vs. 0.043 ± 0.013 , $p=0.07$), but the values of PDW/Plt ratio (0.064 ± 0.022 vs. 0.051 ± 0.018 , $p=0.03$) and of NLR (3.82 ± 2.30 vs. 2.35 ± 0.92 , $p=0.001$) were found to be significantly higher in these patients. In multivariate analysis, only the NLR remains independently associated with cutaneous manifestations ($p=0.001$). Using the ROC curve analysis, a cutoff of 2.70 for NLR had a 63% sensitivity and 69% specificity for cutaneous manifestations.

Conclusion: The hematological parameters related to platelets appear to be modified in patients with SS and cutaneous manifestations. However, only neutrophil to lymphocyte ratio is independently associated with cutaneous involvement in these patients.

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AB0430

MORTALITY IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS AND NEUROPSYCHIATRIC SYMPTOMS

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Background: Little is known about mortality in patients with systemic lupus erythematosus (SLE) presenting with neuropsychiatric (NP) symptoms.

Objectives: We aimed to evaluate all-cause and cause-specific mortality in patients with SLE and NP symptoms.

Methods: All patients with the clinical diagnosis of SLE of 18 years and older that visited the tertiary referral NPSLE clinic of the Leiden University Medical Center between 2007-2018 and signed informed consent were included in this study. Patients were classified as NPSLE if NP symptoms were attributed to SLE and immunosuppressive or anticoagulant therapy was initiated, otherwise patients were classified as non-NPSLE. Municipal registries were checked for current status (alive/deceased). Electronical medical files were studied for clinical characteristics and cause of death. Standardized mortality ratios (SMRs) and 95% confidence intervals were calculated using data from the general Dutch population. In addition, a rate ratio (RR) was calculated using direct standardization to compare mortality in NPSLE with non-NPSLE patients.

Results: 351 patients with the clinical diagnosis of SLE were included, of which 149 patients were classified as NPSLE (42.5%). Compared with the general population, mortality was increased five times in NPSLE (SMR 5.0, 95% CI: 2.6-8.5) and nearly four times in non-NPSLE patients (SMR 3.7, 95% CI: 2.2-6.0), as shown in Table 1. Risk of death due to cardiovascular disease (CVD) was increased in non-NPSLE patients (SMR 6.2, 95% CI: 2.0-14.6) and an increased risk of death to infections was present in both NPSLE and non-NPSLE patients ((SMR 29.9, 95% CI: 3.5 – 105) and SMR 91.3 (95% CI: 18.8 – 266) respectively). However, mortality did not differ between NPSLE and non-NPSLE patients (RR 1.0, 95% CI: 0.5 – 2.0).

Table 1. All-cause mortality in SLE patients presenting with neuropsychiatric symptoms attributed to SLE (NPSLE) or to other causes (non-NPSLE)

	NPSLE (N = 149)	Non-NPSLE (N = 202)
Deaths (N, %)	13 (8.7)	17 (8.4)
Age at death (median, range)	49 (32 – 79)	59 (20 – 89)
Follow-up time (years)	906	1047
Crude mortality rate (per 1000 PY)	14.3	16.2
All-cause mortality*		
Female	5.5 (2.8 – 9.6)	3.4 (1.9 – 5.7)
Male	2.3 (0.1 – 12.8)	6.2 (1.3 – 18.2)
Combined	5.0 (2.6 – 8.5)	3.7 (2.2 – 6.0)

*Standardized mortality ratio, ratio of the observed and expected number of deaths

Conclusion: Mortality was increased in both NPSLE and non-NPSLE patients in comparison with the general population, but there was no difference in mortality between NPSLE and non-NPSLE patients. Risk of death due to infections was increased in both groups.

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AB0431

SALIVARY GLAND ULTRASOUND IN CLINICAL PRACTICE

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Background: Sjögren's syndrome (SS) is characterized by lymphocytic infiltration of the exocrine glands and marked B-lymphocytic cell hyperreactivity involving a variety of serum autoantibodies. ¹ Salivary Gland Ultrasound (SGU) is a simple, fast, and well-tolerated examination, which provides information about glandular structure and has proven to be very useful in the Sjögren Syndrome diagnosis². A prognostic value has also been proposed due to its possible relationship with lymphomas and extra-glandular manifestations.

Objectives: The objective of our study is to evaluate ultrasound results in patients who went through an SGU in clinical practice, its usefulness in the diagnosis of Sjögren's syndrome and the presence of complications (lymphomas, extra-glandular manifestations or factors related to increased lymphoma risk).

Methods: We conducted a retrospective cross-sectional study with review of clinical records that included all those patients coded as SGU in the Ultrasound unit of Rheumatology Department from 2016 to December 2019. Information collected included final diagnosis, laboratory results, clinical manifestations and ultrasound results. We performed an analysis on the frequency of pathological SGU and on the relationship between these lesions in patients with final SS diagnosis and the presence of lymphoma, extra-glandular manifestations and the laboratory values related with increased lymphoma risk (low complement levels, cryoglobulinemia, positive autoimmunity).

Results: SGU was performed in 171 patients in four years, 162 women (94.7%). The previous diagnoses, reason for the request and final diagnosis are shown in Table 1. The vast majority of the SGU were normal, only 28 (16.3%) were pathological, 13 with a grade II and 8 with a grade III. In the other 7 patients grading was not available. Of the 28 patients with pathological SGU, none had lymphoma, only 3 had recurrent parotitis and 15 had had extra-glandular manifestations, mainly arthralgia / arthritis (12). Only 1 patient, with rheumatoid arthritis, had had a lymphoma and the SGU was normal. Antibody positivity was frequent in pathological SGU, 16/23 antinuclear antibodies, 13/22 anti-Ro and 9/23 rheumatoid factor. Of the 86 patients without previous diagnosis, 18 were diagnosed with Sjögren syndrome, 9 with pathological SGU and the rest were normal. No patient diagnosed with a dry non-autoimmune syndrome presented pathological SGU.

Table 1. Previous diagnoses, reason for request and final diagnoses.

Previous diagnoses (n: 171)	Reason for request (n: 171)	Final diagnosis (n: 78)
Without prior diagnosis (n: 86)	Dry non- autoimmune syndrome (n: 127)	Dry non-autoimmune syndrome (n: 60)
Primary Sjögren's syndrome (n: 11)	Primary Sjögren's syndrome (n: 12)	Primary Sjögren's syndrome (n: 18)
Systemic Lupus Erythematosus (n: 9)	Lymphoma (n: 0)	Secondary Sjögren's syndrome (n: 0)
Rheumatoid arthritis (n: 24)	Control (n: 13)	Other diagnoses (n: 7)
Other diagnoses (n: 18)	Other reasons (n: 11)	

Conclusion: The impact of the SGU is low and its use cannot, for now, displace other methods (e.g. salivary gland biopsy) in the diagnosis of SS. Also our low number of patients with pathological SGU together with the low prevalence of the complications studied (e.g. lymphomas = 1) prevents the expected comparisons.

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