Table 2. Type of flare after IS discontinuation in 105 SLE remitted patients.

Type of flare	Number (%)	Severe flare, number (% of all flares)
Arthritis	5 (19.2)	2 (7.7)
Skin manifestations	6 (23.1)	1 (3.9)
Serosal involvement	2 (7.7)	0
Haematological involvement	5 (19.2)	2 (7.7)
Lupus nephritis	8 (30.8)	8 (30.8)
Total	26	13 (50)

Conclusion: In our SLE cohort, the withdrawal of IS therapy in remitted patients did not seem to influence damage progression in the medium-term.

Disclosure of Interests: : None declared

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OP0248

THE IMPACT OF EXERCISE ON HAND FUNCTION AND QUALITY OF LIFE OF PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS: A RANDOMIZED CONTROLLED TRIAL

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Background: Systemic Lupus Erythematosus (SLE) has a significant impact on the ability to perform daily activities and patients' quality of life. To date, no studies have examined the effect of exercise on hand function and quality of life of SLE patients.

Objectives: To determine the effect of exercise on hand strength, dexterity and performance of daily activities, and the quality of life of SLE patients.

Methods: A randomized, 24-week follow-up trial was designed. A total of 240 consecutive SLE patients fulfilling the SLICC classification criteria were evaluated. Sixty two patients who met the inclusion criteria [age > 18 years, upper limb arthralgias, DASH (Disabilities of the Arm, Shoulder, and Hand) score > 10 and stable drug regimen for ≥ 3 months], were randomly assigned to the exercise group (n=32) or the routine care (control) group (n=30).

Patients in the exercise group received by the hand therapist a 30 min daily program at home of strengthening and stretching upper limb exercises for 12 weeks. Performance of daily activities was evaluated with the DASH and HAQ questionnaires, the grip and pinch strength with the Jamar dynamometer and pinch gauge tools respectively, the dexterity with the Purdue pegboard test, and the quality of life with the LUPUSQoL questionnaire, at 0, 6, 12 (end of the exercise program) and 24 weeks for both groups. SLE activity and cumulative organ damage were evaluated with the SLEDAI and SLICC/ACR-DI, respectively.

Results: There were no statistically significant differences between two groups in age (p=0.062), sex (p=0.346), disease duration (p=0.065), SLEDAI (p=0.937), SLICC/ACR-DI (p=0.242), number of tender joints (p=0.703), and use of corticosteroids (p=0.640), hydroxychloroquine (p=0.985) or immunosuppressives (p=0.806). Thirty patients (93.75%) from the exercise group completed the 12-week exercise program and 28 (87.5%) were re-evaluated at 24 weeks; 30 patients (100%) of control group completed the 24-week study.

The percent changes of DASH and HAQ scores were significantly lower (improvement) in the exercise group compared to control group at all-time points. Moreover, all percent changes of grip strength, pinch strength hand dexterity and the LupusQoL score were significantly higher in the exercise group compared to control group at all-time points (Table 1).

Table 1. Comparison between groups of percent changes from baseline to 6, 12 and 24 weeks for all parameters.

	Evaluation time (weeks)	Exercise Group	Control Group	P-value
DASH score	6	-33.7 (28.4)	-1.3 (33.8)	<0.001
	12	-43.4 (31.5)	-11.2 (34.5)	<0.001
	24	-51.9 (47.8)	-7.1 (54.1)	<0.001
HAQ score	6	-20 (49.8)	49.77 (39.9)	0.013
	12	-55 (70.4)	-9.72 (42.2)	<0.001
	24	-69.8 (56.3)	-9.13 (60.4)	<0.001
Grip strength (DH)	6	9.9 (32.8)	2.39 (35.5)	0.044
	12	20.9 (43.4)	4.10 (30.2)	<0.001
	24	23.1 (41)	13.51 (36.8)	0.020

Pinch strength (JAW)	6	17.2 (50)	5.98 (37.4)	0.049
	12	27.1 (55.8)	0 (48.5)	0.002
Dexterity (COM)	24	34.2 (57.6)	2.04 (56.7)	<0.001
	6	17.4 (19.4)	0 (18.6)	<0.001
LUPUSQoL score (PH)	12	23.6 (32)	3.13 (31.1)	0.004
	24	22.2 (30.3)	9.55 (22.5)	0.003
	6	9.5 (49.9)	-5.62 (30.5)	0.010
	12	32.5 (53.8)	5.59 (28.4)	<0.001
	24	28.6 (74.8)	2.38 (48.8)	0.002

All values are presented as median (interquartile range). DASH=Disabilities of the Arm, Shoulder, and Hand, HAQ=Health Assessment Questionnaire, LUPUS-QoL=Lupus Quality of Life, PH=physical health domain, DH=dominant hand, JAW=tripoid pinch, COM=combination.

Conclusion: Upper limb exercise, significantly improves hand function and quality of life in SLE patients.

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OP0249

ANTIPHOSPHOLIPID SYNDROME (APS) IN SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) LEADS TO A MORE SEVERE DISEASE

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Background: Antiphospholipid antibodies (aPL) have been associated with organ damage and certain features in SLE patients.

Objectives: Our aim was to investigate the differences between SLE patients according to the presence of aPL and/or clinical antiphospholipid syndrome.

Methods: Patients from the RELESSER-T registry were included. RELESSER-T is a multicenter, hospital-based registry, with retrospective cross-sectional collection of data from a large representative sample of adult non-selected patients with SLE attending Spanish rheumatology services from the public national health system.

Results: We included 3651 SLE patients and 1368 were positive for aPL (44.9% of patients were positive for anticardiolipin antibodies, 27.3% showed positivity for anti b2glycoprotein I and 24% for lupus anticoagulant). Overall 2283 patients were classified as SLE no aPL, 528 as SLE-APS and 840 as SLE-aPL. Demographic data, clinical and laboratory features in the different groups are showed in **Table 1**. Regarding cardiovascular risk factors, SLE-APS patients had higher rates of hypertension, dyslipidemia and diabetes than SLE-aPL and SLE no aPL patients ($p < 0.001$, $p < 0.001$ and $p = 0.022$, respectively). SLE-APS patients showed a lower prevalence of photosensitivity and higher frequencies of serositis, proteinuria (>0.5 grs), urinary cell casts, seizures and psychosis ($p \leq 0.001$). Overall, SLE-APS patients showed a lower rate of cutaneous manifestations and higher rates of neuropsychiatric, cardiac, pulmonary, renal, joint and ophthalmological manifestations (**Table 1**). In accordance with a more severe clinical profile, higher frequency of anti-DNA antibodies and hypocomplementemia were observed in the SLE-APS group ($p < 0.001$). In addition to a higher disease activity (SLEDAI), SLE APS patients presented more damage accrual with higher values in SLICC (1.9±2.2 in SLE APS, 0.9±1.4 in SLE aPL and 1.1±1.6, $p < 0.001$) and Katz indexes (3±1.8 in SLE APS, 2.7±1.7 in SLE aPL and 2.6±1.6 in SLE no aPL, $p < 0.001$).