Conclusion: In this cohort, although all three criteria have sufficient specificity, sensitivity and negative predictive value of 1997 ACR criteria are the lowest. Overall, 2019 EULAR/ACR and 2012 SLICC criteria have a comparable performance, but if only ANA positive cases and controls are analysed, the specificity of both criteria decrease to less than 90%. Some SLE patients with a clinical diagnosis lacked sufficient number of criteria. Mostly, patients with Sjögren's syndrome or antiphospholipid syndrome are prone to miscategorization by both recent criteria.

REFERENCES:

Disclosure of Interests: None declared

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POSO707 SALIVARY GLAND ULTRASONOGRAPHY AND THE CLINICAL FEATURES USING ESSDAI IN PATIENTS OF EARLY-ONSET VERSUS LATE-ONSET WITH PRIMARY SJÖGREN’S SYNDROME

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Background: Primary Sjögren’s syndrome (pSS) is a chronic inflammatory autoimmune disease characterized by lymphocyte infiltration in salivary and lacrimal glands. pSS affects primarily middle-aged and elderly patients, although younger age groups may also be involved. However, differences of etiology and pathogenesis between early-onset pSS (EoSS) and late-onset pSS (LoSS) are unknown. Recently, standardized outcome tools for measuring disease-specific activity and patients’ reported symptoms have been formulated by the European League Against Rheumatism (EULAR) SS study group: the EULAR SS Disease Activity Index (ESSDAI) for systemic features of pSS [1]. Also, as the new imaging techniques, salivary gland ultrasonography (SGUS) proved valuable for assessing salivary gland involvement in SS and seemed to exhibit good diagnostic properties. In addition, previous studies have demonstrated usefulness of SGUS for the prognostic stratification of patients with pSS [2, 3, 4].

Objectives: The aim of this study was to examine the differences of etiology and pathogenesis between EoSS and LoSS using ESSDAI and SGUS.

Methods: Fifty-six pSS patients who fulfilled the American College of Rheumatology (ACR) / European League Against Rheumatism (EULAR) classification criteria for SS were studied. Based on the disease onset age, all pSS patients were divided into two groups as those with the onset age of 40 years old or younger (EoSS: n=26) and those with the onset age of older than 65 years old (LoSS: n=30). The clinical findings were evaluated ESSDAI and OMERACT SGUS score at the first visit to our hospital. The ESSDAI (0–123) proposes the evaluation of 12 domains or organ systems (constitutional, lymphadenopathy, glandular, articular, cutaneous, pulmonary, renal, peripheral nervous system, central nervous system, muscular, hematological and biology). All patients were examined SGUS by a single investigator who was blinded to device (TUS-A300; Canon Medical Systems, Tokyo, Japan) with a linear transducer (75-10MHz).

The OMERACT SGUS score was used for graded changes in the parenchymal homogeneity of salivary glands: grade 0, normal-appearing salivary gland parenchyma; grade 1, minimal change: mild inhomogeneity without hypo/anechoic areas; grade 2, moderate change: moderate inhomogeneity with focal hypo/anechoic areas; grade 3, severe change: diffuse inhomogeneity with hypo/anechoic areas occupying the entire gland volume [5].

Results: The proportions of positive sera of RF, anti-SS-A and anti-SS-B antibodies were not different in the two groups, but the disease activities were higher in the EoSS patients compared to the LoSS patients by measuring ESSDAI (7.30 vs 4.23, p=0.006), especially in constitutional domain (1.50 vs 0.60, p=0.03), articular domain (1.54 vs 0.40, p=0.0002) and biological domain (1.35 vs 0.90, p=0.04). No difference in salivary secretion was found between two groups (EOSS: 6.02 vs LoSS: 6.31 ml/10min), but the OMERACT SGUS score was higher in LoSS than in EoSS patients (2.00 vs 2.70, p=0.0002).

Conclusion: Although serological findings were not different, EoSS patients had higher disease activity but less severe salivary gland degeneration than that in LoSS patients, suggesting the pathogenesis of these two groups was different.

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Disclosure of Interests: None declared

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POSO708 PSYCHIATRIC DISORDERS IN PATIENTS WITH DIFFERENT PHENOTYPES OF NEUROPSYCHIATRIC SYSTEMIC LUPUS ERYTHEMATOSUS (NPSLE)

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Background: Patients with systemic lupus erythematosus (SLE) may present with psychiatric disorders. These are important to recognize, as they influence quality of life and treatment outcomes and strategies.

Objectives: We aimed to study the frequency of psychiatric morbidity as classified by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) in patients with SLE and neuropsychiatric symptoms of different origins.

Methods: In the neuropsychiatric SLE (NPSLE) clinic of the Leiden University Medical Center, patients undergo a standardized multidisciplinary assessment by a neuropsychologist, neuropsychologist, vascular internal medicine, rheumatologist, physician assistant and psychiatrist. After two weeks, a multidisciplinary consensus meeting takes place, in which the symptoms are attributed to SLE requiring treatment (major NPSLE) or to minor involvement of SLE or other causes (minor/non-NPSLE). Consecutive patients visiting the NPSLE clinic between 2007-2019 were included. Data of psychiatric evaluation and current medication use were extracted from medical records. The presence of cognitive dysfunction was established during formal neuropsychological assessment.

Results: 371 consecutive SLE patients were included, of whom 110 patients had major NPSLE (30%), 141 patients had minor NPSLE (37%) and 120 patients had minor/non-NPSLE (33%). The most frequently diagnosed psychiatric disorders in the total group were cognitive dysfunction (42%) and depression (23%), as shown in Table 1. Furthermore, anxiety was present in 5% and psychotic disorders in 4% of patients. In patients with minor/non-NPSLE, especially depression (26% vs 15%) and anxiety (6% vs 2%) were more common than in major NPSLE. Cognitive dysfunction (54% vs 36%) and psychotic disorders (6% vs 4%) were more common in patients with major NPSLE than minor/non-NPSLE.

Objective: The aim of this study was to examine the differences of etiology and pathogenesis between EoSS and LoSS using ESSDAI and SGUS.

Methods: Fifty-six pSS patients who fulfilled the American College of Rheumatology (ACR) / European League Against Rheumatism (EULAR) classification criteria for SS were studied. Based on the disease onset age, all pSS patients were divided into two groups as those with the onset age of 40 years old or younger (EoSS: n=26) and those with the onset age of older than 65 years old (LoSS: n=30). The clinical findings were evaluated ESSDAI and OMERACT SGUS score at the first visit to our hospital. The ESSDAI (0–123) proposes the evaluation of 12 domains or organ systems (constitutional, lymphadenopathy, glandular, articular, cutaneous, pulmonary, renal, peripheral nervous system, central nervous system, muscular, hematological and biology). All patients were examined SGUS by a single investigator who was blinded to device (TUS-A300; Canon Medical Systems, Tokyo, Japan) with a linear transducer (75-10MHz).

The OMERACT SGUS score was used for graded changes in the parenchymal homogeneity of salivary glands: grade 0, normal-appearing salivary gland parenchyma; grade 1, minimal change: mild inhomogeneity without hypo/anechoic areas; grade 2, moderate change: moderate inhomogeneity with focal hypo/anechoic areas; grade 3, severe change: diffuse inhomogeneity with hypo/anechoic areas occupying the entire gland volume [5].

Results: The proportions of positive sera of RF, anti-SS-A and anti-SS-B antibodies were not different in the two groups, but the disease activities were higher in the EoSS patients compared to the LoSS patients by measuring ESSDAI (7.30 vs 4.23, p=0.006), especially in constitutional domain (1.50 vs 0.60, p=0.03), articular domain (1.54 vs 0.40, p=0.0002) and biological domain (1.35 vs 0.90, p=0.04). No difference in salivary secretion was found between two groups (EOSS: 6.02 vs LoSS: 6.31 ml/10min), but the OMERACT SGUS score was higher in LoSS than in EoSS patients (2.00 vs 2.70, p=0.0002).

Conclusion: Although serological findings were not different, EoSS patients had higher disease activity but less severe salivary gland degeneration than that in LoSS patients, suggesting the pathogenesis of these two groups was different.

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Dissociative Experience Scale-II (DES) is a standardized tool thought to be a result of cognitive dysfunction, but fogs can also be the result of pathological dissociation in the general population. A. van Dijck, et al. The measurement of dissociation in normal and clinical populations: Meta-analytic validation of the Dissociative Experiences Scale (DES). Clinical Psychology Review 1996; 16: 365-382.

Disorder of the Dissociative Experience Scale is often reported by patients with systemic lupus erythematosus (SLE). The present study was conducted to investigate the prevalence of dissociative symptoms in SLE patients. The rates of hospitalization in patients with SLE is around 10% per year.

References:

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LUPUS FOG IS NOT DISSOCIATIVE FOG
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Background: The presence of a ‘fog’ is frequently reported by patients with systemic lupus erythematosus (SLE). However, little is known about this lupus fog: it is thought to be a result of cognitive dysfunction, but fogs can also be the result of dissociation. The Dissociative Experience Scale-II (DES) is a standardized tool to study dissociation. In the general adult population, scores range from 4.4-14.19

Methods: Patients visiting the tertiary referral center for neuropsychiatric systemic lupus erythematosus (NPSLE) of the LUMC between 2007-2019 were included. All patients underwent a standardized multidisciplinary assessment. Patients were classified as NPSLE if neuropsychiatric symptoms were attributed to SLE and immunosuppressive or anti-coagulant therapy was initiated, otherwise patients were classified as minor/non-NPSLE. Dissociation was studied using the DES. The DES separates different types of dissociative symptoms: amnesia, absorption/imagination and depersonalization/derealization. It also contains one question regarding evaluating the presence of a dissociative fog: “Some people sometimes feel as if they are looking at the world through a fog, so that people and objects appear far away or unclear”.

Results: DES questionnaires were available for 337 patients, of which 97 had NPSLE, 240 had minor/NPSLE and 97 had non-NPSLE. The most common type of dissociation was absorption/imagination (median: 12, range 0-75) and depersonalization/derealization was infrequent (median: 1, range 0-84). 43 patients (13%) had an abnormal score (>25) on the dissociative fog question.

Conclusion: Dissociative symptoms are within normal range in patients with SLE and neuropsychiatric symptoms, regardless of underlying etiology. Dissociative fog seems uncommon and therefore lupus fog is most likely not the result of dissociation.