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.

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 DORIS remission (PGA was excluded). In general, PGA rating was dependent on disease activity (clinical SLEDAI; p≤0.0001), depression (Center for Epidemiological Studies Depression Scale; p=0.049), pain reported by the patient (numeric rating scale; p≤0.0001) and hypocomplementemia (p≤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 (β=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.