**AB0565**  
**CHANGES IN HEALTH RELATED QUALITY OF LIFE IN RENAISSANCE COHORT OF RUSSIAN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS**  

E. Aseeva, L. Vorobyova, S. Soloviev, G. Kollubaeva, S. Glukhova. **Intensive care department, V.A. Nasonova Research Institute of Rheumatology, Moscow, Russian Federation; **Rheumatology department, National Center of Cardiology and Internal Medicine named after Academician M. Mirrakhimov, Bishkek, Kyrgyzstan

**Background:** The Lupus Quality of Life (LupusQol) is recommended to assess health related quality of life (HRQOL) in systemic lupus erythematous (SLE).

**Objectives:** The aim of the current study was to assess HRQOL in the first year observation in cohort of patients with systemic lupus erythematous in Russian Federation (RENAISSANCE).

**Methods:** The LupusQol-Russian was administered to a cohort of 128 Russian patients affected with SLE at baseline and follow up visit (in 12 months). Disease activity was evaluated by the SLE disease activity Index-2000 (SLDAI-2K), and chronic damage by the Systemic Lupus International Collaborating Clinics Damage Index score (SDI) at baseline and follow up visit.

**Results:** 128 patients (118 (92%) women; aged 33,02±11,04 years, mean disease duration 100,0±84,3 months) were included. Mean SLDAI 2K was 10,4±11,6, mean SDI = 1.3±1.6, mean daily prednisolone 16.8±10.9 mg/day).

**Conclusions:** The LupusQol-Russian is sensitive to change in SLE patients with active SLE. The HRQOL correlated with disease activity, daily prednisolone and biologic.

**Disclosure of Interest:** None declared


---

**Abstract AB0565 – Table 1. Characteristics of the patients included in the study**

<table>
<thead>
<tr>
<th>LupusQol domains</th>
<th>Baseline, mean ±SD</th>
<th>12 month, mean ±SD</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health</td>
<td>63,5±42,03</td>
<td>66,7±23,09</td>
<td>0,004</td>
</tr>
<tr>
<td>Pain</td>
<td>67,4±25,10</td>
<td>73,6±24,27</td>
<td>0,002</td>
</tr>
<tr>
<td>Planning</td>
<td>61,3±28,70</td>
<td>67,3±27,11</td>
<td>0,008</td>
</tr>
<tr>
<td>Intimate</td>
<td>64,9±35,60</td>
<td>72,5±29,58</td>
<td>0,01</td>
</tr>
<tr>
<td>relationship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burden to others</td>
<td>53,0±27,78</td>
<td>57,3±29,62</td>
<td>0,04</td>
</tr>
<tr>
<td>Emotional health</td>
<td>63,1±22,02</td>
<td>67,6±19,99</td>
<td>0,01</td>
</tr>
<tr>
<td>Body image</td>
<td>58,3±29,45</td>
<td>69,4±23,01</td>
<td>0,003</td>
</tr>
<tr>
<td>Fatigue</td>
<td>59,8±24,66</td>
<td>65,6±22,95</td>
<td>0,006</td>
</tr>
</tbody>
</table>

**AB0566**  
**ANTI-PHOSPHOLIPID ANTIBODIES SERO-NEGATIVIZATION IN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS TREATED WITH BELIMUMAB**  

E. Rubini, M. Radin, I. Cecchi, D. Roccaccio, S. Sciascia. **Università Degli Studi di Torino, Turin, Italy**

**Background:** Belimumab is a monoclonal antibody that blocks the B lymphocyte stimulus, preventing it to bind its receptor on B-lymphocyte’s surface, thus avoiding B cell activation. Despite some benefits showed in murine models of anti phospholipid syndrome (APS), the use of belimumab in this condition needs further investigation.

**Objectives:** To investigate changes in the antiphospholipid antibodies (aPL) profile in Systemic Lupus Erythematosus (SLE) patients treated with belimumab.

**Methods:** We retrospectively collected data from patients who attended the S. Giovanni Bosco Hospital, Turin, Italy. Inclusion criteria comprised: a) fulfilled ACR criteria for SLE, b) persistent aPL positivity (confirmed ≥3 occasions over a time >24 months before belimumab treatment), c) previous or ongoing belimumab therapy.

**Results:** This retrospective study involved 3 patients with diagnosis of SLE (median age 39(range 33–51), male:female 2:1). Table 1 resumes the characteristics of patients. All 3 patients received belimumab because of SLE flares. Before the treatment, Patient#1, classified as SAPS, presented a persistent triple positivity for lupus anticoagulant (LA), high-titer aCL IgG isotype (>200 GPL) and anti-β2Gcprotein 1 antibodies (>50 GPL) (anti-β2GPI) IgG isotype. Patient#2 was persistently positive for IgG aCL and IgM anti-β2GPI (both 20–30 GPL and MPL, respectively; cut-off >7U), and had a history of pregnancy morbidity. Patient#3, classified as SAPS, presented positivity of LA and IgG aCL (10–20 GPL).

After 12 months since belimumab was started, a marked reduction of aPL was noticed, as follows. Patient#1 became negative for antiβ2GPI, while his aCL titre significantly decreased. Anti-β2GPI and aCL both turned negative in Patient#2. After being on belimumab for one year, she planned a pregnancy and she stopped the treatment; after 8 months since suspension, IgG anti-β2GPI antibodies were detectable (cut-off >3.5 U). Patient#3 was persistently negative for aCL while being on belimumab. When he discontinued the therapy, IgG aCL antibodies returned positive. Figure 1 illustrates aPL titres of the 3 patients in relationship with belimumab therapy.

**Disclosures:** Despite its limitations, this pilot study is the first report of aPL negativization after starting therapy with belimumab. The clinical relevance of these findings should be investigated in prospective multicenter studies.

**References:**


Objectives: To determine the relationship between vitamin D levels and disease activity in SLE patients.

Methods: It is a prospective, cross-sectional study, in all patients who attended the rheumatology clinic of the Hospital Docente Padre Billini in the period August–October 2017, where the levels of vitamin D and activity of the disease were measured with SELENA-SLEDAI (≤3 without activity, 3–12 moderate activity, >12 high activity). Vitamin D deficiency is defined as serum levels of 25 (OH) D <10 ng/ml, insufficiency levels serum levels of 25 (OH) D of <30 ng/ml.

Results: 45 patients who met criteria SLE SLCIC 2012 were included, 97.7% (44) were women. The most frequent age range was 31–45 years, 24.4% (11) had decreased calcium levels. The vitamin D values were insufficient in 77.7% (35) of the patients and deficient in 4.4% (2) according to SELENA-SLEDAI 77.7% (35) had no activity of the disease, 20% (9) had moderate activity and 2.2% (1) had

Vaccines provide long lasting protective immunity against microbial pathogens and prevent clinically relevant infections. Recommended vaccinations in SLE patients include H. Influenza, Pneumococcal, Hepatitis A and B, and Human Papilloma Virus (HPV). Influenza vaccines are given annually and a Pneumococcal booster dose is given at 5 years following the initial vaccine.

Objectives: To assess whether, in routine clinical practise, patients with SLE are immunised against preventable disease according to EULAR recommendations and to assess the level of patient awareness.

Methods: A questionnaire was designed to assess the degree of compliance with current recommendations adapted from the EULAR-recommended vaccinations in patients with autoimmune inflammatory rheumatic diseases on DMARD therapy. The questionnaire enquired into the awareness and uptake of the influenza B, pneumococcal and hepatitis B vaccines. They were sent out by postal mail, with an enclosed stamped address envelope, to all SLE patients within the university hospitals of Leicester (UHL) NHS trust identified via the rheumatology patient database. Questions included awareness of the need to have vaccinations whilst on DMARDs. The audit was conducted over a three month period and the results were compiled in Microsoft excel.

Results: Of the 396 SLE patients within UHL, 86 responded. Among the patients studied 38% were on DMARD therapy, an equal proportion claimed they were not and 23% were unclear if they were on DMARD therapy. Approximately 65% were unaware of the need for vaccinations and only 27.9% acknowledged awareness for the need of the 3 vaccines mentioned above. Fifty-six (60%) patients had the influenza vaccine yet only 26 (28%) and 15 (21.8%) had the Pneumococcal and Hepatitis vaccines respectively.

Conclusions: The increased infection rate in SLE can be reduced through vaccination. This highlights the importance of increasing both physician and patient awareness. Although the sample size was small, the above audit has revealed that current local practice, with regards to ensuring that all SLE patients are appropriately vaccinated, requires improvement. This can be achieved through patient and healthcare worker education, and also creating a checklist that can be added to the clinic notes. Working together with our primary care colleagues will also help bridge the divide between compliance and non-compliance. Such measures will aim to improve mortality and morbidity in SLE patients.

REFERENCES: