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

Johanna Mücke, Christina Düsing, Gamal Chehab, Matthias Schneider. *Polidinic and Hiller Research Unit for Rheumatology, Heinrich-Heine-University Duesseldorf, 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 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

Matteo Piga, Alberto Floris, Daniela Perra, Elisabetta Chessa, Mattia Congia, Alessandro Mathieu, Alberto Cauli. *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 0.01–0.59, $p = 0.015$) 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

^{1,2}Etienne Crickx, ³Farah Tamirou, ^{1,4}Tessa Huscenot, ⁵Nathalie Costedoat, ⁶Marion Rabant, ⁷Alexandre Karras, ¹Tatiana Fadeev, ⁵Véronique Le Guern, ⁸Philippe Remy, ⁹Auréli Hummel, ³Bernard Lauwerys, ¹Jean-Claude Weill, ¹Claude-Agnès Reynaud, ³Frédéric Houssiau, ^{1,2}Matthieu Mahévas. *¹Institut Necker-Enfants-Malades, INSERM-U1151/CNRS-UMS 8253, Université Paris Descartes, Paris; ²APHP, Internal Medicine Dept., Henri-Mondor Hospital, Université Paris-Est, Créteil, France; ³Service de Rhumatologie, Cliniques Universitaires Saint-Luc, Brussels, Belgium; ⁴APHP, Dept. of Internal Medicine, Lariboisière Hospital, Paris; ⁵APHP, Internal Medicine Dept., Cochin Hospital, Paris; ⁶APHP, Pathology Dept., Necker Hospital, Paris; ⁷APHP, Nephrology Dept., HEGP, Paris; ⁸APHP, Nephrology Dept., Henri-Mondor Hospital, Créteil; ⁹APHP, Nephrology Dept., Necker Hospital, Paris, France*

10.1136/lupus-2020-eurolupus.30