A PHQ-2 score ≥ 3 points has a sensitivity of 87% and a specificity of 78% for detecting a major depressive disorder compared to a structured clinical interview. [3] A positive screening result was either addressed during subsequent medical consultation or by notifying the patient's general practitioner. The PHQ-2 is a short form of the PHQ-9 which previously had been validated in rheumatoid arthritis. [4].

Results: Overall, 26% of patients stated depressive symptoms (PHQ score ≥ 3). Table 1 shows the prevalence of depressive symptoms by disease entity which was not significantly different among the subgroups ($\chi^2(5)=6$, $p=0.3$). However, given our results indicating depressiveness to be common across subgroups, all of these patients merit further evaluation. The PHQ-2 was widely accepted by patients, and seemed very feasible due to its concise form.

	Age				PHQ-2				PHQ-2 ≥ 3	
	Mean	Median	N	SD	Mean	Median	N	SD	N	%
Rheumatoid Arthritis, RF+	62.1	61.0	169	11.9	1.7	2.0	169	1.4	37	22
Rheumatoid Arthritis, RF-	63.1	64.0	51	13.7	1.9	2.0	51	1.7	16	31
Psoriatic Arthritis	54.6	55.0	59	11.4	1.5	1.0	59	1.4	11	19
Ankylosing Spondylitis	47.7	48.0	47	13.0	1.7	2.0	47	1.6	13	28
Various rheumatic diseases *	60.0	63.0	82	14.8	2.0	2.0	82	1.6	25	30
Not diagnosed yet/initial assessment	55.8	55.0	77	17.8	1.9	2.0	77	1.7	24	31

* Polymyalgia, Connective tissue diseases, and other.

Conclusion: The PHQ-2 questionnaire is a highly feasible and well accepted tool in routine clinical practice, helping to screen for depressive symptoms as a highly prevalent condition across rheumatic diseases. Real world evidence of depressive symptoms may improve healthcare by shedding light on the patients' mental well-being and comorbidity.

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THE IMPACT OF ACHIEVEMENT OF RESPONSE AT ONE YEAR AFTER STARTING THERAPY ON THE LONG-TERM OUTCOME OF LUPUS NEPHRITIS

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Background: A variable percentage of lupus nephritis (LN) patients (pts) achieve response after the start of induction therapy. The impact of response on long-term renal outcome of LN is still unclear.

Objectives: To establish the response rate at one year after starting induction therapy and its impact on long-term development of chronic kidney disease (CKD) in LN.

Methods: 381 biopsy proven LN pts (86% females, mean age 31.3 $\pm$ 12.1 years), (18 pts: class II; 88 pts: class III; 199 pts: class IV; 76 pts: class V ISN/RPS) with estimated glomerular filtration rate (eGFR) 89.8 $\pm$ 40.4 and proteinuria 4.3 $\pm$ 3.9 g/24h entered this study. As induction therapy, pts received methylprednisolone pulses (72%), oral prednisone (28%), cyclophosphamide (55%), mycophenolate mofetil (24%), azathioprine (5.5%), other immunosuppressants (15.5%). During a follow-up of 13.5 years after LN diagnosis, 53 pts (13.9%) developed CKD and 22 (5.8%) died.

Definitions: Complete response (CR) at one year: eGFR $>$ 60 ml/min and proteinuria $\leq$ 0.5/die, partial response (PR): eGFR $>$ 60 ml/min, 50% reduction of proteinuria to sub-nephrotic range, no response (NoR): all the other cases. Survival curves were drawn using the Kaplan-Meier estimate and compared using the log-rank test. Cox regression model was used to test variables at univariate and at multivariate analysis.

Results: One year after the start of therapy, 220 pts (58%) achieved CR, 100 pts (26%) PR and 61 pts NoR. CKD developed in 11 out of 220 CR pts (5%), 18 out of 100 PR pts and 24 out of 61 NoR (39%). CKD free survival at 5, 10, 15 and 20 years were 99.5%, 96.5% 95.2% and 92.5 in CR pts, 99%, 90%, 87.6% and 83% in PR pts, and 81%, 65%, 54% and 44% in NoR pts ($p < 0.0001$). In detail: CR vs RP $p = 0.067$, RP vs NoR $p < 0.0001$, and CR vs NoR $p < 0.0001$. We have searched for the predictors of NoR among the clinical/therapeutic characteristics at diagnosis of LN. At univariate analysis, chronicity index at renal biopsy ($p = 0.0001$), serum creatinine ($p = 0.001$), eGFR ($p = 0.036$), presentation with nephritic syndrome or rapid progressive renal failure ($p = 0.02$), serum albumin ($p = 0.02$) and arterial hypertension ($p = 0.001$), were the predictors of NoR at one year. At multivariate analysis chronicity index ($p = 0.013$) and arterial hypertension ($p = 0.017$) were the independent predictors.

Conclusion: The achievement of CR or PR at one year is associated with preservation of renal function in the long-term. For this reason, any effort should be made to achieve response. Patients with impaired renal function, with high chronicity index at renal biopsy and arterial hypertension should be more tightly monitored as they have the highest risk of NoR.

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EARLY MENOPAUSE AND/OR DURATION OF MENOPAUSAL HORMONAL TREATMENT MAY INCREASE THE RISK OF RHEUMATOID ARTHRITIS IN TOBACCO EXPOSED WOMEN: RESULTS OF THE E3N COHORT

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Background: Smoking has been reproducibly reported as associated with an increased risk of ACPA-positive Rheumatoid Arthritis (RA) [1]. The involvement of female hormones in the pathogenesis of RA is supported by numerous observations: a 2-4 female to male ratio before age 50, but below 2 after the age of 60, an increased incidence in the first year post-partum, and a peak of RA incidence around the age of menopause. To date, many studies have evaluated the association between hormonal