disease activity and organ damage were associated with impaired HRQoL in all aspects, while Asian patients reported better PCS scores (and β=0.29; P=0.007) and FACT-Fatigue scores (β=−0.33; P=0.002).

Conclusion: BMI above normal was highly associated with HRQoL impairment, especially in physical aspects. Further survey to examine causality is warranted to support structured weight control strategies as an intervention towards a more favourable HRQoL.

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FR01069

ANTINUCLEAR ANTIBODY SEROCONVERSION DURING FOLLOW-UP IN PATIENTS WITH SYSTEMIC LUPUS ERYSHEMATOSUS

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Background: Systemic lupus erythematosus (SLE) is a chronic autoimmune disease characterized by the presence of autoantibodies and a variable spectrum of clinical manifestations and disease severity. The 2019 criteria for SLE classification by the American College of Rheumatology and European League against Rheumatism define ANA positivity by immunofluorescence or by an equivalent solid-phase assay as the entry criterion (1). However, the prevalence of ANA positivity and the reliability of solid-phase assays in SLE are still a matter of controversy (2). Furthermore, the significance of ANA negativisation during follow-up is uncertain (3).

Objectives: Our aim was to retrospectively analyse data on the frequency of ANA seroconversion during the follow-up in a cohort of SLE patients with renal involvement.

Methods: Adult patients independent of age at SLE onset with a follow-up duration of at least 36 months starting from January 2009 (for standardization of ANA measurement) and with at least one ANA measurement per year were included in this retrospective longitudinal study. Data on demographic, clinical and laboratory characteristics of the study population are reported in table 1. ANA have been measured with Hep2 cell immunofluorescence assay.

Table 1. Demographic, clinical and laboratory baseline characteristics of the 121 patients suffering from systemic lupus erythematosus (SLE).

Demographics

| Gender, %F (n) | 93 (112) |
| Age in years, means/SD | 41±12.6 |

Clinical features

| Age at SLE onset in years, means/SD | 28±11.9 |
| SLE duration in years, means/SD | 13.8±5.5 |
| SLEDAI, median (min-max) | 4 (0 – 27) |

Laboratory profile

| Serum creatinine mg/dL, median (min-max) | 0.8 (0.4 – 2) |
| 24h urine protein g/24h, median (min-max) | 0.5 (0 – 13.8) |
| ANA, %pos (n) | 93 (112) |
| Anti-ENA, %pos (n) | 49 (59) |
| Anti-dsDNA, %pos (n) | 43 (51) |

Results: A total of 121 SLE subjects with renal involvement were enrolled. Mean follow-up ± standard deviation (SD) was 8 ± 2 years. Ten subjects (8.3%) with positive ANA at the beginning resulted ANA negative at the end of the follow-up. These subjects had different initial ANA titres: 1:1280 (n=1), 1:640 (n=2), 1:320 (n=2), 1:160 (n=3) and 1:80 (n=2); 48 subjects (39.7%) showed a decrease in ANA titre. Of the 9 patients (7.4%) that were negative at the beginning of follow-up, 6 remained negative, whereas 3 showed ANA positivity at the end of the follow-up with ANA titres 1:160 (n=2) and 1:320 (n=1). No differences between subjects with and without ANA variation in terms of age (p=0.551), disease duration (p=0.786), SLEDAI at the beginning (p=0.453) and at the end of follow-up (p=0.169) were observed. ANA negativisation and titre variations at the end of follow-up did not correlate with any of the treatments taken during follow-up, including a history of cyclophosphamide (p=0.788).

Conclusion: In our cohort of patients with SLE and renal involvement, 10% of patients experienced negativisation and around 40% of patients showed a decrease in ANA titre during follow-up, independent of disease characteristics and previous treatment. Further studies are warranted to clarify the underlying mechanisms and clinical significance of ANA seroconversion and titre variation in SLE patients. However, based on our results, ANA positivity seems to be a relatively stable parameter further supporting its use as an entry classification criterion for SLE.

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FR01070

THERAPEUTIC TARGETS AND QUALITY INDICATORS IN SYSTEMIC LUPUS ERYSHEMATOSUS (SLE), DEFINED ACCORDING TO THE 2019 UPDATE OF THE EULAR RECOMMENDATIONS: DATA FROM THE “ATTIKON” LUPUS COHORT

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Background: Targets of therapy and quality of care are receiving increased attention in the management of SLE, as outlined in the 2019 update of the EULAR recommendations for SLE treatment.

Objectives: To assess compliance with quality with decision and attainment of treatment targets, according to recent EULAR recommendations, in the SLE cohort of “Attikon” Rheumatology Unit.

Methods: 100 consecutive SLE patients followed for at least one year were. A 30 Item Quality Indicator Set (QIS) was developed, according to the 2019 EULAR recommendations for SLE, to include laboratory tests for diagnosis and monitoring, evaluation of disease activity and damage using validated indices, use of patient-reported outcomes, counselling for women's health and reproduction issues, attainment of targets of therapy (remission or low disease activity state (LLDAS) with low-dose glucocorticoids (GC, ≤7.5mg/day prednizone) and hydroxychloroquine (HCQ doses≤5mg/kg/day)), prevention of disease flares and prevention and management of co-morbidities. Chart review and patient interview was performed to assess the degree of compliance with each item of the QIS and achievement of treatment targets.

Results: Disease activity was monitored by means of validated indices in 31% and antiphospholipid antibody testing during the first 6 months from diagnosis was performed in 58.8% of patients. Sustained remission (defined as remission of a sustained period of 12 months) or LLDAS was achieved by only 3% and 22% respectively; in contrast, other targets of therapy, such as ≤1 minor flares during last year, were achieved by 85% (43% had complete absence of flares), 90.2% of patients receiving low-dose GC and 81.8% corrected HCQ dose. Fertility and pregnancy counselling were offered in 40% (12/30 eligible women) and 63.3% (19/30) of patients, respectively, while 65.4% had a Pap Test and only 3 of 32 eligible patients had received the HPV vaccine. Annual lipid status was assessed in 43% and counselling for smoking cessation in 44.6%. Flu vaccination was performed in 77%, while pneumococcal (including both of the pneumo- coccal vaccines) and herpes-zoster vaccination, were given in 32.7% and 2% (1/44 eligible patients) respectively.

Conclusion: Our real-life data suggest low vaccination rates (excluding flu) and suboptimal management of cardiovascular risk factors in lupus patients. While the majority of patients received the suggested doses of GC and HCQ, only one quarter of patients achieved remission or LLDAS. There is an unmet need for new therapies in SLE to improve therapy targets.

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