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FRI0180 SURVEY ON HELP-SEEKING AND DISEASE TRAJECTORY IN SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: Few studies in Latin America have analysed the time lag since patients experience the first joint symptoms until they consult a physician, and a diagnosis is made, and most of them have dealt with patients sustaining Rheumatoid Arthritis (RA)^{1,2}.

Objectives: To study both patient and disease factors that have some bearing on the time lag until a physician is first consulted and a diagnosis is made.

Methods: Multiple-choice survey to patients of 18 years of age or older who met **Systemic Lupus Erythematosus (SLE)** Classification Criteria (2012). The following aspects were measured: **time lag from symptom onset to first medical consultation (Time 1), time lag since first medical consultation until a diagnosis is made (Time 2), and time lag until the first consultation with a rheumatologist.**

Patients were interviewed at the time or within 6 months of diagnosis, and asked about the physician they first consulted and the one who made the diagnosis. They were also requested to describe one disease onset out of 4 trajectories: acute, acute with temporary remissions, chronic with partial improvements, or sustained chronic. Patients were required to recount their response to the first symptoms, the limitations brought about by the disease (employing the Steinbrocker scale), and whether help-seeking was first aimed at consulting a physician or they decided to wait. A group of patients with Rheumatoid Arthritis (RA) answered the same survey. Every patient signed an informed consent form, and the study was approved by the Hospital Bioethics Committee.

Results: Twenty-eight patients with SLE and 29 patients with RA filled in the survey. SLE patients were younger as expected (32 years vs 49 years; $p < 0.001$). Acute was the most common disease trajectory in SLE patients (36% vs 34%; $p 0.8$) and chronic in RA (38% vs 32%; $p 0.8$). The first professional consulted was an on-duty physician in SLE (36% vs 24% in RA; $p 0.5$). Except for the matter of computer at home and/or a mobile phone with an Internet connection at home, both groups were similar, although SLE patients showed a trend to better level education and lesser impact of the disease on daily life at the beginning (see Table 1).

Table 1.

	SLE	RA	P
n	28	29	
Education (median)	Secondary	Secondary	0.07
Had a job	11 (39%)	15 (52%)	0.5
Had health insurance	8 (29%)	15 (52%)	0.1
Had computer/mobile phone with an Internet connection	25 (89%)	18 (62%)	0.04
Steinbrocker (median with range 25-75%)	3 (2-3)	3 (3-4)	0.06
Immediately sought medical help	15 (54%)	16 (56%)	0.9
Did not know what to do when the first symptoms appeared	7 (25%)	13 (45%)	0.2
Diagnosis made by a rheumatologist	20 (71%)	23 (80%)	0.7

Time 1 in patients with SLE was significantly lower with a median of 7 days, range (25-75%) 1-30 days vs 30 days in RA, range 14-180 ($p 0.01$), and the former also showed a trend to lower median Time 2: 81 days, range 25-209 vs 185 days in RA, range 60-275 ($p 0.1$). Besides, they showed a significantly shorter time lag until the first visit to a rheumatologist with a median of 120 days, range 35-225 vs 330 days, range 120-450 in patients with RA ($p 0.005$).

Conclusion: SLE patients consult a physician and visit a rheumatologist sooner than RA patients do, and they also show a trend to obtain a faster diagnosis. Education, health insurance, employment, the disease impact on their daily life and initial response to the symptoms do not appear to account for their swiftness in seeking medical help.

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FRI0181 ORGAN DAMAGE FREE SURVIVAL IN SOUTHERN CHINESE PATIENTS WITH ACTIVE LUPUS NEPHRITIS

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Background: The goals of treatment of lupus nephritis (LN) are to induce remission, retard the progression of chronic kidney disease, prevent organ complications and ultimately reduce mortality. Previous cohort studies of LN have mainly focused on the risk of mortality and development of end stage renal failure (ESRF) (renal survival). The cumulative frequency of LN patients who survive without organ damage, which correlates better with the balance between treatment efficacy and toxicity, as well as quality of life, has not been well studied.

Objectives: To study the organ damage free survival and its predictive factors in patients with active LN.

Methods: Consecutive patients who fulfilled ≥ 4 ACR/SLICC criteria for SLE and with biopsy proven active LN between 2003 and 2018 were retrospectively analyzed. Those with organ damage before LN onset were excluded. Data on renal parameters and treatment regimens were collected. Complete renal response (CR) was defined as normalization of serum creatinine (SCr), urine P/Cr (uPCR) < 0.5 and inactive urinary sediments. Partial renal response (PR) was defined as $\geq 50\%$ reduction in uPCR and $< 25\%$ increase in SCr. Organ damage of SLE was assessed by the ACR/SLICC damage index (SDI). The cumulative risk of having any organ damage or mortality since LN was studied by Kaplan-Meier's analysis. Factors associated with a poor outcome were studied by a forward stepwise Cox regression model, with entry of covariates with $p < 0.05$ and removal with $p > 0.10$.

Results: 273 LN patients were identified but 64 were excluded (organ damage before LN onset). 211 LN patients were studied (92% women; age at SLE 30.4 ± 13.5 years; SLE duration at LN 1.9 ± 3.1 years). 47 (22%) patients had nephrotic syndrome and 60 (29%) were hypertensive. Histological LN classes was: III/IV $\pm$ V (75.1%), I/II (7.8%) and pure V (17.1%) (histologic activity and chronicity score 7.0 ± 4.2 and 1.8 ± 1.5 , respectively). Induction regimens were: prednisolone (33.1 ± 17.5 mg/day) in combination with intravenous cyclophosphamide (CYC) (21.4%; 1.0 ± 0.2 g per pulse), oral CYC (8.6%; 96.4 ± 37.8 mg/day), azathioprine (AZA) (14.3%; 78.6 ± 25.2 mg/day), mycophenolate mofetil (MMF) (22.8%; 1.9 ± 0.43 g/day) and tacrolimus (TAC) (17.1%; 4.3 ± 1.1 mg/day). After a follow-up of 8.6 ± 5.4 years, 94 (45%) patient developed organ damage ($SDI \geq 1$) and 21 (10%) patients died. The commonest organ damage was renal (36.3%) and musculoskeletal (17.9%), and the causes of death were: infection (38.1%), malignancy (19.0%), cardiovascular events (9.5%) and ESRF complications (9.5%). At last visit, 114 (55%) patients survived without any organ damage. The cumulative organ damage free survival at 5, 10 and 15 years after renal biopsy was 73.5%, 59.6% and 48.3%, respectively. The 5, 10 and 15-year renal survival rate were 95.2%, 92.0% and 84.1% respectively. In a Cox regression model, nephritic relapse (HR 3.72[1.78-7.77]), proteinuric relapse (HR 2.30[1.07-4.95]) and older age (HR 1.89[1.05-3.37]) were associated with either organ damage or mortality, whereas CR (HR 0.25[0.12-0.50]) at month 12 were associated with organ damage free survival. Baseline SCr, uPCR and histological LN classes were not significantly associated with a poor outcome. Among patients with class III/IV LN, the long-term organ damage free survival were not significantly different in users of MMF (reference) from CYC (IV/oral) (HR 1.45[0.76-2.75]) or TAC (HR 1.03[0.26-1.62]) as induction therapy.

Conclusion: Organ damage free survival is achieved in 55% of patients with active LN upon 9 years of follow-up. CYC/MMF/TAC based induction regimens did not differ for the long-term outcome of LN. Targeting complete renal response and preventing renal relapses remain important goals of LN treatment.

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FRI0182 RISK FACTORS ASSOCIATED WITH RENAL INVOLVEMENT IN PRIMARY SJÖGREN'S SYNDROME: DATA FROM THE SPANISH SJÖGRENSEN COHORT

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