prednisone intake ≤7.5 mg, and negative predictors of remission and LDA were number of flares in the 3 years before belimumab treatment initiation and baseline renal involvement. Notably, patients spending at least 50% of follow-up in LDA (66%) or at least 25% of follow-up in remission (42.9%) accumulated less damage at the end of the follow-up.

Consequently, this study provided novel evidence that an earlier use of belimumab in patients with active SLE and low damage may maximise its efficacy in clinical practice.

Learning Objectives

- Explain the importance of achieving remission or LDA in SLE management
- Describe the role of belimumab in achieving remission or LDA in post-hoc analysis of the randomised control trials
- Discuss the best use of belimumab in clinical practice settings

REFERENCES


13 CAN WE WITHDRAW LOW-DOSE PREDNISONE IN REMITTED PATIENTS?

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Maintenance of remission has become central in the management of systemic lupus erythematosus (SLE). However, an active disease-free state is generally maintained only when patients are on medication, which often leads to treatment-related complications. Therefore, once remission has been achieved, prolonged maintenance treatment inevitably requires a regimen of drug de-escalation. The recent EULAR recommendations for the treatment of SLE during chronic maintenance treatment advocate that glucocorticoids (GC) should be, when possible, withdrawn.1 However, in routine practice a significant proportion of treating physicians prefers to continue a low dose GC regimen, despite clinical remission, which is most likely due to the fear that withdrawal of low-dose GCs may lead to a severe flare, even after very long intervals of remission.2 In a recent prospective randomised controlled trial, we showed that, in SLE patients in remission and with stable treatment regimen for at least 1 year, withdrawal of 5 mg of prednisone was associated with a fourfold increase (i.e. 27%), in the risk of flare, as defined by the SFI or the BILAG index.3 Other SLE treatments remained unmodified during this study. In particular, at study entry 91% and 27% of the patients were also treated with hydroxychloroquine and an immunsuppressant, respectively. The 27% relapse rate observed in the withdrawal group in our study is in line with the ones recently reported in two recent cohorts.4 5 Tani et al described the longitudinal study of a cohort of 91 SLE Italian patients who attempted stopping GC treatment.4 A total of 77 patients successfully stopped GC. For those patients who were successfully withdrawn from GC, 18 flares (23%) were recorded after a median follow-up period of about 2 years. As in our study, 72% of flares were mild. The time period since the last flare was the sole determinant predictor of disease flare identified. A recent observational study, performed by Goswami et al in India, reported that 21% of patients in remission undergo exacerbation of the disease after GC withdrawal with most of the flares occurring in the first year of follow-up.5 Therefore, until the availability of effective drugs with little or no toxicity, it is recommended to not abandon the option of using very low doses of GCs (i.e. ≤5 mg prednisone) given their potential benefits in SLE patients in remission, especially those at low cardiovascular risk.

Learning Objectives

- Define remission in SLE patients
- Discuss drug de-escalation in SLE patients in remission

REFERENCES


14 CAN WE WITHDRAW IMMUNOSUPPRESSANTS IN REMITTED PATIENTS?

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Remission has recently emerged as a potential target in the management of systemic lupus erythematosus (SLE), indeed remission is not uncommon and is associated with improved prognosis.1 2 Nevertheless, the best management of remitted patients, especially those in stable remission, remains elusive. In particular, whether immunosuppressive therapy (IS) may be