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

1. Gatto M, Zen M, Iaccarino L, et al. New therapeutic strategies in systemic lupus erythematosus management. *Nat Rev Rheumatol* 2019;**15**(1):30–48.
2. Zen M, Iaccarino L, Gatto M, et al. Prolonged remission in Caucasian patients with SLE: prevalence and outcomes. *Ann Rheum Dis* 2015;**74**(12):2117–22.
3. Zen M, Iaccarino L, Gatto M, et al. The effect of different durations of remission on damage accrual: results from a prospective monocentric cohort of Caucasian patients. *Ann Rheum Dis* 2017;**76**(3):562–65.
4. Zen M, Iaccarino L, Gatto M, et al. Lupus low disease activity state is associated with a decrease in damage progression in Caucasian patients with SLE, but overlaps with remission. *Ann Rheum Dis* 2018;**77**(1):104–10.
5. Oon S, Huq M, Golder V, et al. Lupus Low Disease Activity State (LLDAS) discriminates responders in the BLISS-52 and BLISS-76 phase III trials of belimumab in systemic lupus erythematosus. *Ann Rheum Dis* 2019;**78**(5):629–33.
6. Parodis I, Emamikia S, Gomez A, et al. Clinical SLEDAI-2K zero may be a pragmatic outcome measure in SLE studies. *Expert opinion on biological therapy* 2019;**19**(2):157–68.
7. Saccon F, Zen M, Gatto M, et al. Remission in systemic lupus erythematosus: testing different definitions in a large multicentre cohort. *Ann Rheum Dis* 2020;**79**(7):943–50.
8. Fanouriakis A, Adamichou C, Koutsoviti S, et al. Low disease activity-irrespective of serologic status at baseline-associated with reduction of corticosteroid dose and number of flares in patients with systemic lupus erythematosus treated with belimumab: A real-life observational study. *Semin Arthritis Rheum* 2018;**48**(3):467–74.
9. Sbeih N, Mathian A, Pineton de Chambrun M, et al. Achieving lupus low-disease activity and remission states under belimumab in refractory systemic lupus erythematosus: time and organ involvement matter. *Ann Rheum Dis* 2019;annrheumdis-2019-215732.
10. Gatto M, Saccon F, Zen M, et al. Early disease and low baseline damage predict response to belimumab in patients with systemic lupus erythematosus. *Arthritis Rheumatol* 2020 doi: 10.1002/art.41253 [published Online First: 2020/04/11]

13

CAN WE WITHDRAW LOW-DOSE PREDNISONE IN REMITTED PATIENTS?

Zahir Amoura. Pitié-Salpêtrière University Hospital, Paris, France

10.1136/lupus-2020-la.13

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 immunosuppressant, 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

1. Fanouriakis A, Kostopoulou M, Alunno A, et al. 2019 update of the EULAR recommendations for the management of systemic lupus erythematosus. *Ann Rheum Dis* 2019;**78**(6):736–45.
2. Ngamjanyaporn P, McCarthy EM, Sergeant JC, et al. Clinicians approaches to management of background treatment in patients with SLE in clinical remission: results of an international observational survey. *Lupus Sci Med* 2017;**4**(1):e000173.
3. Mathian A, Pha M, Haroche J, et al. Withdrawal of low-dose prednisone in SLE patients with a clinically quiescent disease for more than 1 year: a randomised clinical trial. *Ann Rheum Dis* 2020;**79**(3):339–46.
4. Tani C, Elefante E, Signorini V, et al. Glucocorticoid withdrawal in systemic lupus erythematosus: are remission and low disease activity reliable starting points for stopping treatment? A real-life experience. *RMD open* 2019;**5**(2):e000916.
5. Goswami RP, Sit H, Ghosh P, et al. Steroid-free remission in lupus: myth or reality; an observational study from a tertiary referral centre. *Clin Rheumatol* 2019;**38**(4):1089–97.

14

CAN WE WITHDRAW IMMUNOSUPPRESSANTS IN REMITTED PATIENTS?

Margherita Zen. University of Padova, Italy

10.1136/lupus-2020-la.14

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