260 HOW MUCH DIFFERENCE CAN WE MAKE BY STANDARDIZED ASSERTIVE MANAGEMENT OF CARDIOVASCULAR RISK FACTORS IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS: A REAL-LIFE CLINIC STUDY

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Background: Patients with SLE have an increased risk of developing cardiovascular disease (CVD) compared with healthy people of the same age and gender. It is recognized that generic CVD risk factors contribute to this increased risk. There are no consensus standards on how to manage these conventional risk factors in SLE patients. Challenges include establishing a simple, effective protocol that can be operated within a busy NHS clinic, setting standards for investigation and intervention and identifying patients who would benefit.

Methods: We designed a simple one-page protocol with input from doctors working in the lupus clinic and the CVD risk team. The aim was to capture information on age, sex, ethnicity, BMI, smoking status, blood pressure (BP) measurements and lipid levels for every SLE patient attending our lupus clinic. We report the results collected over 9 months. Criteria for intervention were as follows: serum low-density lipoprotein (LDL) >2.6 mmol/l in patients >40 years of age (liaise with the general practitioner to recommend treatment), offer all smokers referral to a smoking cessation service using the Smoking in Lupus leaflet and BP >140/90 mmHg (elevated as defined by the National Institute for Health and Care Excellence), confirmed by repeat reading, should lead to 24 h BP monitoring.

Results: Of a potential cohort of 448 SLE patients, data were collected on 309 patients (69%) with an average age of 47 years; 94% were female, 55% were Caucasian, 25% were Afro-Caribbean/African, 14% were Asian and 6% other. LDL was measured in 256 (82%) patients, of whom 64 were >40 years of age with LDL >2.6 mmol/l, but this only led to intervention being recommended in 13 patients. Smoking was less common among women in this cohort (10%) than in UK women generally (17%), but only one patient accepted referral to smoking cessation.

Forty-three of 309 (14%) patients were eligible for 24 h BP monitoring and 32 were referred, of whom 6 were hypertensive. Three have had their BP drugs increased and the other three have been referred to a hypertension clinic. However, 48% of all patients were already on anti-hypertensives.

Obesity (BMI >30 kg/m²) was seen in 62/309 (20%) patients, of whom 52% were on steroids, 47% on BP drugs and 11% on statins. Twenty-six per cent of obese patients were hypertensive, 5% diabetic and 26% had LDL >2.6 mmol/l.

Conclusion: All data were collected during normal clinical consultations and the protocol could readily be applied to >300 patients within 9 months. The results suggest that smoking and hypertension would not be rewarding targets for intervention. Our patients are very reluctant to change smoking behaviour and, in this cohort, BP is already managed appropriately in most patients. However, high LDL may represent an unmet need for intervention, and the one-fifth of patients who are obese may be a group with clustering of cardiovascular risk factors who could be targeted more stringently.

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