### Table 1. Data that ≥ 75% centres collected

<table>
<thead>
<tr>
<th>Sociodemographic</th>
<th>Racial background, Educational attainment, Occupation, Smoking status, Alcohol consumption, Contraception use, Pregnancy history (number of pregnancies, miscarriage, stillbirth and neonatal death)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLE specific</td>
<td>Date at and age of diagnosis, Disease duration, Family history of SLE, ACR 1997 classification criteria, SLEDAI-2000 disease activity measure</td>
</tr>
<tr>
<td>Comorbidity</td>
<td>Diabetes, Hypertension, Bone disease, Osteoporosis, Cerebrovascular disease, Ischaemic heart disease, Renal disease, Infection, Malignancy, Cardiovascular risk factors: smoking status, diabetes, hypertension and obesity, Renal data: renal biopsy, BP, serum creatinine, Urine Protein-Creatinine Ratio and estimated GFR</td>
</tr>
<tr>
<td>Baseline bloods</td>
<td>FBC, Complement C3/C4, ESR, LFTS</td>
</tr>
<tr>
<td>Baseline immunology</td>
<td>Anti-cardiolipin antibody, ANA (IIF),ENA,Lupus anticoagulant, Anti-Beta2 glycoprotein</td>
</tr>
<tr>
<td>Treatment data</td>
<td>Current Biological (Name, Dose, Frequency, Start date), Immunosuppressant (Name, Dose, Frequency, Start date), Antimalarial (Name, Dose, Frequency, Start date), V/PO Glucocorticoid (Name, Dose, Frequency, Start date), NSAID (Name only), Previous Biological (Name only), Immunosuppressant (Name only), PO Glucocorticoid (Name, Dose, Start date, End date), Antimalarial (Name, Start date, End date, Reason for cessation)</td>
</tr>
</tbody>
</table>

### Table. Multivariate Cox regression analysis: adjusted hazard ratio for risk factors of mortality in SLE patients

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Hazard ratio</th>
<th>95% Confidence interval</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male vs. Female</td>
<td>1.329</td>
<td>0.800-2.08</td>
<td>0.272</td>
</tr>
<tr>
<td>Age</td>
<td>1.057</td>
<td>1.045-1.070</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Pulmonary arterial hypertension</td>
<td>2.709</td>
<td>1.631-4.499</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>SLEDAI score</td>
<td>1.074</td>
<td>1.040-1.109</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.984</td>
<td>0.661-1.465</td>
<td>0.936</td>
</tr>
<tr>
<td>Cardiovascular event</td>
<td>0.534</td>
<td>0.661-1.465</td>
<td>0.044*</td>
</tr>
<tr>
<td>End-stage renal disease</td>
<td>2.489</td>
<td>1.559-3.973</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Hydroxychloroquine</td>
<td>0.704</td>
<td>0.479-1.036</td>
<td>0.075</td>
</tr>
<tr>
<td>Cyclophosphamide</td>
<td>1.687</td>
<td>1.058-2.689</td>
<td>0.028*</td>
</tr>
</tbody>
</table>

**Without PAH**

- Male vs. Female: 1.329, 0.800-2.080, 0.272
- Age: 1.057, 1.045-1.070, <0.001
- Pulmonary arterial hypertension: 2.709, 1.631-4.499, <0.001
- SLEDAI score: 1.074, 1.040-1.109, <0.001
- Hypertension: 0.984, 0.661-1.465, 0.936
- Cardiovascular event: 0.534, 0.661-1.465, 0.044
- End-stage renal disease: 2.489, 1.559-3.973, <0.001
- Hydroxychloroquine: 0.704, 0.479-1.036, 0.075
- Cyclophosphamide: 1.687, 1.058-2.689, 0.028

**With PAH**

- Male vs. Female: 1.329, 0.800-2.080, 0.272
- Age: 1.057, 1.045-1.070, <0.001
- Pulmonary arterial hypertension: 2.709, 1.631-4.499, <0.001
- SLEDAI score: 1.074, 1.040-1.109, <0.001
- Hypertension: 0.984, 0.661-1.465, 0.936
- Cardiovascular event: 0.534, 0.661-1.465, 0.044
- End-stage renal disease: 2.489, 1.559-3.973, <0.001
- Hydroxychloroquine: 0.704, 0.479-1.036, 0.075
- Cyclophosphamide: 1.687, 1.058-2.689, 0.028

**Figure 1.** Survival curves of SLE patients with and without PAH. Abbreviations: SLE, systemic lupus erythematosus; PAH, pulmonary arterial hypertension

**References:** NIL.

**Acknowledgements:** NIL.

**Disclosure of Interests:** None declared.

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**AB0604**

**IDENTIFYING THE RISK FACTORS AND INCREASING MORTALITY OF PULMONARY ARTERIAL HYPERTENSION IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS**

**Keywords:** Prognostic factors, Systemic lupus erythematosus, Epidemiology

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**Background:** Patients with systemic lupus erythematosus (SLE) have a risk of pulmonary arterial hypertension (PAH), which could be fatal.

**Objectives:** The goal of this study was to identify the risk factors for mortality in patients with PAH.

**Methods:** Patients with SLE treated at Chang Gung Memorial Hospital were included in this retrospective cohort study. Univariate and multivariate COX regression analysis was conducted as well as Kaplan–Meier survival curve analysis were done to investigate risks in SLE patients.

**Results:** The average age at diagnosis was 40.78 ± 15.92 years. A total of 42 (6.1%) of the 689 patients had PAH. Patients with PAH exhibited shorter follow-up duration, higher disease activities, higher incidence rates of comorbidities patients without PAH. Physicians preferred to use more Cyclophosphamide and less hydroxychloroquine in PAH patients. Cox regression analysis indicated that PAH (hazard ratio = 2.709, 95% CI = 1.631, 4.499, p < 0.001), old age at diagnosis (HR = 1.057, 95% CI = 1.045, 1.070, p < 0.001), high SLEDAI score (HR = 1.074, 95% CI = 1.040, 1.109, p < 0.001), end-stage kidney disease (ESKD) (HR = 2.533, 95% CI = 1.620, 3.961, p < 0.001) and Cyclophosphamide treatment (HR = 1.687, 95% CI = 1.058, 2.689, p < 0.028) were all linked to increased mortality. Moreover, the Kaplan–Meier survival curve analysis revealed that patients with pericarditis had a higher mortality rate (log-rank test, p < 0.001).

**Conclusion:** A 6.1% proportion of SLE patients have manifestations of PAH. Moreover, these patients need intense screening and treatment of PAH.

**REFERENCES:** NIL.

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**AB0605**

**ALTERNATION OF FUNCTIONAL CONNECTIVITY BETWEEN THE RIGHT INSULAR CORTEX AND RIGHT THALAMUS IS RELEVANT TO FATIGUE IN SYSTEMIC LUPUS ERYTHEMATOSUS: A PRELIMINARY STUDY**

**Keywords:** Imaging, Systemic lupus erythematosus

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**Background:** Fatigue is one of the most common symptoms in patients with systemic lupus erythematosus (SLE) [1]. Resting-state functional magnetic resonance imaging (rs-fMRI) has emerged as a powerful tool for mapping large-scale networks in the human brain. To explore the neural mechanism of fatigue, several studies evaluated the functional connectivity between brain region of interests using rs-fMRI. However, there are still few reports on patients with SLE.

**Objectives:** To identify the fatigue-specific functional connectivity in patients with SLE.

**Methods:** rs-fMRI data were acquired from SLE patients with fatigue and healthy controls (HCs). Functional connectivity of SLE patients and HCs were analyzed and compared by ANCOVA, adjusted for age and sex. On the day of rs-fMRI imaging, SLE Disease Activity Index score with the Safety of Estrogens in SLE National Assessment modification (SELENA-SLEDAI) was assessed, and the Chalder fatigue scale, fatigue assessment questionnaire, was collected. The association among SELENA-SLEDAI, the results of the questionnaire, and functional connectivity was evaluated by correlation analysis.

**Disclosure of Interests:** None Declared.

**DOI:** 10.1136/annrheumdis-2023-eular.1285

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**References:** NIL.

**Acknowledgements:** NIL.

**Disclosure of Interests:** None Declared.

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