Abstract O13 Table 1 Description of the cohort at first visit and pregnancy outcomes

Median maternal age at conception (IQR)	31.9 years (29–35)
Median disease duration at the time of pregnancy (IQR)	10 years (6–14)
Median duration from the last flare (IQR)	4.1 years (2–6)
Mean duration of pregnancy (IQR)	37.1 weeks (36–40)
Birthweight median value (IQR)	2802.1 grams (2595–3231)
Patients with active disease at the beginning of pregnancy (%)	5 (6.6%)
LLDAS BUT NOT remission (%)	5 (6.6%)
LLDAS (%)	60 (80%)
Complete remission off treatment (%)	5 (6.6%)
Clinical remission off treatment (%)	10 (13.3%)
Clinical remission on treatment (%)	21 (28%)
Complete remission on treatment (%)	17 (22.6%)
Preterm prelabour rupture of membranes	11 (14.6%)
Preterm delivery (%)	19 (25.3%)
SGA infant (%)	14 (18.6%)
IUGR (%)	1 (1.3%)
IUFD (%)	2 (2.6%)
Gestational diabetes (%)	4 (5.3%)

pregnancy with respect to active patients (OR 12.47, $p < 0.02$). Patients in LLDAS but not remission showed an increased risk of flare with respect to remitted patients ($p < 0.001$) while no significant differences were found between patients in clinical versus complete remission. No associations were found between disease status at the beginning of pregnancy and obstetric complications.

Conclusions These data confirm that disease remission is one important predictor of pregnancy outcomes in SLE. While serology seems not to have a substantial role, a residual disease activity at conception might impact on pregnancy outcomes. Available definitions of remission and LLDAS could be valid treatment targets in the family planning perspective.

O14 THE INFLUENCE OF ANTIPHOSPHOLIPID-ANTIBODIES ON INR VALUES MEASURED WITH THE COAGUCHEK

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Introduction Patients with the antiphospholipid syndrome on anticoagulant therapy can be monitored with the INR using Point Of Care (POC) devices. However, INR values could be falsely elevated due to antiphospholipid-antibodies using POC devices. Previous studies that have compared INR values measured with POC devices and a laboratory coagulometer in APS patients varied in the methods, which makes the interpretation of the results difficult. We have, therefore, conducted this single center study to investigate whether INR values in APS patients measured with the most commonly used POC device (CoaguChek) in the Netherlands are comparable with whole blood INR values in our laboratory in the UMC Utrecht.

Methods INR values measured by the CoaguChek and by the coagulometer in our laboratory measured with the Owren method using a rabbit brain derived thromboplastin were

compared in 20 consecutive APS patients. A paired students T-test was performed to compare both means and a p value < 0.05 was considered as statistically significant. Linear regression analysis was performed to express the correlation between both test methods. A Bland-Altman plot was constructed to illustrate the agreement of the POC and laboratory INR. A difference > 0.5 was considered clinically significant.

Results No statistically significant difference between the INR measured with the CoaguChek and the coagulometer in our laboratory was found ($p > 0.05$). Furthermore, an acceptable correlation was found in the linear regression analysis ($r = 0.893$). However, in 3 patients with triple antiphospholipid antibody positivity, a clinically relevant difference in the INR was found (> 0.5).

Conclusion In conclusion, the CoaguChek generates comparable results with the coagulometer in our clinic. However, in a subset of patients with triple positivity the CoaguChek show a clinical relevant difference. Therefore, results of the CoaguChek in this group of patients should be interpreted with caution.

O15

CONCORDANCE BETWEEN THE NEW SLE-DAS, DORIS AND DORIA REMISSION CRITERIA FOR SLE: ARE THEY DIFFERENT IN A REAL-LIFE CLINICAL SETTING?

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Background Systemic Lupus Erythematosus Disease Activity Score (SLE-DAS), a new, continuous measure, presents improved sensitivity to change as compared to SLE Disease Activity Index (SLEDAI-2K). It comprises 17 items, including important manifestations absent in SLEDAI (hemolytic anemia, gastrointestinal and cardiopulmonary involvement). The Doria and DORIS clinical remission criteria are both based in SLEDAI. This study aims to compare the attainment of clinical remission defined by SLE-DAS, DORIS and Doria criteria in a real-life clinical setting.

Methods Cross-sectional study of all SLE patients fulfilling ACR'97 and/or SLICC'12 classification criteria followed at an academic lupus clinic from January to September 2019. Fulfillment of DORIS, Doria and SLE-DAS clinical remission status was verified for each patient. The SLE-DAS clinical remission criteria were defined as a score of 0 in all clinical items of SLE-DAS and prednisone dose of 0–5 mg/day. We compared the attainment of clinical remission for each patient according to the three definitions. Sensitivity, specificity, positive and negative predictive values of SLE-DAS remission for Doria and for DORIS remission were calculated.

Results The study population included 293 patients (female = 86.7%; mean age = 47.7 years; mean disease duration = 14.4 years). The proportion of patients in clinical remission was 76.5% as defined by the DORIS and Doria criteria. Patients in clinical remission according to the SLE-DAS definition exactly matched those defined by either Doria or DORIS criteria and there were no discordant cases. From patients in clinical remission, 17%, 93.3%, and 30.4% were treated with

prednisone, antimalarials, and immunosuppressants, respectively.

Conclusions In a real-life cohort of SLE patients, clinical remission is consistently defined by applying either SLE-DAS, DORIS or Doria criteria. SLE-DAS definition is more straightforward, as it does not require the PGA or additional manifestations not included in SLEDAI.

016

DO WE NEED PHYSICIAN GLOBAL ASSESSMENT FOR REMISSION IN SLE? ANALYSIS FROM AN SLE-COHORT AT A TERTIARY CENTER

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Background/Purpose The definition of an accurate target for a treat to target (T2T) approach in SLE has been challenging over the past years. Recently four definitions of remission were presented by the international DORIS task force comprising the parameters clinical activity (cSLEDAI), steroid dose, immunosuppressive therapy, serology and physician global assessment (PGA). In particular the PGA, its threshold and general utility have been and still are discussed controversially. It was our aim to evaluate the added value of PGA in remission assessment.

Methods In this monocentric cross-sectional study, patients with SLE according to the 1997 American College of Rheumatology (ACR) criteria were enrolled and assessed between September 2016 and December 2017. Two different definitions of remission were applied. The internationally accepted DORIS remission and a modified DORIS remission excluding PGA. Factors influencing PGA were assessed in the entire cohort. Regression analyses were used to establish differences between patients in DORIS and modified DORIS remission.

Results A total of 233 patients were included (87.6% female). 98 (41.9%) patients fulfilled any of the four DORIS remission definitions while 154 (66.1%) patients were in modified remission (PGA was excluded). In general, PGA rating was dependent on disease activity (clinical SLEDAI; $p \leq 0.0001$), depression (Center for Epidemiological Studies Depression Scale; $p = 0.049$), pain reported by the patient (numeric rating scale; $p \leq 0.0001$) and hypocomplementemia ($p \leq 0.0001$). Damage (SLICC damage index, SDI) did not influence PGA ($p = 0.98$). Both, DORIS and modified DORIS remission were associated with lower damage ($\beta = 0.026$ vs $p = 0.003$), lower pain on NRS ($p = 0.001$ vs. $p = 0.013$), normal complement ($p = 0.0005$ vs $p = 0.005$) and better illness perception ($p = 0.006$ vs $p = 0.023$). Patients in modified DORIS remission tendentially received more often immunosuppressive therapy ($p = 0.046$).

Conclusion Exclusion of PGA in remission assessment led to an increase of patients in remission. Clinical parameters and factors associated with DORIS remission vs. modified DORIS remission were similar, hence the added value of PGA in our cohort regarding remission assessment is questionable. PGA remains an option for treating physicians to contribute their own opinion and experience and to not rely on objective measures only. The use and especially the correct threshold of PGA for remission still has to be discussed.

017

TREATMENT TARGET IN NEWLY DIAGNOSED SLE PATIENTS: LOW DISEASE ACTIVITY AND REMISSION ARE INDEPENDENTLY ASSOCIATED WITH LOWER ACCRUAL OF EARLY DAMAGE

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Background/Purpose To compare the independent effect of achievement and maintenance of lupus low disease activity state (LLDAS) and clinical remission (CR) in preventing early damage accrual in the early stage of systemic lupus erythematosus (SLE) management.

Methods In a monocentric inception cohort of 116 newly diagnosed SLE patients, LLDAS and CR achievement at 6 months (T1) after treatment initiation and their maintenance over the next 12 (T2) months were assessed. Early damage was assessed (T2) using the SLICC/damage index. Uni- and multivariate analysis were performed to evaluate the association of LLDAS and CR with early damage.

Results LLDAS achievement was significantly more frequent than CR both at T1 (42.2% vs. 21.6%, $p < 0.001$) and T2 (46.6% vs. 31.9%, $p = 0.022$), with an increasing trend in the overlap rate observed over follow-up (from 51.0% at T1 to 68.5% at T2). Higher SLEDAI score (OR: 1.33, 95%CI 1.04–1.71, $p = 0.022$) at baseline, but not higher prednisone dose, was associated with failure to achieve CR at T1.

The overlap between persistent LLDAS and persistent CR between T1 and T2 was observed in 41.7% of cases. On multivariate analysis, the achievement of CR (OR 0.1, 95%CI 0.01–0.59, $p = 0.015$) and LLDAS without CR (OR 0.2; 95%CI 0.06–0.99, $p = 0.049$) at T1, as well as younger age at onset (OR 0.95, 95%CI 0.91–0.98, $p = 0.004$), were negatively associated with early damage. Patients who achieved LLDAS at T1 and steadily persisted in this condition until T2 developed significantly less damage compared to those who failed to maintain it during the T1-T2 interval ($p = 0.003$), those who achieved it later than T1 ($p < 0.001$) or those who had never been in this condition ($p < 0.001$).

Conclusions Although CR is recommended as the primary treatment target in SLE, LLDAS may represent a valid alternative in the early stage of SLE management. LLDAS and CR maintenance should be targeted to prevent damage.

019

EVOLUTION OF KIDNEY ANTIBODY SECRETING CELLS MOLECULAR SIGNATURE IN LUPUS PATIENTS WITH ACTIVE NEPHRITIS UPON IMMUNOSUPPRESSIVE THERAPY

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