daily. The median (range) duration of treatment was 165,5 (10–432) months. Median (range) HCQ concentrations in serum were 241 (0–734) ng/mL and mean (±2SD) QTc interval was 416,8 (±50,1) ms. In total, 16 patients had QTc ≥440 ms, including one man. Of these patients, five had QTc ≥460 ms. No patient had QTc >500 ms. We found no significant correlation between serum concentrations of HCQ and QTc intervals (r = 0,175, p = 0,088) (Figure 1). In the study group, only three patients had evidence of cardiomyopathy.

Conclusion In this study, we could not detect a correlation between serum concentrations of HCQ and prolonged QTc in SLE patients. Low dose HCQ treatment in SLE appears to be safe regarding development of cardiomyopathy.

PO.3.54 ASSOCIATION OF LUPUS NEPHRITIS AND ECHOCARDIOGRAPHIC PARAMETERS

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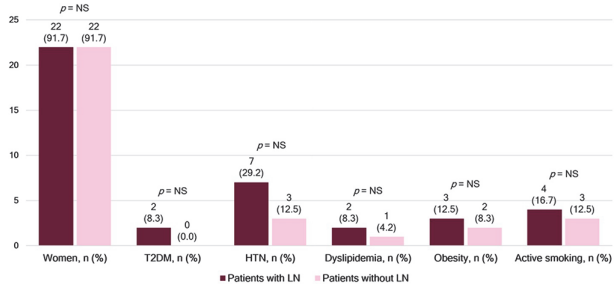
Purpose It is estimated that approximately 40% of systemic lupus erythematosus (SLE) patients develop lupus nephritis (LN) throughout the evolution of the disease. In a previous study, patients with LN had 8 times more risk of myocardial infarction and 4 times more risk of cardiovascular mortality than SLE patients without LN. Therefore, we aimed to compare the echocardiographic parameters between SLE patients with and without LN.

Methods This was a cross-sectional study nested of a SLE cohort. We recruited patients with SLE diagnosis according to the 2019 EULAR/ACR classification criteria, aged ≥ 18 years. A transthoracic echocardiogram was performed by two certified echocardiographers blinded to clinical information. Patients with LN were included and matched to patients without LN by age (± 5 years) and gender. Distribution was evaluated with the Kolmogorov-Smirnov test. Comparisons were done with Chi-square or Fisher's exact test for qualitative variables, and Student's T-test or Mann-Whitney's U-test for quantitative variables. A p-value < 0.05 was considered statistically significant.

Results A total of 48 SLE patients, 24 with LN and 24 without LN, were included. Mean age of patients with LN was 36.9 ± 10.4 years, compared to 36.5 ± 9.3 years in patients without LN, p = 0.873. There was a higher prevalence of hypertension in patients with lupus nephritis, however, the comparison was not significant. The demographic characteristics are shown in Figure 1. When comparing the echocardiographic parameters between groups, we found a significant difference in the left ventricular mass index, which was higher in LN patients (66.9 g/m2 vs 54.8 g/m2, p = 0.035). The comparisons of echocardiographic parameters between both groups are shown in Table 1.

Conclusions Patients with LN had higher left ventricular mass index than patients without LN. An increased left ventricular mass could lead to the development of ventricular hypertrophy and diastolic dysfunction, which are associated to higher cardiovascular mortality. The performance of a transthoracic echocardiogram should be considered as part of the cardiovascular evaluation of SLE patients, especially those with LN.



Abstract PO.3.54 Figure 1 Comparison of demographic characteristics between SLE patients with and without LN

Abstract PO.3.54 Table 1 Comparison of echocardiographic findings of SLE patients with and without LN

Variables	Patients with LN (n=24)	Patients without LN (n=24)	*p*-value
LV mass index, g/m^2, mean ± SD	66.9 ± 21.8	54.8 ± 16.1	**0.035**
RWT, mean ± SD	0.37 ± 0.08	0.34 ± 0.10	0.265
LV geometry abnormality, n (%)	7 (29.2)	4 (16.7)	0.303
LAESVI, ml/m^2, mean ± SD	29.72 ± 10.80	26.04 ± 8.76	0.208
LVEF, %, mean ± SD	58.16 ± 7.42	58.04 ± 7.04	0.953
LVESV, ml, median (IQR)	39.0 (26.0-54.5)	32.5 (23.7-39.7)	0.185
LVEDV, ml, mean ± SD	92.10 ± 25.09	81.57 ± 27.80	0.211

PO.3.55 ESTIMATION OF CARDIOVASCULAR RISK AMONG SLE PATIENTS: ANALYSIS FROM A MONOCENTRIC COHORT

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Purpose Systemic Lupus Erythematosus (SLE) is an heterogeneous systemic autoimmune disease. Cardiovascular (CV) involvement is one of the most important, linked to an increased morbidity and mortality. Considering only the traditional CV risk factors and scores, the real risk of CV events is underestimated. There is a growing need to elaborate new CV scores and to identify subgroups of patients with a major CV risk1.

Methods We describe our population of SLE patients, in which we analyze the distribution of traditional CV risk factors and scores using V-Cramer and Fisher's exact test p value.

We have 43 patients with CV risk factors (38 female and 5 male), with mean age of 52.69 (± 14.42) years (from 18 to 76 years old) and mean disease duration of 13 years. 32.5% of patients have a renal involvement, 55.8% a cutaneous involvement, 72% an articular involvement and 11.6% with a known cardiac involvement.

Results In our cohort 48.8% of patients was a smoker. No correlation was found between smoke and organ involvement, but there is an inverse correlation with antiphospholipid (APL) immunity (v cramer 0.44, fisher's exact test p value 0.005): 75% of patients with APL immunity do not smoke. No correlation was found between dyslipidemia or hypertension and organ involvement, duration of steroid-therapy major of 5 years or CV events, instead there is a correlation between diabetes mellitus and cardiac involvement (V cramer 0.47, Fisher's exact test p-value 0.03). We also analyzed the distribution of Modified Framingham' score and QRisk3 score, but no correlation with organ involvement or CV events was found.

Conclusions Our analysis confirm that considering only traditional CV risk factors is not adequate to estimate real CV risk among SLE patients and that there is a lack of suitable scores. In our department, we have decided to refer our patients to a team of specialized cardiologists in order to identify patients with an increased CV risk and to perform a tight follow – up.

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PO.3.56 ANTI- RO/SSA ANTIBODIES AND ELECTROCARDIOGRAPHIC ABNORMALITIES IN SLE PATIENTS: PRELIMINARY DATA OF A MULTIDISCIPLINARY STUDY IN A MONOCENTRIC COHORT

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Purpose Cardiovascular involvement is common in patients with systemic lupus erythematosus (SLE) and changes in heart rhythm are frequent in addition to the manifestations included in the classification criteria (2019 ACR/EULAR). QTc-interval prolongation is a risk factors for serious adverse events and sudden cardiac death. Previous studies have identified specific therapy (e.g. hydroxychloroquine) and anti-Ro/SSA antibodies as risk factors.[1] The aim of our study is to estimate the prevalence of QTc prolongation in a monocentric cohort and to evaluate possible correlation with autoantibodies and therapies.

Methods An electrocardiographic study (ECG) was proposed to patients affected by SLE consecutively attending our Lupus Clinic from November 2021 to March 2022. All subjects were tested for anti-Ro/SSA antibodies. Exclusion criteria were: severe valvulopathies, hypertrophic or dilated cardiomyopathy, previous pacemaker or implantable cardioverter-defibrillators implants. QTc measurement was calculated using the Bazett's formula and prolongation was defined according to American Heart Association/American college of Cardiology recommendations (QTc>470 ms for males, QTc>480 ms for females).[2] Quantitative variables were compared with T-test.

Results From November 2021 to March 2022, 120/137 (87.56%) patients with SLE consecutively seen in the clinic, accepted to undergo an ECG : 109 females (90.8%), 11 (9.2%) males; 106 (88.3%) Caucasians (median age 53.2 [IQR 42.3–58.7], median disease duration 20.0 years [12.0–28.2]). Fifty-four (45%) patients were positive for anti-Ro/SSA antibodies. Median QTc was 408.4 [IQR 389.1–428.3] ms and only 2/120 (1.7%) had a prolonged QTc (one female anti-Ro/SSA negative and one female anti-Ro/SSA positive with respectively a QTc of 488 ms and 492 ms). Comparing QTc of anti-Ro/SSA positive patients to those of anti-Ro/SSA negative patients no statistical difference was observed (409.0 [390.1–427.2] ms vs 407.0 [389.2–430.4] ms; p=0,7907). Various other electrocardiographic alterations were found: 3 (2.5%) 1st degree atrioventricular block, 15 (12.5%) bundle branch blocks BBB (13 right BBB and 2 left BBB), 32 (26.7%) repolarization anomalies, 1 (1.0%) Wolff Parkinson White; none of these patients had a QTc prolongation.

Conclusions The preliminary results of this study show a lower prevalence of QTc prolongation compared to previous studies [1]with no differences between anti-Ro/SSA positive and anti-Ro/SSA negative patients. Further details will be available with data from 24hours ECG and a better characterization of anti-Ro/SSA antibodies (isotypes and titers).

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PO.3.57 CORRELATION BETWEEN DISEASE ACTIVITY AND ECHOCARDIOGRAPHIC PARAMETERS IN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS

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Purpose Patients with systemic lupus erythematosus (SLE) have an increased risk of developing a cardiovascular event than the general population, due to immunological factors and a systemic inflammatory state. We aimed to evaluate the association of the Systemic Lupus Erythematosus Disease Activity Index (SLEDAI) and echocardiographic parameters in SLE patients.

Methods This was a cross-sectional study. We recruited a total of 67 patients with SLE diagnosis according to the 2019 EULAR/ACR classification criteria, aged ≥18 years. Patients with a previous cardiovascular event (myocardial infarction, stroke or peripheral artery disease), another connective tissue

Abstract PO.3.57 Table 1 Demographic and clinical characteristics

Characteristics	SLE patients (n=67)
Age, years, median (IQR)	37.0 (24.0-42.0)
Women, n (%)	60 (89.6)
T2DM, n (%)	3 (4.5)
Hypertension, n (%)	14 (20.9)
Dyslipidemia, n (%)	4 (6.0)
Obesity, n (%)	9 (13.4)
Active smoking, n (%)	8 (11.9)
Disease duration, months, median (IQR)	72.0 (28.0-120.0)
SLEDAI, median (IQR)	8.0 (4.0-12.0)
Hydroxychloroquine, n (%)	59 (88.1)
Glucocorticoids, n (%)	54 (80.6)
LV mass index, g/m^2, median (IQR)	60.14 (47.69-77.77)
E/e', median (IQR)	6.58 (5.80-8.45)
LAVI, ml/m^2, median (IQR)	26.46 (20.71-31.26)
LVEF, %, mean ± SD	57.86 ± 6.76
GLS, %, mean ± SD	-18.97 ± 3.30
TAPSE, mm, median (IQR)	22.0 (20.0-24.0)

SLE, systemic lupus erythematosus; T2DM, type 2 diabetes mellitus; SLEDAI, Systemic Lupus Erythematosus Disease Activity Index; LV, left ventricular; E/e', the ratio between early mitral inflow velocity and mitral annular early diastolic velocity; LAVI, left atrial volume index; left ventricular ejection fraction; GLS, global longitudinal strain; TAPSE, tricuspid annular plane systolic excursion.