

SA has been reported four times more often as compared to other non-veteran cohorts. (Wong 2015). The risk of developing dementia is increased in older individuals with OSA (Shastri, Bangar, & Holmes, 2015). The prevalence and characteristics of older adults with dementia and sleep apnea is not well known and long-term population-based studies on mortality have been lacking. Recent studies have reported overall mortality rates of 19%, in those individuals with SA, an increased rate of 1.5-3 times the mortality rate as compared to those individuals those without SA. Current recommendations support SA screening of high risk individuals including those with symptoms of snoring, fatigue, memory and concentration problems and mood changes. (Krist 2018). Despite a large number of older adults with suspected SA and comorbidities, the majority are not screened, referred, diagnosed and treated. In this VA pilot study of outpatient older male veterans with dementia and SA, N=195, mean age 75.83 years, SD=9.1, 51.3% were white, 37.5% were black. Frequently found comorbidities were: hypertension 88%, congestive heart failure 41%, Diabetes. 62% and stroke 21%. Of note, among those who died, SA was significantly related to congested heart failure ($r=.32$, $p<.001$) and COPD ($r=.40$, $p<.001$). The overall mortality rate of 27% was higher than previous reports. Further investigation is needed to better understand the relationship between comorbidities, and SA, screening, treatment and mortality.

LIFITEGRAST 5% FOR DRY EYE DISEASE: COMBINED EFFICACY AND SAFETY FROM FIVE RANDOMIZED CONTROLLED TRIALS

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Five randomized, double-masked, placebo-controlled trials were conducted in the US in adults with DED, an eye dryness score (EDS, visual analogue scale [VAS], 0–100) ≥ 40 , and inferior corneal staining score ([ICSS], 0–4) ≥ 2.0 at study entry: four 84-day efficacy trials (phase 2, lifitegrast n=58, placebo, n=58; phase 3: OPUS-1, n=293, n=295; OPUS-2, n=358, n=360; OPUS-3, n=355, n=356) and a 1-year safety study (SONATA, lifitegrast n=220, placebo n=111). The pooled population had a mean age of 59.4 years, and 76% were females. Lifitegrast treatment, versus placebo, significantly improved EDS from baseline to day 84 in three of the four trials: OPUS-1 (treatment effect [TE] 4.7; $P=0.0311$), OPUS-2 (TE 12.3; $P<0.0001$), and OPUS-3 (TE 7.5; $P=0.0003$). Lifitegrast significantly improved ICSS in the phase 2 (TE 0.25; $P=0.0498$) and OPUS-1 (TE 0.23; $P=0.0007$) trials, and nominally in OPUS-3 (TE 0.17;

nominal $P=0.0135$). The responder analyses from OPUS-2 and OPUS-3 assessed the proportion of subjects with an EDS reduction from baseline (≥ 10 , ≥ 15 , ≥ 20 points), and percentage change from baseline (≥ 30 , ≥ 50 , $\geq 70\%$), to days 14, 42 and 84. More subjects achieved $\geq 30\%$ EDS reduction with lifitegrast versus placebo in Opus-2, and Opus 3 at days 14, 42, and 84 (all nominal $P<0.0001$). A similar trend was seen at other response thresholds. Pooled safety data (lifitegrast n=1287; placebo, n=1177) indicated Lifitegrast was well tolerated with no serious ocular adverse events. Lifitegrast significantly improved signs and symptoms of DED in adult subjects, with EDS improvements observed starting at day 14 after treatment.

PREDICTORS OF SHORTNESS OF BREATH DURING STAIR CLIMB IN COMMUNITY-DWELLING INDIVIDUALS WITH COPD

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Dyspnea is the primary and most disabling symptoms seen in chronic obstructive pulmonary disease (COPD). Primary pathophysiological changes such as dynamic hyperinflation have been associated with the etiology of dyspnea in chronic obstructive pulmonary disease (COPD). However, since the experience of dyspnea “derives from interactions among multiple physiological, psychosocial and environmental factors”, a single correlate to accurately predict dyspnea has not been established. The purpose of this study was to identify factors that could predict shortness of breath during stair climb (SOB-SC) in community dwelling adults with COPD. We hypothesized that physical activity and muscle strength would significantly predict SOB-SC. Individuals with COPD who participated in the National Health and Nutrition Examination Survey (NHANES) between years 1999-2002 were selected for this study. Participants were excluded if they had significant mobility limitations. Socioeconomic, demographic variables, and clinical variables including BMI, physical activity, comorbidities, muscle strength, ankle brachial index, waist circumference and inflammatory markers were extracted. Logistic regression models were plotted with SOB-SC as the categorical dependent variable after assessing for collinearity using the forced-entry method. Individuals with COPD had a significantly greater proportion of SOB-SC ($\chi = 134.87$, $p < 0.001$). Larger waist circumference ($p = 0.002$, $CI = 0.04 - 0.13$), presence of cardiovascular disease ($p = 0.001$, $CI = 0.76 - 2.37$) and Caucasian race were found to significantly predict SOB-SC after controlling for covariates. This study reinforces the importance of screening for cardiovascular disease and lifestyle modification in this population subgroup. Future studies examining differences in COPD severity are needed.

SESSION 1325 (POSTER)

CROSS CULTURAL STUDIES

A QUALITATIVE REVIEW OF OLDER ADULT PERSPECTIVES ON HEALTHY AGING IN THE CIRCUMPOLAR NORTH

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