total ENAT and seven domains ('Managing pain',

Abstract PO.7.152 Table 1 Comparison of ENAT scores (mean% of max) (SD) between patient with SLE and AAV

ENAT domain	All n=52	SLE n=26	AAV n=26	p
Managing pain	49.7 (29.7)	48.9 (28.4)	50.4 (32.0)	0.846
Movement	47.7 (33.3)	42.8 (32.1)	49.7 (34.4)	0.469
Feelings	63.5 (31.2)	54.2 (31.2)	71.9 (29.5)	0.050
Disease process	77.3 (22.0)	71.2 (22.7)	84.0 (20.0)	0.037
Treatments	60.4 (34.8)	45.8 (36.0)	74.3 (28.6)	0.010
Self-management	76.4 (20.8)	76.1 (19.6)	76.6 (22.9)	0.945
Support systems	52.9 (29.5)	46.3 (30.5)	59.7 (28.0)	0.122
Total ENAT	59.9 (23.7)	54.0 (23.1)	65.7 (23.3)	0.096

'Movement', 'Feelings', 'Disease process', 'Treatment', 'Self-management' and, 'Support systems') each containing 4–7 items (from 'not at all important' = 0, to 'extremely important' = 3). The participants responses are presented as 'mean % of the domain score' (from 0 = no to 100 = highest). For comparisons paired samples t-test were used.

Results Twenty-six matched pairs (89% female), mean (SD) disease duration 6.1 (8.4) years, were included. The mean age was 44 (13.1) years for SLE and 58.5 (16.2) years for AAV ($p=0.003$). Educational length was reported as mean 14.9 (3.3) years among SLE patients and 12.8 (2.7) years among AAV patients ($p=0.1$).

Among all patients, the mean total ENAT was generally high 59.9% (range 12.8–100%) and did not differ between the two diseases ($p = 0.1$) (Table 1). The highest education need in SLE, were 'Self-management' (76.1%) and the 'Disease process' (71.2%), and lowest educational need in SLE were found in the domains 'Movement' (mean 42.8%) and 'Treatments' (mean 45.8%). Patients with SLE reported a lower educational need compared to AAV, statistically significantly in three of the domains, 'Treatments' (74.3% vs. 45.8%, $p = 0.01$), 'Disease process' (84.0% vs. 71.2%, $p = 0.04$) and 'Feelings' (71.9% vs. 54.2%, $p = 0.05$).

Conclusions In this pilot study with SLE and AAV, educational needs regarding 'Treatments', 'Disease process' and 'Feelings' were lower in SLE compared to AAV, despite that the participants were matched for disease duration and sex, two variables previously found to be indicators of increased educational needs. Although, this study indicated lower needs in SLE compared to AAV, significant patient educational needs were identified among SLE especially concerning self-management and disease process. If other factors such as age play a role in the educational need must be explored in a larger sample with more variations in age among the participants. However, the results indicates that healthcare providers must further develop their support activities to help patients manage life with SLE based on these expressed needs.

PO.7.153 SYSTEMIC LUPUS-DERMATOMYOSITIS OVERLAPPING SYNDROME: A CASE REPORT

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Introduction About 10 to 20% of myositis are associated with other connectivitis as scleroderma, Sjogren's syndrome and systemic lupus erythematosus (SLE). Nearly 10 to 15% - with specific immunological markers are associated with cancers.