characterized by a lower cumulative prednisone dosage, reduced maximum prednisone dosage and a higher number of methylprednisolone pulses was associated with an increased likelihood of achieving prolonged remission. The results are presented in detail within table 1 and figure 1.

Conclusions This study underscores the significant impact of early GC management patterns in achieving prolonged remission among SLE patients. Identifying clusters of GC usage provides insights into optimizing treatment strategies and promoting sustained remission. The findings emphasize the importance of tailored GC regimens to improve long-term outcomes in SLE patients.

Acknowledgements Dr. Ruiz-Irastorza was supported by the Department of Education of the Basque Government, research grant IT 1512–22. Dr. Hernandez-Negrin was supported by Consejería de Transformación Económica, Industria, Conocimiento y Universidades. Junta de Andalucía-Sevilla (Spain), research grant PREDOC-00826.

P66 CUTANEOUS VASCULITIS IN PATIENTS WITH ACTIVE VERSUS INACTIVE SYSTEMIC LUPUS ERYTHEMATOSUS: A CASE SERIES

[1]Catherine Grace Hobayan, [2]Abraham Korman, [3]Judith Lin. *[1]College of Medicine, The Ohio State University, Columbus, Ohio, USA; [2]Dept. of Dermatology, The Ohio State University, Columbus, Ohio, USA; [3]Division of Rheumatology and Immunology, Dept. of Internal Medicine, The Ohio State University, Columbus, Ohio, USA*

10.1136/lupus-2024-el.120

Objective Cutaneous vasculitis (CV) is a rare manifestation of systemic lupus erythematosus (SLE). The aim of this study was to determine differences in clinical and laboratory characteristics of CV patients with active versus inactive SLE.

Methods Nine patients with a diagnosis of SLE confirmed by rheumatology and dermatology who had biopsy-proven CV between 2015–2022 at a single institution were identified for retrospective chart review. Active SLE (ASLE) indicates symptomatic SLE. Inactive SLE (ISLE) indicates that SLE is in remission.

Results Three patients had ASLE, and six patients had ISLE. Clinical manifestations of CV include palpable purpura, ulcers, and urticarial lesions. CV in patients with ASLE presented within 1 year of initial SLE diagnosis, whereas CV in ISLE presented later than 1 year after initial SLE diagnosis. 66.7% of ASLE patients required a total of three or more immunosuppressive medications; this was also true for 66.7% of ISLE patients. Serologic findings and blood counts were not found to be correlated with SLE activity or presence of CV. 100% of ASLE patients had hypocomplementemia, compared to 50% of ISLE patients. Complements were not predictive of CV in ISLE patients except for those with urticarial vasculitis on biopsy.

Conclusion CV can concomitantly occur in ASLE but may also develop when SLE is in remission. In patients with a history of SLE, CV often requires aggressive immunosuppressive treatment regardless of SLE activity. Larger-scale prospective studies are necessary to confirm findings.

Acknowledgements This study was approved by the Institutional Review Board of the Ohio State University (#2023E0607) and supported by Award #UL1TR002733 from the National Center for Advancing Translational Sciences (NCATS). The content is solely the responsibility of the authors and does not necessarily represent the official views of NCATS or the National Institutes of Health.

P67 THE SLE-DAS ENABLES EASY IDENTIFICATION OF SLE PATIENTS WITH SEVERE DISEASE ACTIVITY AND WORSE HEALTH-RELATED QUALITY OF LIFE: DERIVATION AND VALIDATION IN POST-HOC STUDY OF ANIFROLUMAB PHASE 2 AND 3 CLINICAL TRIALS

[1,2]Diogo Jesus, [3,4]Carla Henriques, [3,5]Ana Matos, [6]Andrea Doria, [2,7]Luís Sousa Inês. *[1]Rheumatology Dept., Centro Hospitalar de Leiria, Leiria, Portugal; [2]Faculty of Health Sciences, University of Beira Interior, Covilhã, Portugal; [3]School of Technology and Management, Polytechnic Institute of Viseu, Viseu, Portugal; [4]Centre for Mathematics, University of Coimbra, Coimbra, Portugal; [5]Research Centre in Digital Services (CISeD), Viseu, Portugal; [6]Reumatology Unit, Dept. of Medicine, University of Padova, Padova, Italy; [7]CHUC Lupus Clinic, Rheumatology Dept., Centro Hospitalar e Universitário de Coimbra, Coimbra, Portugal*

10.1136/lupus-2024-el.121

Background Accurate and practical outcome measures for clinical trials in SLE are lacking.

Objectives (i) To derive and validate the SLE-DAS cut-off value for defining severe disease activity (SDA); (ii) to evaluate if patients in SDA by SLE-DAS, SLEDAI-2K and BILAG-2004 present worse health-related quality of life (HR-QoL).

Methods Post-hoc analysis of aggregated intention-to-treat data from the placebo arms from MUSE, TULIP-1 and -2 trials (NCT01438489, NCT02446912 and NCT02446899) of anifrolumab versus placebo for moderate-to-severe SLE. We analyzed the BILAG-2004, SLEDAI-2K and the patient reported outcomes (PROs) [(LupusQoL, EQ-5D, FACIT-F and Patient Global Assessment (PtGA)]. The SLE-DAS was retrospectively scored. Derivation of the SLE-DAS cut-off for SDA, was performed using data from the MUSE and TULIP-2 trials at week 12, through bootstrap based method for ROC curve analysis against BILAG-2004 (numerical score >11). Performance of the SLE-DAS SDA cut-off was assessed using TULIP-1 trial data. We further compared the HR-QoL PROs between patients in SDA *vs* non-SDA by SLE-DAS, SLEDAI-2K (>12) and BILAG-2004, using Mann-Whitney test. The magnitude of these differences was compared using Cohen's d.

Results At week 12, from 438 SLE patients, 46.6% and 42.4% were classified in SDA by BILAG-2004 in the derivation and validation cohorts, respectively. In the derivation cohort, the best cut-off to identify patients in SDA was SLE-DAS >9.90 (AUC=0.847, 95%CI:0.811–0.882). When applied in the validation cohort this cut-off showed a sensitivity =77.8% and a specificity =79.6%. Patients in SDA by SLE-DAS and BILAG-2004 presented significantly worse impact in all HR-QoL PROs ($p<0.0001$ and $p<0.001$, respectively) (table 1). In contrast, patients in SDA by SLE-DAI-2K did not present significantly severe impact in EQ-5D, FACIT-F, PtGA and 5/8 domains of LupusQoL. Notably, the SLE-DAS SDA presented numerically higher effect sizes for all HR-QoL PROs, as compared to BILAG-2004 and SLEDAI-2K.

Conclusion The SLE-DAS is an easy-to-use tool for identifying patients in SDA. The SLE-DAS SDA identifies patients with worse HR-QoL, thus enabling good agreement between the physicians' and patients' perspectives. This study suggests that SLE-DAS SDA may present higher ability to discriminate patients with worse aspects of HR-QoL.

Abstract P67 Table 1 Health-related quality of life comparison between patients in severe disease activity (SDA) *vs* non-SDA according to SLE-DAS (>9.90), BILAG-2004 (numerical score >11) and SLEDAI-2K (>12)

	SLE-DAS Non-SDA *vs* SDA		BILAG-2004 Non-SDA *vs* SDA		SLEDAI-2K Non-SDA *vs* SDA	
	*p**	Cohen's d (95%CI)	*p**	Cohen's d (95%CI)	*p**	Cohen's d (95%CI)
LupusQoL						
Physical Health	<0.0001	0.56 (0.37–0.75)	0.0002	0.35 (0.16–0.54)	0.1795	0.16 (-0.10–0.42)
Pain	<0.0001	0.58 (0.39–0.77)	0.0001	0.35 (0.16–0.55)	0.4527	0.06 (-0.20–0.32)
Planning	<0.0001	0.49 (0.29–0.68)	0.0003	0.30 (0.11–0.49)	0.2072	0.13 (-0.13–0.39)
Intimate relationship	0.0002	0.33 (0.14–0.53)	0.0099	0.24 (0.04–0.44)	0.4939	0.07 (-0.20–0.34)
Burden to others	<0.0001	0.44 (0.25–0.63)	<0.0001	0.41 (0.22–0.60)	0.0422	0.25 (-0.01–0.52)
Emotional health	<0.0001	0.44 (0.25–0.63)	0.0011	0.31 (0.12–0.50)	0.0158	0.32 (0.06–0.58)
Body Image	0.0002	0.31 (0.11–0.50)	0.0001	0.39 (0.19–0.58)	0.0230	0.24 (-0.02–0.51)
Fatigue	<0.0001	0.52 (0.33–0.71)	0.0001	0.39 (0.20–0.58)	0.0699	0.23 (-0.03–0.49)
EQ-5D Index Score	<0.0001	0.47 (0.27–0.66)	0.0003	0.33 (0.14–0.52)	0.7710	-0.02 (-0.28–0.24)
EQ-5D VAS	<0.0001	0.49 (0.30–0.68)	0.0001	0.38 (0.19–0.57)	0.3352	0.15 (-0.11–0.41)
FACIT-F	<0.0001	0.60 (0.41–0.79)	0.0001	0.40 (0.21–0.59)	0.3125	0.12 (-0.14–0.38)
PtGA	<0.0001	0.47 (0.28–0.66)	<0.0001	0.41 (0.22–0.60)	0.1903	0.19 (-0.07–0.45)

Non-SDA: Non-Severe Disease Activity; PtGA: Patient Global Assessment; SDA: Severe Disease Activity. *Mann-Whitney test.

Acknowledgement This publication is based on research using data from data contributors AstraZeneca that has been made available through Vivli, Inc. Vivli has not contributed to or approved, and is not in any way responsible for, the contents of this publication.

P68 COMPARATIVE ANALYSIS OF EFFICIENCIES OF IMMUNOSUPPRESSIVE DRUGS IN SLE WITH DIFFERENT CLINICAL PRESENTATION AND THEIR MOLECULAR STRATIFICATION: A PROSPECTIVE STUDY FROM INDIA

[1]Abhibroto Karmakar, [2]Uma Kumar, [3]Smita Prabhu, [4]Vinod Ravindran, [3]Shankar Prasad, [3]Varashree BS, [1]Subhradip Karmakar, [1]Mukhyaprana M Prabhu. *[1]Dept. of General Medicine, Kasturba Medical College Manipal, Udupi, India; Dept. of Biochemistry, All India Institute of Medical Sciences, New Delhi, India; [2]Dept. of Rheumatology, All India Institute of Medical Sciences, New Delhi, India; [3]Dept. of Nephrology and Biochemistry, Kasturba Medical College Manipal, Udupi, India; [4]Centre for Rheumatology, Calicut, India*

10.1136/lupus-2024-el.122

Objectives 1) Compare the clinical manifestations in SLE patients at diagnosis and after treatment. 2) Stratifying SLE patients on (flare and remission) based on different immunosuppressants (CYC, HCQ and MMF) with optimal therapeutic approach.

Methods The prospective and longitudinal study was performed in the Department of Medicine, Rheumatology, Biochemistry and Nephrology in KMC Manipal and AIIMS New Delhi from Oct 2022 to Oct 2023.

42 lupus patients evaluated with clinical manifestations at diagnosis and after treatment with Cyclophosphamide, Hydroxychloroquine and Mycophenolate. BILAG scoring was done to evaluate the organ involved with disease activity. Blood plasma profiling for molecular stratification of patients at different stages of the disease and genomic DNA was isolated for SNPs non-responding to the above drugs apart from clinical study. Ethics approval from both institutions have been taken for the study and patients gave their informed consent.

Abstract P68 Table 1 The graph explains the clinical features in percentage at the time of diagnosis and after treatment treatment