two hospitals, and the treatment strategy, selection of steroid, initial dose of steroid and drugs used together with steroid have been quite similar. Therefore, it should be possible to clarify the background factors associated with ONF.

Objectives: To perform the purpose of the study were to clarify the factors related to silent ONF in patients with SLE and, in case of ONF, to clarify the clinical characteristics between unilateral and bilateral.

Methods: One hundred thirty-two patients (18 males and 114 females) with SLE were selected on the basis of having been newly diagnosed and requiring high-dose prednisolone, including pulse therapy with methylprednisolone, as the initial treatment. All the patients initially underwent plain radiography and MRI at the start of corticosteroids to detect any early changes in the femoral head. Subsequently these examinations were performed three months thereafter. The laboratory parameters were evaluated at the beginning of steroid treatment and at one month thereafter. All statistical analyses were performed with SPSS v. 13 (SPSS Inc., Chicago, IL, USA). Statistical tests considered significant at a P (two sided) < 0.05, and marginal significant at P = 0.05–0.10. Tests were 2-tailed, and differences at p < 0.05 were considered significant.

Results: By three months after the start of corticosteroid treatment, asymptomatic ONF was diagnosed by MRI in 33 patients (25.0%), being bilateral in 21 patients and unilateral in 12. Serological activity (C3, C4, CH50 and anti-ds DNA antibody), renal function (eGFR, serum creatinine and urinary protein), anti- phospholipid antibodies, and SLEDAI were not correlated with asymptomatic ONF. BMI, BSA, and the initial dose of prednisolone per unit body weight, BMI and BSA were not correlated with silent ONF. Additionally, the occurrence of ION was not related to SLEDAI. However, patients with angitis tended to increase the incidence of ONF (p=0.069). Patients with a higher triglyceride level had bilateral ONF (p<0.002) and 4 weeks after the start of steroid treatment (p=0.004) and total cholesterol level 4 weeks after the start of steroid treatment (p=0.036) showed a significantly higher in patients with asymptomatic ONF. In patients with ONF, the level of creatinine clearance was tended to lower (p=0.062). In unilateral and bilateral studies, both anti-ds DNA antibody and C3 were not correlated. However, despite no difference in initial steroid dosage, CH50 was significantly lower and C4 was tended to lower in patients with unilateral ONF.

Conclusion: Asymptomatic ONF is common in patients with SLE. Both of high triglyceride and total cholesterol levels are important risk factors for ONF. In unilateral and bilateral studies, excess steroid dosage relative to serologic activity of SLE might contribute to the development of bilateral ONF. In the pathogenesis ONF, it was suggested that SLE activity and steroids are closely related.

REFERENCES:

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AB0642

ANTI-SSA POSITIVITY AND SALIVARY GLAND ULTRASOUND AS SCREENING TOOLS FOR PRIMARY SJÖGRÉN’S SYNDROME IN PATIENTS WITH SICCA SYMPTOMS

Keywords: Imaging, Sjogren syndrome, Ultrasound

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Background: Salivary Gland ultrasound is a sensitive point of care investigation for the assessment of salivary gland dysfunction. It can be abnormal in patients with primary Sjogren’s syndrome(pSS), Sarcoidosis, IgG4 disease, Systemic infections, Infections and Tumors.

Objectives: To understand the utility of Anti-SSA, ANA and Anti-SSA/SSB and Salivary gland ultrasound for diagnosing primary Sjogren’s Syndrome in patients with Sicca symptoms.

Methods: In the current study, In patients referred to the department of Clinical Immunology and Rheumatology, King George’s Medical University, with Sjicca Symptoms, a salivary Gland Ultrasound was performed and in those with abnormal ultrasound (Hoevear Score ≥1) Clinical and serological evaluation were performed. The Sensitivity and Specificity of Salivary Gland ultrasound with a Hoevear score ≥17 to diagnose primary Sjogren’s Syndrome was assessed, and the utility of ANA, Anti-SSA and Anti-SSA positivity in patients with abnormal ultrasound was assessed.

Results: A total of 78 patients with sicca symptoms and abnormal salivary gland ultrasound (Hoevear Score ≥1) were included of these, 36 were diagnosed with primary Sjögren’s syndrome and 42 with other diseases, including 12 with Rheumatoid arthritis, 8 with Systemic lupus erythematosus, 7 with systemic sclerosis, 4 with IgG4 related disease and 4 with Sarcoidosis. 7 patients did not have any autoimmune rheumatic disease after evaluation. The mean age of pSS patients was 36.42 ±11.68 and for non-pSS patients was 44.45 ±15.31. A Hoevear score ≥17 has a sensitivity and specificity of 80.56% and 78.57%, respectively. Adding ANA to the screening protocol improved the sensitivity but reduced the specificity while adding Anti-SSA to the screening protocol improved sensitivity, specificity, positive likelihood ration, accuracy and area under curve for diagnosing pSS.

Conclusion: Anti-SSA positivity and abnormal salivary gland ultrasound in patients with Sicca symptoms can be effective screening tools for diagnosis primary Sjögren’s Syndrome.

Table 1. Performance of different Screening methods in pSS Screening

<table>
<thead>
<tr>
<th>Method</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Positive Likelihood Ratio</th>
<th>Negative Likelihood Ratio</th>
<th>Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ultrasound</td>
<td>80.56%</td>
<td>82.35%</td>
<td>3.7593</td>
<td>0.2799</td>
<td>79.49%</td>
</tr>
<tr>
<td>Ultrasound + ANA</td>
<td>80.56%</td>
<td>82.35%</td>
<td>3.7593</td>
<td>0.2799</td>
<td>79.49%</td>
</tr>
<tr>
<td>Ultrasound + Anti SSA</td>
<td>80.56%</td>
<td>82.35%</td>
<td>3.7593</td>
<td>0.2799</td>
<td>79.49%</td>
</tr>
</tbody>
</table>

REFERENCES: NIL.

Disclosure of Interests: None Declared.

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AB0643

THE ANALYSIS OF RISK FACTORS FOR PRETERM BIRTH AND LOW BIRTH WEIGHT IN SLE PATIENTS WITH OR WITHOUT ATTAINED LLADAS AT THE CONCEPTION

Keywords: Systemic lupus erythematosus, Pregnancy and reproduction

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Background: Women with systemic lupus erythematosus (SLE) have a higher risk for adverse pregnancy outcomes (APOs) including preterm birth (PB) and low birth weight (LBW) [1]. These APOs are revealed to be related to uncontrolled higher disease activity during pregnancy [2]. Currently, lupus low disease activity state (LLDAS), which is a comprehensive disease activity index, is suggested to be the treatment target to control damage accumulation. However, it is controversial whether achieving LLADAS during pregnancy can be a sufficient therapeutic target to prevent APOs.

Objectives: We analyze the risk factors for PB and LBW in SLE patients with or without achieving LLADAS at conception.

Methods: We used the data of SLE patients who have been treated at the planning for pregnancy from a single center cohort. We divided into LLDAS achieved

Table 1. Risk factor for PB and LBW with or without LLADAS achievement

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>PB (≥7%)</th>
<th>LBW (≤3%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucocorticoid use**</td>
<td>80.00%</td>
<td>70%</td>
</tr>
<tr>
<td>Mean glucocorticoid dose, mg/day</td>
<td>11.8±6.5</td>
<td>14.8±6.5</td>
</tr>
<tr>
<td>C3, mg/dl</td>
<td>85.6±18.0</td>
<td>85.0±21.9</td>
</tr>
<tr>
<td>C4, mg/dl</td>
<td>20.5±6.5</td>
<td>19.6±6.5</td>
</tr>
<tr>
<td>Anti-SSA/ Anti SSB</td>
<td>40.9±5.8</td>
<td>9.4±1.8</td>
</tr>
<tr>
<td>Anti-SSA/ Anti SSB antibody, IU/l</td>
<td>15.1±6.0</td>
<td>3.8±4.5</td>
</tr>
</tbody>
</table>

Values are presented as mean ± standard deviation or number (%). **Wilcoxon rank sum test; *P < 0.05.

We analyzed the risk factors for PB and LBW in SLE patients with or without achieving LLADAS at conception.
OUTCOMES AND FACTORS PREDICTING MORTALITY IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS ADMITTED TO INTENSIVE CARE UNIT

Keywords: Prognostic factors, Systemic lupus erythematosus, Descriptive studies
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Background: SLE is a chronic autoimmune disease; the course of illness is interspersed with disease flares, infections, adverse drug events which may warrant intensive care admission. Outcomes and factors affecting mortality in these patients are not well established.

Objectives: The primary objective is to describe the outcomes and causes of mortality of SLE patients admitted to ICU. Secondary objective is to analyse factors associated with mortality.

Methods: Single centre retrospective observational study from Krishna Institute of Medical Sciences, a tertiary care hospital in South India. Patient with SLE admitted to intensive care unit due to any cause between 2016 and 2021 were included. Data was collected about the characteristics of disease prior to their admission to the ICU, as well as the clinical features, laboratory values and their apecue measures during ICU stay. Statistical analysis was done with SPSS.

Results: Eighty seven patients were included in the study. Mean age was 33.16 ± 12.6 years and 87% were females. Most common causes for admission were infection in 51 (58%) and disease flare in 31 (35%) patients; 34 (39%) patients had a combination of disease flare and infection. Mean APACHE II score at admission was 1732 and mean SLEDAI-2k score at presentation was 15.16. The mean duration of ICU stay was 6.02 ± 6.58 days. Mechanical ventilation was needed for 45 patients (51%), inotropic support in 36 patients (41%) and dialysis in 19 patients (21%). The mortality rate was 21% (19 cases), 18/19 patients had both very high disease activity and sepsis. Factors correlating with mortality (on multivariate analysis) included higher APACHE II score at presentation, presence of fever, acute kidney injury, low serum albumin, low hematocrit, low Glasgow coma scale, sepsis, need for mechanical ventilation, inotropic support and renal replacement therapy.

Conclusion: Mortality rate in our study population was 21%, which is in line with observed trend in last 2 decades. The leading cause of admission to ICU in our cohort was disease flare resulting from poor compliance and infections. Mortality resulted from a combination of high disease activity with infection; a difficult to manage situation for the rheumatologist and the intensivist.

REFERENCES:

PREVALENCE AND DESCRIPTION OF AUTOIMMUNE POLYENDOCRINE SYNDROMES IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS: EXPERIENCE OF A SINGLE CENTER

Keywords: Systemic lupus erythematosus, Comorbidities, Epidemiology
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