erythema multiforme-like (EM) lesions, positive speckled ANA, RF and Anti-SJT antibody, later known as anti Ro/La antibodies. In 2000, Zeitouni et al extended the definition by including all types of systemic lupus erythematosus (SLE) and proposed major and minor criteria, while in 2012 Torchia et al proposed another set of criteria defining Rowell syndrome as a distinct subtype of chronic cutaneous lupus. To date, Rowell syndrome as a distinct entity remains in question.

Objectives: To establish whether patients with clinically suggestive Rowell syndrome, meet the proposed criteria and form a distinct SLE subgroup.

Methods: A retrospective study which included SLE patients who associated EM-like lesions was carried out in the Rheumatology Department Cluj-Napoca, between 2008 and 2019. Clinical, immunological and histopathological parameters were recorded.

Results: Among 200 patients who fulfilled the 2012 SLICC criteria, 12 patients with target lesions, resembling EM, were identified. Four patients were excluded: 3 were not fully investigated and 1 was *My. pneumoniae* positive, thus 8 patients were studied. The majority of patients (87.5%) developed the cutaneous lesions after diagnosis. In all cases, the erythematous maculopapular rash with targetoid aspect was present, with poorly defined borders and a dusky center and a diameter between 2 to 6 cm. The lesions extended to the trunk and limbs, sparing the acral and mucosal areas. Five patients associated pruritus. The lesions could not be linked to any viral or bacterial infection in any of the cases. With regard to drug allergies, a link with AZA and HCQ was suspected in three patients – which was infirmed.

The majority of patients (87.5%) had negative anti-ds DNA, 87.5% presented speckled pattern ANA, one patient exhibited ANA rods and rings pattern, with a negative serology for B and C hepatitis and no antiviral therapy. Of note, 25% had positive rheumatoid factor, 87.5% had positive anti-Ro antibody and 37.5% of patients exhibited chilblains.

The first three classifications were tested on all patients: 25% met Rowell's criteria, 12.5% met Lee's criteria and 87.5% met Zeitouni's criteria, with only 1 patient meeting all 3, and 1 patient meeting none of them.

In the cases in which the SLE etiology of the lesion was in question from a clinical point of view, a biopsy was performed. In one case the histopathological examination described lymphocytic infiltrates and few eosinophils in the dermis, suggestive of drug allergy. Interestingly, this patient met all 3 classification criteria. Another report described thin epidermis, parakeratosis, dyskeratosis and spongiosis with dermis and perivascular lymphocytic infiltrate- findings highly suggestive for EM; this report belonged to the patient who met neither of the 3 classifications, but who associated a rods and rings ANA pattern. The third histopathological report was inconclusive.

Conclusion: Our study shows that patients with suspected clinical, immunological or histological Rowell syndrome do not meet all studied classifications criteria. Furthermore, studied classifications are incongruent. Should Rowell syndrome be a distinct entity it would most certainly be a very rare one. Further study is needed to better frame LES and EM.

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AB0565

EXPERIENCE IN THE USUAL PRACTICE OF PATIENTS WITH INFLAMMATORY MYOPATHIES AT THE DONOSTIA UNIVERSITY HOSPITAL

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Background: Inflammatory myopathies (IM) are a heterogeneous group of acquired diseases, characterized by the presence of muscle weakness and inflammation. This group includes idiopathic polymyositis (PM), idiopathic dermatomyositis (DM), PM/DM associated with neoplasia, associated with rheumatic autoimmune diseases, juvenile PM/DM, inclusion body myositis (MCI) and immunomediated necrotizing myopathies (IMNM).

Objectives: Inflammatory myopathies (IM) are a heterogeneous group of acquired diseases, characterized by the presence of muscle weakness and inflammation. This group includes idiopathic polymyositis (PM), idiopathic dermatomyositis (DM), PM/DM associated with neoplasia,

associated with rheumatic autoimmune diseases, juvenile PM/DM, inclusion body myositis (MCI) and immunomediated necrotizing myopathies (IMNM).

Methods: A retrospective search of all patients assessed in the service diagnosed with IM was performed. The computerized medical records were reviewed. The variables collected were: sex, age, underlying disease and immunosuppressive and biological treatments used, antibodies, and complementary tests. The immunosuppressant sought were methotrexate (MTX), azathioprine (AZA), hydroxychloroquine (HCQ), tacrolimus, mycophenolate (MMF), cyclophosphamide (CFM), cyclosporine (CsA), chloroquine; intravenous immunoglobulins (IVIG), rituximab (RTX). The quantitative variables are shown with the median and interquartile range; the qualitative ones are shown with the absolute value and its percentage

Results: 42 patients were found diagnosed with IM; the average age of diagnosis was 54 years, with a predominance of women with 71.4%. Table 1 shows the clinical characteristics, complementary tests and treatments used in these patients. The registered deaths were 8 (19%); of which 6 (75%) were related to their cancer, one patient with IM with pulmonary involvement died in the context of a respiratory infection at 91 years of age, and the other patient in the context of a bowel obstruction with 87 years of age. Two (4.7%) patients presented an overlap syndrome, one with scleroderma and the other with systemic lupus erythematosus. The median CPK was higher at the time of diagnosis in patients in the IM group with pulmonary involvement. We also observed a greater involvement of the swallowing muscles, 7 (16%) in patients with IM associated with malignancy, and those who were more associated in the initial IVIG treatment, 9 (21%). The mean follow-up time of these patients is 94 months. The most widely used immunosuppressant drug was MTX 76%; followed by 50% IVIG and 38% AZA; among those who maintain current treatment the most used is MTX 28% second of RTX 17%.

Conclusion: Despite the fact that IM are a serious disease, more than 80% of patients continue to follow up, IM presented more aggressively in IM patients associated with malignancy, and presented less aggressively in patients diagnosed at the juvenile age. In 40% of the patients, no specific antibody was found; possibly due to the fact that most of these patients were diagnosed more than 7 years ago, where the antibody pool was much more restricted than today's

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AB0566

POLYAUTOIMMUNITY AND MAJOR ORGAN INVOLVEMENT PREVALENCE IN SJÖGREN'S SYNDROME: THYROID, LIVER, LUNG AND KIDNEY AS TARGETS. A SINGLE CENTER CROSS SECTIONAL STUDY

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Background: Polyautoimmunity has been described to be associated with primary Sjögren's syndrome (SjS) and the most frequent observed associated autoimmune diseases (AID) are autoimmune thyroid disease, autoimmune hepatitis and primary biliary cirrhosis, which are common organ-specific AID. In the same track, renal and lung involvement has increasingly been documented in SjS further highlighting its systemic nature.

Objectives: To describe and classify prevalence of polyautoimmunity and major organ involvement in a primary SjS-cohort.

Methods: This cross-sectional study included 179 patients [160 (89%) females and 19 (11%) males] diagnosed with primary SjS and fulfilling the ACR classification criteria (1) that had been admitted to our outpatient clinic between December 2008 and December 2018. Demographic and disease-specific characteristics were recorded in all patients.

Results: In our cohort the median age at diagnosis was 57 years (range: 20-85). Thyroid AID was found in 55/179 (30%) patients, with the following distribution: Hashimoto thyroiditis without (n=21) and with hypothyroidism (n=22), Graves's disease without (n=4) and with thyroidectomy (n=8). Liver AID was detected in 8/179 patients (4%), 3 patients with autoimmune hepatitis and 5 patients with primary biliary cirrhosis. Regarding major organ involvement, 20/179 (11%) patients had renal manifestations: renal insufficiency (n=12), glomerulonephritis (n= 3), interstitial nephritis (n=2) and IgA nephritis (n=3). Eight/179 (4%) patients had lung manifestations: interstitial fibrosis (n=6), emphysema (n=1) and chronic obstructive pulmonary disease (n=1).

Conclusion: Our results add evidence for the presence of polyautoimmunity and major organ involvement in SjS. We found a slightly lower prevalence of polyautoimmunity and major organ involvement compared to recently reported data (2). Nonetheless, extra-glandular organ involvement should be assessed in order to elucidate cumulative damage and how it might impact outcome, prognosis and therapeutic approaches in SjS.

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AB0567 DISEASE PATTERN IN EARLY AND NON-EARLY SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: Systemic lupus erythematosus (SLE) is an autoimmune disease with a high degree of variability at onset, creating challenges in the accurate estimation of its pattern in early stages¹.

Objectives: To evaluate the pattern of the disease in patients with early and non-early systemic lupus erythematosus from physician's perspective.

Methods: Performed case-control study included SLE patients that fulfilled SLICC classification criteria, 2012. The research included two groups: patients with early SLE – 1st group (disease duration ≤24 months) and non-early SLE – 2nd group (disease duration ≥24 months). The pattern of the disease activity was assessed by SLEDAI-2K, SLAM, PGA and PhGA for SLE activity, SLICC/ACR DI for disease irreversible changes and SF-8 for the quality of life (QoL). We correlated disease activity scores within groups and activity indices with the QoL using intra- and inter-class correlation coefficients

Results: A total of 101 SLE patients was analyzed. First group (early SLE) included 34 patients while the second group (non-early SLE) included 67 patients. The disease duration ± SD (range) was 12,42±8,70 (0.1-24) and 146,41±81,64 (31-432) months, respectively. The disease activity was high in both groups. The QoL was appreciated as low, compared to general population, by both components, in 2 groups. The damage index was higher in the 2nd group, which can be explained by longer disease duration and development of irreversible changes during the course of lupus.

The PhGA showed stronger and higher correlation with disease activity and QoL in patients with longer disease duration. These can be explained by the more accurate assessment of patients that have longer disease duration, while the unpredictable evolution and the assessment of early SLE is being challenging for the physician. Also, physician's judgment was influenced by the presence of irreversible organ damage in patient with longer disease, while in early disease course they were concerned mostly about disease activity.

Conclusion: The clinical picture of SLE was characterized by high disease activity and low QoL in both, early and non-early lupus, while occurrence of irreversible organ changes was more characteristic for the longer disease. The disease parameters (activity, damage and QoL) correlated with PhGA mostly in patients with non-early SLE, the appreciation of the disease pattern being challenging in the early disease course.

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Table 1. General characteristic of the study group

Parameters of the disease	Gr I, Nr 34	Gr II, Nr 67	p
SLAM ± SD (range), points	7,47±4,40 (0-24)	7,31±4,10 (1-19)	>0,05
SLEDAI ± SD (range), points	7,02±4,16 (0-17)	6,26±4,43 (0-18)	>0,05
PhGA ± SD (range), points	45,61±19,45 (10-82)	48,35±19,50 (5-82)	>0,05
PGA± SD (range), points	46,97±19,39 (10-93)	47,98±22,41 (5-90)	>0,05
SLICC/ACR DI	0,23±0,43 (0-1)	1,07±1,29 (0-5)	<0,001
SF-8 ± SD, points	38,79±10,60 41,80	36,76±10,33	>0,05
PCS (physical component status)	±10,83	41,97±10,47	>0,05
MCS (mental component status)			

Table 2. Correlation of PhGA with other SLE parameters

	Early SLE group PhGA (correlation coefficient r)	Non-early SLE group PhGA (correlation coefficient r)
PGA	0,86*	0,81*
SLAM	0,48***	0,60*
SLEDAI	0,20	0,50*
SF-8 PCS	0,56*	0,54*
SF-8 MCS	0,41**	0,50*
SLICC/ACR DI	0,12	0,37**

*<0,001 **<0,01 ***<0,05

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AB0568 THE EFFECT OF DEPRESSIVE AND ANXIETY ON QUALITY OF LIFE IN PATIENT WITH SYSTEMIC LUPUS ERYTHEMATOSUS IN RENAISSANCE COHORT

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Background: Systemic lupus erythematosus (SLE) patients are at high risk of depression and anxiety. These two states cause severe loss of health related quality of life (HRQoL) for patient with SLE.

Objectives: The aim of the current study was to assess the effect of depressive and anxiety on HRQoL in a cohort of patients with systemic lupus erythematosus in Russian Federation (RENAISSANCE).

Methods: Consecutive patients who fulfilled SLICC 2012 criteria for SLE were recruited. Depressive and anxiety symptoms were assessed by the Hospital Anxiety and Depression (HAD) scale (0-21 points). Health-related quality of life (HRQoL) was assessed by the validated specific questionnaires LupusQoL-Russian. Disease activity was evaluated by the SLEDAI-2K, and chronic damage by the Systemic Lupus International Collaborating Clinics Damage Index score (SDI).

Results: 328 Russian SLE patients were enrolled in the study (M/F 30/298, mean age 34.4±11.5 years, mean disease duration 106.3±97.9 months; mean SLEDAI 2K 9.6±8.0; mean SDI 0.2±0.6. 34 (10,3%) patients had HADS-depression score of ≥10 and 76 (23,1%) of patients had HADS-anxiety score of ≥10. Patients with depressive score of ≥10 had significantly lower the scales "Planning", "Emotion health" and "Fatigue" (p<0,0001) of the LupusQoL than those with score <10. Similarly, significant lower "Emotion health" and "Fatigue" (p<0,0001) were noted in those patients with HAD-anxiety score ≥10 compared to those <10 and they also had low score of "Burden to others" unlike those who are not anxiety. (Table 1).

Conclusion: Depressive and anxiety symptoms in SLE patients and were associated with significantly poorer HRQoL.

Table 1. Effect of anxiety and depressive on HRQoL in SLE patient

LupusQoL domains	HADS-anxiety<10	HADS-anxiety ≥10	p	HADS – depressive<10	HADS-depressive ≥10	p
Physical health	70,3±22,2	50,2 ±21,2	<0,0001	67,9±23,1	48,2±18,7	<0,0001
Pain	73,8±23,3	52±22,3	<0,0001	71,2±23,8	50,7±26,9	<0,0001
Planning	68,4±26,8	42,8 ±26,3	<0,0001	65,8±21,2	35,3±21,2	<0,0001
Intimate relationship	75,9±30,6	56,7 ±29,8	<0,0001	73,2±31,1	58,3±33,6	0,05