to severe fatigue or psychological issues, amongst other reasons. As such reduced work capacity and/or work loss may occur.

So, how should we assess and monitor patients with SLE?  The (frequency of) assessments depends on the stage of disease (diagnosis and follow-up). Disease activity (active disease [i.e. every 1–3 months] versus stable disease [i.e. every 6–12 months]), and specific conditions (i.e. pregnancy, thrombosis and bone fractures). Measuring disease activity with validated instruments (i.e. SLEDAI-2k, BILAG 2004) at each visit is recommended, in addition to a history and clinical examination, laboratory assessments (including blood, urine and immunology test) and eventually other investigations (i.e. imaging or biopsy); using these instruments results in better outcome, although the evidence is of low-moderate quality. However, high disease activity is associated with poor outcome (higher mortality rate, higher level of organ damage and comorbidities). Conversely, lower levels of disease activity and remission are associated with better outcome. It is important that clinical symptoms can be due to one or any combination of the following: disease activity, thrombosis or active inflammation, drug toxicity, chronic damage due to the disease or to its treatment, or to comorbidity (i.e. infection). Yearly assessment of disease damage (with SLICC Damage Index, SDI) is recommended, although the evidence of better outcome is of low-moderate quality. However, early and late damage is associated with small to moderate increase in mortality, further damage in the future and reduced quality of life and therefore is justified to assess. Regular assessment of cardiovascular (CV) risk factors in particular as well as corticosteroid-associated adverse events is recommended, with moderate-high quality evidence for CV assessment.

The rationale and principles of treat-to-target (T2T) in SLE and how to incorporate T2T in daily clinical practice will be discussed.

Learning Objectives
• Describe the relevance of systematic assessment of disease activity, disease damage, comorbidities and quality of life
• Explain the current clinical practice guidelines in SLE, and define unmet needs in order to improve our daily practice
• Discuss the current state of T2T in SLE

Neuropsychiatric (NP) involvement is one of the most complex and challenging features of systemic lupus erythematosus (SLE) encompassing the central (CNS), peripheral (PNS) and autonomous nervous system (ANS) as defined by the American College of Rheumatology standard nomenclature and case definitions. NPSLE has a negative impact on patient’s quality of life and is associated with increased morbidity and mortality. The full disease burden of NPSLE is not clearly known, because robust epidemiology studies are lacking or biased by different methodology design. A realistic estimate of the prevalence of NP involvement in SLE is around fifty percent of SLE patients.

The challenge of diagnosis: As none of the NP syndromes that occur in SLE have features that are specific for SLE, determination of the correct attribution of NP events in SLE patients is a challenging but critical step in the treatment of individual patients and in performing research studies. In fact, erroneous attribution can lead to suboptimal treatment and to incorrect designation of patient groups in research studies. Approximately 30% of all NP events are attributable to SLE (NPSLE) and present most frequently around the time of SLE onset. Modern and rapidly evolving neuroimaging technologies can help clinicians in both diagnosis and follow up. A multidisciplinary expert team represents the best strategy for NPSLE.

The challenge of treatment: The main proposed pathogenetic pathways include both ischemic and neuroinflammatory mechanisms with evidence for complement and microglia activation. Following diagnosis and causal attribution, the treatment of NPSLE should be tailored to the type of NP event, the predominant putative pathogenic mechanism, in addition to the history (acute or chronic), activity and severity of the clinical event. To treat NPSLE, in the absence of high-level evidence, it is necessary to develop pragmatic therapeutic strategies supported by expert opinion, published observational cohort data on NPSLE and extrapolation from experience with other organ system disease in SLE. To date, therapeutic options include symptomatic, anti-thrombotic and immunosuppressive agents. Therapeutic recommendations released by EULAR in 2010 and, more recently, by ACR/EULAR in 2019 are available.

Although neuropsychiatric manifestations of SLE have been recognised for over 100 years, unmet needs for patients with NPSLE still exist, including a lack of diagnostic biomarkers, lack of novel therapies and lack of clinical trials, which should be focused on future research agendas.

Learning Objectives
• Explain the diagnostic challenges in NPSLE with focus on the attribution and neuroimaging
• Discuss the current knowledge about the main pathogenetic mechanisms of NPSLE
• Explain the available and novel therapeutic options to treat NPSLE
• Describe unmet needs in the approach to the diagnosis and management of NPSLE

REFERENCES

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DIAGNOSIS AND TREATMENT OF NEUROPSYCHIATRIC LUPUS
Marcello Govoni. University of Ferrara, Italy
10.1136/lupus-2020-la.20
Six months following the beginning of Covid-19 pandemic in China, data on the risk of SARS-CoV-2 infection among patients with autoimmune rheumatic diseases are now available. However, the rapid spread of the pandemic has not allowed proper design of prospective studies, thus evidence came mostly from case series and observational studies.

The early enthusiasm on hydroxychloroquine (HCQ) antiviral properties should not suggest that patients who are long-term treated with antimalarials, such as patients with systemic lupus erythematosus (SLE), are protected against SARS-CoV-2 infection. Indeed, a French report on 17 HCQ-treated SLE patients dampened the enthusiasm.1

A recent report from Covid-19 Global Rheumatology Alliance has described 80 SLE patients with Covid-19, mostly females under 65 years of age, 64% of whom were already taking HCQ before the infection: the rate of hospitalisation and the need for intensive care did not differ between patients who were and those who were not taking HCQ.2 A study group from Northern Italy – the Italian epicentre of the pandemic – reported an incidence of 2.5% of Covid-19 (higher compared to the general population of the same region) in 165 patients with SLE.3

Patients with SLE are possibly at risk of developing symptomatic or severe Covid-19, not only because of their disease or treatment but as a consequence of associated comorbidities known to worsen the outcome of SARS-CoV-2 infection.4 5

What do we know so far? SLE patients should not withdraw their medication. Before drawing any other conclusion, large registry data are needed to clarify the incidence and the outcome of Covid-19 in patients with SLE.

Learning Objectives
• Describe the current evidence for risk of SARS-CoV-2 infection among patients with autoimmune rheumatic diseases, notably SLE
• Explain why it is important to ensure robust evidence are available to clarify the outcome of Covid-19 in patients with SLE

REFERENCES

Meet the Editor
22 WHAT IS HAPPENING IN THE WORLD OF PUBLISHING?
Ronald van Vollenhoven. Amsterdam University Medical Centers, The Netherlands

In this three-part workshop we will discuss the big changes taking place in the world of publishing, how successfully to submit your next paper, and what it takes to be a great reviewer.

The world of medical-scientific publishing is undergoing dramatic change at a rapid pace. The traditional model of printed journals, to which individuals and institutions can subscribe, has been upended by the emergence of open-access journals, whose publications are accessible online for all. Traditional journals have relatively high costs associated with producing and distributing printed materials to their readers, and they derive their income from subscriptions, institutions paying the lion’s share. The business model for online journals is based in part on much reduced costs, and on charging authors for publishing. Advertising features prominently in both models. At the start of the third decennium, it is clear that openness has been embraced by political and societal forces. The biggest drawbacks are the complexity of having two systems side by side, shifting costs to scientists without compensation, and the proliferation of non-serious, ‘predatory’ on-line publications.

Publishing remains one of the main obligations and challenges for the aspiring scientist. In this workshop, I will discuss ‘tips and tricks’ for the process of submitting and revising your manuscript.

Reviewing the work of fellow scientists is an honor and a credit to your standing as a scientist. I will discuss how you can make reviewing papers enjoyable, stimulating and a win-win. A good review should be factual, scholarly, generous, and concise: ‘brevity is the soul of wit’ (Hamlet, William Shakespeare).

Roundtable: Refractory Lupus Manifestations: Definition and Treatment
23 REFRACTORY LUPUS NEPHRITIS
Sandra Navarra. University of Santo Tomas, Manila, Philippines

Lupus nephritis (LN) affects approximately 50–70% and accounts for the highest morbidity and mortality among lupus patients. Established treatment protocols for LN typically include immunosuppressive therapy in combination with glucocorticoids. Although the survival of LN patients has improved over the last 2 decades due to earlier recognition and more