Despite these potential pitfalls, we believe that the EULAR/ACR criteria are a relevant step forward in appropriately defining who has SLE, and in teaching doctor and medical students how to approach a patient with possible SLE. The data have clearly demonstrated that ANA negative SLE is uncommon, and ANA are a useful entry criterion or screening parameter in case of suspected SLE. The analysis of interactions has important implications in that it has shown interactions within domains, upholding this concept, but not found significant associations between domains (or items in various domains). The latter in fact is an argument that SLE is indeed a disease, not a syndrome, and that it is the effector arm of the autoantibodies in any given SLE patient that underlies the variability.

Conclusions We will need more knowledge on autoantibodies, not less, and probably more clinical training, but this is more of a chance than a challenge. Above all, it has been remarkably easy to work together in this huge group, over the Atlantic and beyond, and I am deeply grateful for the contribution of so many colleagues. This large team experience of collegiality and friendship will hopefully help the further worldwide collaboration that is necessary for advancing the field.

Acknowledgements The EULAR/ACR SLE classification project was equally supported by EULAR and ACR. Please refer to the publications for contributors to this effort.

Abstract 16 Figure 1 Delineations of cutaneous diseases. Thomas Bateman, London (1918)

(Systemic Lupus Erythematosus). The modern history of lupus is notably marked by the discovery of lupus cells (LE cells) by Hargraves in 1948, of antinuclear antibodies by Miescher in 1954 and by the recognition of DNA as the main target of ANAs by Seligman in 1957.

Many treatments have been proposed for lupus throughout the ages, including the use of cauterization & caustics (from the middle age to the modern era), radium (1900–1905), and even concentrated sun light & UVs in London in 1905! Quinine was introduced in 1894 while most modern treatments for SLE appeared in the second half of the 20th century: glucocorticoids (1948–1952), quinacrine (1951), cyclophosphamide (1954), hydroxychloroquine (1956), azathioprine (1957) and mycophenolate mofetil (1980s). The end of the 20th century and the beginning of the 21st century are marked by a better understanding of the pathogenesis of the disease and the systematic evaluation of treatments, paving the way for improved diagnosis and better care for lupus patients.

Background Lupus patient’s expectations are no different than everyone else’s: ‘A better life’. But achieving it requires different steps because it entails (1) A prompt diagnosis, (2) Access to effective treatment with low side-effects, (3) Resolving