was one of the questions in the interview, where the patients themselves elaborated on their answers.

Results: Of the included six SSc patients with PAH, 4 (67%) were female and 2 (33%) men with mean disease duration of 5 years since PAH diagnosis (Table 1). NYHA functional class varied from 1 (mild) to 4 (severe) with a median of 3. Patients reported fatigue (VAS) was the most prominent symptom (Figure 1), confirmed by the results from the interviews. This also lead to physical and psychological challenges in everyday life, and reduced HRQoL. The patients` were mostly satisfied with the nurses, but felt some nurses had not the time when the patients needed it the most. The patients also highlighted that they felt that some of the nurses did not have enough knowledge about the diagnosis. This led to patients` repetition and explanation why their oxygen level was reduced, why they had heavy breathing or why it was not possible to measure pulse or oxygen level on the fingers, due to reduces peripheral circulation. The patients` wish was also to be seen and understood by their caregivers and friends.

Conclusion: Our study revealed that fatigue was the main symptom causing reduced HRQoL. Moreover, we show the importance of educated expert nurses in the management of PAH in SSc and the inclusion of information to caregivers, patients and next of kin. Nurse's awareness about the symptom burden and unmet needs of patients with SSc-PAH is important to give the best possible patient care.

Table 1. Patient characteristics.

PATIENT	1	2	3	4	5	6
Gender	K	M	M	K	K	K
Age	32	77	73	67	59	63
SSc duration (y)	11	2	18	3	12	17
PAH duration (y)	6	2	12	2	4	10
PAH treatment	ERA PDE5 PGI2	ERA PDE5	ERA PDE5	ERA PDE5	ERA PDE5	ERA PDE5 PGI2
RHC – mPAP (mmHg)	52	40	60	75	35	61
NYHA Class	3	3	3 to 4	4	1	2 to 3

F: female; M: male; SSc: systemic sclerosis; PAH: pulmonary arterial hypertension; ERA: endothelin receptor antagonist; PDE5: Phosphodiesterase 5 inhibitor; PGI2: Prostacyclin pathway agonist; RHC: right heart catheterization at the time of PH diagnosis; mPAP: mean pulmonary arterial pressure; NYHA: New York Heart Association.

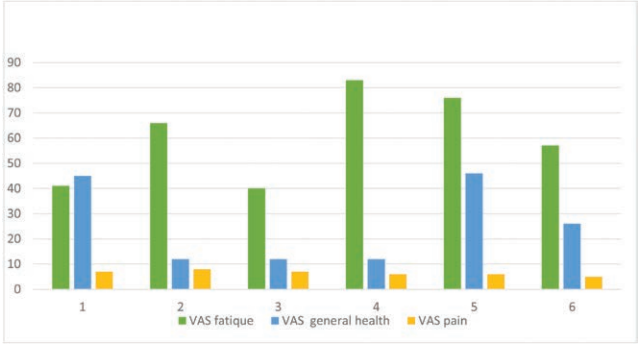

Figure 1. Overview of VAS-Scale, fatigue, general health and pain.

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AB1798-HPR FOOT ALTERATIONS IN SYSTEMIC LUPUS ERYTHEMATOSUS: A 1-YEAR LONGITUDINAL STUDY

Keywords: Systemic lupus erythematosus, Patient reported outcomes

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Background: Systemic lupus erythematosus (SLE) is a chronic autoimmune disease mediated by autoantibodies, with involvement of various organs[1,2]. El 95% of patients with SLE have musculoskeletal involvement[1], most often in the form of arthralgias or non-erosive arthritis affecting mainly the hands and knees. Although the feet are equally affected and can result in significant disability, they have been little studied.

Objectives: To determine changes in foot involvement in patients with SLE after 12 months of follow-up.

Methods: Longitudinal case series. Thirty-six subjects with a diagnosis of SLE were consecutively recruited in the Rheumatology Unit between March and June 2021 and followed up at 12 months. Inclusion criteria were: patients with a diagnosis of SLE according to EULAR/ACR 2019 criteria, with at least one year of evolution and age equal to or older than 18 years. A Rheumatology nurse collected information on socio-demographic data and the questionnaires at baseline and at 12 months. The questionnaires were: SLEDAI (Systemic Lupus Erythematosus Disease Activity Index) and SLICC (Damage Index for Systemic Lupus Erythematosus), quality of life: EQ-5D, foot function: FFI (Foot Function Index), FAAM (Foot and Ankle Ability Measures Questionnaire), FAAM-Sport, FPI (Foot Posture Index). A descriptive analysis of the main variables, and a paired t-test or Wicoxon t-test, as appropriate, were performed between the baseline and 12-month follow-up visits.

Results: Thirty-six patients with SLE (97.2% women) with a mean (SD) age of 49.31 (11.4) years with a range 23-66 years participated. Regarding treatment a total of 22/36 patients (66.2%) had immunosuppressive treatment, 4/36 (11.1%) biological therapy and 26/36 (72.2%) hydroxychloroquine treatment. After 12 months of follow-up, the disease remained stable and there were no significant differences in the SLICC and SLEDAI indices of SLE. There were also no significant differences in the different foot questionnaires administered: FAAM, FAAM-Sport, FPI, FFI after 12 months of evolution. There was only a worsening in VAS EQ5D (p=0.028) although there was no significant change in EQ5D (p=0.773) (Table 1).

Conclusion: In SLE patients with stable disease over one year of follow-up, assessments of foot function and ability remain unchanged. It is important to integrate foot assessment into the joint evaluation because of the high impact on the patient's quality of life and patient functionality.

Table 1.

	Baseline (Mean± SD)	12 months (Mean± SD)	P value
EQ5D	0,54±0,25	0,55±0,23	0,773
EVAEQ5D	66,43±21,61	57,36±24,77	0,028
FFI	37,52±25,23	36,24±25,29	0,965
FAAM	0,65±0,23	1,05±2,57	0,322
FAAM-Sport	0,51±0,28	0,57±0,28	0,779
FPI rigth	2,33±2,19	2,37±2,21	0,324
FPI left	1,36±1,85	1,37±1,88	0,248
SLICC	0,86±1,45	0,72±1,16	0,257
SLEDAI	1,44±1,94	1,02±1,87	0,117

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AB1799-HPR COMPARISON OF EXERCISE CAPACITY, PHYSICAL ACTIVITY LEVEL, AND PERIPHERAL MUSCLE STRENGTH IN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS WITH HEALTHY INDIVIDUALS

Keywords: Systemic lupus erythematosus, Physical therapy/Physiotherapy, Quality of life

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Background: Systemic lupus erythematosus (SLE) is a chronic, autoimmune, inflammatory rheumatic disease that causes tissue damage through autoantibodies and immune complexes. Patients with chronic diseases such as SLE fall into a vicious circle. Fatigue and depression can negatively affect the quality of life and cause patients to stay at home and hence, be physical inactivity. As a result of physical inactivity; the exercise capacity and muscle strength of SLE patients can decrease.