having had a myocardial infarct, stroke or Transient Ischemic Attack after adjustments to age, gender and disease duration (table 2). The predictors of mortality in the MCTD cohort were % ILD of Total Lung Volume after age and gender adjustments (table 3). According to the Harrell’s C index, patient outcomes were accurately predicted by the SLE multivariable model 85% of the time and 84% in the MCTD model.

Conclusions SLE and MCTD are similar in many aspects, but differ in disease manifestations that have an impact on mortality, indicating that different follow-up approaches and management is needed.

S1d: Therapeutic strategies

Abstract S1A:6 Table 3  Mortality prediction in MCTD patients (N=145)

<table>
<thead>
<tr>
<th>Clinical features</th>
<th>Multivariable model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HR</td>
</tr>
<tr>
<td>% ILD of TLV</td>
<td>1.07</td>
</tr>
<tr>
<td>Age at study inclusion</td>
<td>1.09</td>
</tr>
<tr>
<td>Male gender</td>
<td>.45</td>
</tr>
</tbody>
</table>

Abstract S1A:6 Table 1  Characteristics in MCTD and SLE patients

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>SLE N = 243</th>
<th>MCTD N = 145</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at study inclusion, M(SD)</td>
<td>46 (16)</td>
<td>46 (15)</td>
<td>NS</td>
</tr>
<tr>
<td>Age at diagnosis, M (SD)</td>
<td>35 (15)</td>
<td>36 (16)</td>
<td>NS</td>
</tr>
<tr>
<td>Male Gender, N (%)</td>
<td>25 (10)</td>
<td>33 (23)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Disease duration at study inclusion, M(SD)</td>
<td>12 (9)</td>
<td>10 (8)</td>
<td>NS</td>
</tr>
<tr>
<td>Deceased, N (%)</td>
<td>25 (10)</td>
<td>26 (18)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Age at death, M (SD)</td>
<td>69 (14)</td>
<td>68 (15)</td>
<td>NS</td>
</tr>
<tr>
<td>Malar rash</td>
<td>119 (49)</td>
<td>62 (42)</td>
<td>NS</td>
</tr>
<tr>
<td>Arthritis</td>
<td>170 (70)</td>
<td>116 (79)</td>
<td>NS</td>
</tr>
<tr>
<td>Pleuritis</td>
<td>51 (21)</td>
<td>21 (14)</td>
<td>NS</td>
</tr>
<tr>
<td>Pericarditis</td>
<td>36 (15)</td>
<td>19 (13)</td>
<td>NS</td>
</tr>
<tr>
<td>Lupus nephritis</td>
<td>47 (27)</td>
<td>4 (3)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>CNS</td>
<td>18 (7)</td>
<td>11 (8)</td>
<td>NS</td>
</tr>
<tr>
<td>Leukopenia</td>
<td>108 (44)</td>
<td>46 (31)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>48 (20)</td>
<td>19 (13)</td>
<td>NS</td>
</tr>
<tr>
<td>Raynaud</td>
<td>91 (37)</td>
<td>145 (99)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Alopeci</td>
<td>69 (28)</td>
<td>41 (28)</td>
<td>NS</td>
</tr>
<tr>
<td>Myocardial Infarct</td>
<td>12 (5)</td>
<td>3 (5)</td>
<td>NS</td>
</tr>
<tr>
<td>Cerebral infarct</td>
<td>10 (4)</td>
<td>4 (3)</td>
<td>NS</td>
</tr>
<tr>
<td>TIA</td>
<td>5 (2)</td>
<td>1 (1)</td>
<td>NS</td>
</tr>
<tr>
<td>Arterial event</td>
<td>29 (12)</td>
<td>10 (9)</td>
<td>NS</td>
</tr>
<tr>
<td>Venous thrombosis</td>
<td>20 (8)</td>
<td>7 (5)</td>
<td>NS</td>
</tr>
<tr>
<td>Intestinal Lung Disease</td>
<td>3 (1)</td>
<td>52 (35)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>PAH</td>
<td>1 (1)</td>
<td>3 (2)</td>
<td>NS</td>
</tr>
</tbody>
</table>

Abstract S1A:6 Table 2  Mortality prediction in SLE patients (N=243)

<table>
<thead>
<tr>
<th>Clinical features</th>
<th>Multivariable model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HR</td>
</tr>
<tr>
<td>Myocardial infarct, Cerebral infarct or TIA</td>
<td>3.58</td>
</tr>
<tr>
<td>Age at study inclusion</td>
<td>1.09</td>
</tr>
<tr>
<td>Male gender</td>
<td>.41</td>
</tr>
<tr>
<td>Disease duration at inclusion</td>
<td>.98</td>
</tr>
<tr>
<td>Lupus nephritis class III to VI</td>
<td>3.89</td>
</tr>
</tbody>
</table>
Conclusions The inclusion of PGA <0.5 in the definition reduces the frequency of remission only in the long-term (≥5 year). A sustained remission, regardless of its definition, is associated with a lower chronic damage development. The addition of prednisone ≤5 mg/day and/or PGA <0.5 to c-SLEDAI=0/≤1 increases the ability to predict the absence of damage accrual compared with cSLEDAI=0/≤1 without substantial differences among them.