prendisone, 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
Johanna Mucke, Christina Düssing, Gamal Chehab, Matthias Schneider. Policlinic and Hiller Research Unit for Rheumatology, Heinrich-Heine-University Düsseldorf, Germany
10.1136/lupus-2020-eurolupus.28

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. Patients in modified DORIS remission were more likely to receive prednisone, antimalarials, and immunosuppressants (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
Matteo Piga, Alberto Floris, Daniela Ferra, Elisabetta Chessa, Mattia Congiu, Alessandro Mathieu, Alberto Gauli. Reumatologia, Policlinico Universitario AOU e Università di Cagliari, Cagliari, Italy
10.1136/lupus-2020-eurolupus.29

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 0.06–0.99, 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
12Étienne Crickx, 12Farah Tamirisu, 12Tessa Hussenot, 12Nathalie Costedoat, 12Marion Rabant, 12Alexandre Karras, 12Tatiana Fadadev, 12Véronique Le Guem, 12Philippe Remy, 12Audrie Hummel, 12Bernard Lauwerys, 12Jean-Claude Weill, 12Claude-Agnès Reynaud, 12Frédéric Houssiau, 12Mathieu Mahévas. 12Institut Necker-Enfants-Malades, INSERM U1151/CRNS-UMS B253, Université Paris Descartes, Paris; 12APHP, Internal Medicine Dept., Henri-Mondor Hospital, Université Paris-Est, Créteil, France; 12Service de Rhumatologie, Cliniques Universitaires Saint-Luc, Brussels, Belgium; 12APHP, Dept. of Internal Medicine, Lariboisière Hospital, Paris; 12APHP, Internal Medicine Dept., Cochin Hospital, Paris; 12APHP, Pathology Dept., Necker Hospital, Paris; 12APHP, Nephrology Dept., HEGP, Paris; 12APHP, Nephrology Dept., Henri-Mondor Hospital, Créteil; 12APHP, Nephrology Dept., Necker Hospital, Paris, France
10.1136/lupus-2020-eurolupus.30

Abstracts