PO.7.155 STUDY OF THE COMORBIDITIES PRESENT IN THE PATIENTS INCLUDED IN THE REGISTRY OF SYSTEMIC LUPUS ERYTHEMATOSUS OF THE SPANISH SOCIETY OF RHEUMATOLOGY (RELESSER)

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Background The survival of patients with systemic lupus erythematosus (SLE) has increased in recent years, but they have higher morbidity and mortality than the general population.

Purpose To study the prevalence of comorbidities in patients with SLE and its relationship with damage, gender and treatments received.

Methods Cross-sectional multicenter descriptive study of a cohort of adult patients with SLE.

Results We studied 3,656 patients, 90.3% women, mean age (±SD) at diagnosis of 35.2(±14.7) years and duration of SLE of 142.6(±100.8) months. We analyzed 27 comorbidities. 79.73% of the patients presented any, with the maximum accumulated being 14. The most frequent were smoking, dyslipidemia and arterial hypertension. 38.05% of patients accumulated damage. Males accumulated more comorbidities (85.48% vs. 79.1%, p=0.003) and damage (47.03% vs. 37.11%, p<0.001). The first criterion for SLE appeared at a younger age in patients who did not have comorbidities: 27.73 (±12.04) years vs. 34.47(±14.76) years; p<0.001. We found that there is a positive correlation between the number of comorbidities and the number of systems with damage (Spearman's Rho = 0.478, p<0.001). There is a positive correlation between the number of comorbidities and damaged systems with the number of hospitalizations by disease activity (Rho=0.265 and 0.396 respectively, p<0.001 in both contrasts) as well as with the number of serious infections (Rho=0.299 and 0.307 respectively, p <0.001 in both contrasts). We found more patients without comorbidities in those who did not receive glucocorticoids (9.94% vs. 15.48%, p<0.001) and more patients with comorbidities in those who did not receive antimalarials (89.1% vs. 81.78%, p<0.001). There were significant differences in the presence of comorbidities in those treated with cyclophosphamide, mycophenolate, azathioprine or rituximab.

Conclusions A high percentage of patients with SLE have comorbidities. With few exceptions, they are more frequent in males. The onset of SLE was later in patients with more comorbidities. We found variations in comorbidities depending on the treatments received.

PO.7.156 DOES EXPERT OPINION MATCH THE DEFINITIONS OF LOW DISEASE ACTIVITY STATE? PROSPECTIVE ANALYSIS OF 500 PATIENTS FROM A SPANISH MULTICENTER COHORT

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OBJECTIVES To apply current definitions of Lupus Low Disease Activity State (LLDAS) to a large cohort and evaluate the

Abstract PO.7.156 Table 1 Reason of disagreement between patients that did not fulfill LLDAS definition and expert assessment as remission or low disease activity

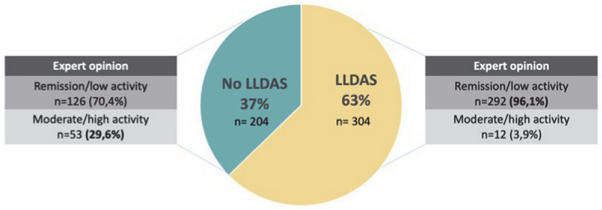
Descriptors of disease activity	Not achievement of LLDAS Number (%) n=126 (100%)
1.SLEDAI-2 K ≤4, with no activity in major organ systems (renal, CNS, cardiopulmonary, vasculitis, haemolytic anaemia, fever) and no gastrointestinal activity	59 (46.8%)
2.No new features of lupus disease activity compared to the previous assessment	74 (58.7%)
3. PGA (scale 0–3) ≤1	4 (3.3%)
Immunosuppressive medications	
4. Current prednisolone (or equivalent) dose ≤7.5 mg daily	16 (12.7%)
5. Well-tolerated standard maintenance doses of immunosuppressive drugs and approved biologic agents, excluding investigational drugs	

SLEDAI: systemic lupus erythematosus; CNS: central nervous system; PGA: physician global assessment

Abstract PO.7.156 Table 2 Agreement between expert opinion and definition of LLDAS or modified LLDAS definition

	Agreement % (95% CI)
LLDAS original definition	71.4 (70.17–70.54)
LLDAS modified (a) eSLEDAI-2K ≤ 4 excluding serology	74.2 (72.34-75.66)
LLDAS modified (b) prednisone ≤ 10 mg	71.3 (69.43-73.02)
LLDAS modified (c) prednisone ≤ 5 mg	70.3% (68.75-72.04)
LLDAS modified (d): excluding "no new clinical features compared to previous"	82.6 % (81.38-83.96)
LLDAS modified (a), (b) and (d)	85.68% (84.29-86.98)

LLDAS: lupus low disease activity state; SLEDAI: systemic lupus erythematosus disease activity index



Abstract PO.7.156 Figure 1 Comparison of LLDAS and expert opinion

concordance between LLDAS and the clinical status according to the expert opinion.

Methods A cross-sectional analysis of a prospective multicenter study of SLE patients from seven Spanish Rheumatology Departments with high level of expertise in SLE. We applied the LLDAS definition and evaluated the agreement between the LLDAS and the clinical status according to the expert opinion. Modifications in LLDAS definition were also explored.

Results 508 patients were included (92% women; mean age (±SD): 50.4 years (± 13.7). A total of 267 (54.4%) patients were in DORIS remission and 304 (62.7%) in LLDAS. Remission was the most frequent state considered by the rheumatologist (n=206, 41.6%). Agreement between expert opinion and LLDAS was 71.4%. Most cases (96.1%) in LLDAS, were classified as remission or low activity by the expert. Of the patients that did not fulfill LLDAS, 126 (70.4%) patients were classified as remission/low disease activity (Figure 1). The main reasons for discordance were the presence of new manifestations compared to previous visit and a SLEDAI 2-K >4 (Table 1). The modification of the LLDAS definition excluding the comparison with previous assessment increases the agreement to 82.6% (95% CI: 81.61–83.96%). Decreasing the cut-off point of prednisone dose to 5mg/daily did not change the agreement (Table 2).

Conclusion Almost two thirds of SLE patients were in DORIS remission or in LLDAS. There is a good correlation between LLDAS and the physician's opinion, particularly for those patients who fulfill LLDAS definition. A modification in LLDAS definition excluding the comparison with previous assessment have an increase in the agreement with the expert opinion.

PO.7.157 DOES REMISSION ACCORDING DORIS 2021 MATCH THE TREATING RHEUMATOLOGIST JUDGEMENT? ANALYLIS AT RECRUITMENT OF A PROSPECTIVE STUDY OF 500 SLE PATIENTS FROM A SPANISH MULTICENTER COHORT

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Introduction An accurate target in Systemic Lupus Erythematosus (SLE) Treat to Target strategies has been challenging over the past years. Recently, a new definition of remission was updated in 2021 by the international DORIS (Definition of Remission in SLE) taskforce.

Objective To quantify the proportion of patients who achieve DORIS and evaluate the agreement between DORIS and the treating rheumatologist judgement.

Methods Prospective multicenter study of SLE patients (ACR 1997 Classification Criteria or Clinical diagnosis by the Physician) from seven Spanish Rheumatology Departments. DORIS 2021 remission definition was applied and the rheumatologists were asked to classified the activity of the disease in 5 different categories: remission, serologically active clinically quiescent (SACQ), low, moderate or high activity. Statistical analysis: descriptive cross-sectional (at the time of recruitment) analysis was done. Analysis of the level of agreement between expert opinion and the definition of remission was evaluated using Cohen's kappa. The reasons of disagreement were evaluated.

Abstract PO.7.157 Table 1 Patient demographics and disease characteristics

	Number (%) or mean (± SD) (n = 508 patients)
Female gender	460 (92%)
Age at diagnosis (years)	40.7 (± 21)
Disease duration at enrollment (years)	10,8 (± 9.9)
Age at enrollment (years)	50.4 (± 13.71)
ACR criteria (a)	
ANA	489 (96.26%)
Immunologic	394 (77.56%)
Arthritis	378 (74.41%)
Haematologic	289 (56.89%)
Malar rash	228 (44.88%)
Photosensitivity	224 (44.09%)
Mouth ulcers	176 (34.65%)
Renal	167 (32.87%)
Serositis	98 (19.29%)
Discoid rash	68 (13.39%)
Neurologic	28 (5.51%)
Number of ACR criteria for SLE	5 (± 1.5)
Number of SLICC criteria for SLE	6.24 (± 2.24)
SLEDAI-2K score at enrollment	2.8 (± 3.31)
SLICC/ACR-DI score at enrollment	0.96 (± 1.36)
Damage present at enrollment	253 (49.8%)
Clinical SLEDAI-2 K (no complement or a dsDNA)	1.6 (±2.7)
Current hypocomplementaemia	152 (29.9%)
Current elevated a-dsDNA	125 (24.6%)
PGA at enrollment	0.2 (0.49)

Abbreviations: SLE, systemic lupus erythematosus; ACR, American College of Rheumatology; SLEDAI, SLE disease activity index; PGA, physician global assessment; ANA, antinuclear antibody; ds DNA, double stranded DNA. SLICC/ACR-DI: Systemic Lupus International Collaborating Clinics (SLICC/American College of Rheumatology (ACR) damage index (SDI) (a) Ever present based on ACR criteria.