cutpoints for defining S2K RI-50 response in clinical trials of pts w/moderate-severe SLE disease activity.

Disclosure of Interest: Z. Touma Grant/research support from: Janssen Research and Development, LLC, M. Urowitz Grant/research support from: Janssen Research and Development, LLC, D. Gladman Grant/research support from: Janssen Research and Development, LLC, C. Wagner Employee of: Janssen Research and Development, LLC, B. Hsu Employee of: Janssen Research and Development, LLC, M. Chevrier Employee of: Janssen Research and Development, LLC, S. Rose Employee of: Janssen Research and Development, LLC, B. Zhou Employee of: Janssen Research and Development, LLC, R. Gordon Employee of: Janssen Research and Development, LLC

DOI: 10.1136/annrheumdis-2018-eular.4877

FRI0340 DOSAGE OF HYDROXYCHLOROQUINE (PLAQUENIL) ONLINE SURVEY BY PATIENT ORGANISATION NVLE

Z. Osmani, W. Zacouris-Verweij, S. Otteron behalf of Lupus APS committee. *Lupus APS committee, NVLE patient association, Utrecht, Netherlands*

Background: Hydroxychloroquine (HCQ) has been proven effective in several immune mediated diseases. Long-term use of HCQ is very common in patients with systemic autoimmune disease. The greatest advantage of HCQ is that it may reduce the risk of flares and thereby allow glucocorticoid dose reduction. The risk/benefit ratio of HCQ is excellent but HCQ is also known for its potentially severe and fortunately rare side effect: retinal toxicity. In The Netherlands, there are no standard guidelines regarding the dosing of HCQ and ophthalmologic screening of HCQ-induced complications. The American Academy of Ophthalmology (AAO) has recently published their revised recommendations on screening and dosing of HCQ. Risk of retinal toxicity is mainly determined by the two most significant risk factors: daily dose of HCQ (mg/kg/day) and duration of HCQ therapy (years). The AAO recommends a maximum daily HCQ dosage of <5.0 mg/kg real weight, to reduce the risk of toxicity. ^{Marmor, 2016}

Objectives: To raise more attention for the revised recommendation of the AAO, our patient organisation started an online survey asking patients with (systemic) autoimmune diseases which dose of HCQ (mg) they take on a daily basis.

Methods: Patients in the Netherlands were given the opportunity to complete the online survey at the website of the NVLE (Dutch patient association for people with Lupus Erythematosus, Anti-Phospholipid Syndrome, Systemic Sclerosis and Mixed Connective Tissue Disease) from July 26th – November 18th, 2017. The promotion of the survey took place solely through Social Media with a link to the survey. A total of 24 questions had to be filled in to complete the survey. Each individual was asked to write down their real weight (kg) for calculating the daily HCQ dosage (mg/kg/day).

Results: A total of 705 individuals completed the online survey. The daily dosage (mg/kg/day) was available from 645 patients. The majority were females (n=645) and diagnosed with (systemic) lupus erythematosus (n=518). The average dosage of HCQ was 4.50±1.68 mg/kg/day. The daily dosage of 5 mg/kg was exceeded by 258 of the patients (40%). Eighty-one individuals (12.6%) used a daily dosage of ≥5 mg/kg for more than 10 years. The most reported HCQ-induced complications were gastrointestinal complaints (n=55), problems with vision (n=43), and nausea (n=32).

Conclusions: Patients (and prescribing physicians) should be informed about risk of toxicity, proper dose levels, and the importance of regular annual screening. Physicians prescribing HCQ must aim for a daily HCQ dosage of less than 5.0 mg/kg/day, especially for patients using HCQ for already more than 10 years. (Inter)national guidelines regarding the screening and dosing of HCQ should be provided by the authorities to secure patient safety and reduce the frequency of (severe) retinal complications.

REFERENCE:

- [1] Michael F, Marmor, et al. Recommendations on Screening for Chloroquine and Hydroxychloroquine Retinopathy (2016 Revision). *Ophthalmology* 2016;123(6):1386–94.

Acknowledgements: We would like to thank prof. dr. Frank van den Hoogen for his advice and dr. Els van de Ende for reading our abstract.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.2495

FRIDAY, 15 JUNE 2018

SLE, Sjögren's and APS – clinical aspects (other than treatment)

FRI0341 LUPUS LOW DISEASE ACTIVITY STATE (LLDAS) VERSUS CLINICAL REMISSION AS TREATMENT TARGETS IN THE FIRST 18 MONTHS OF SYSTEMIC LUPUS ERYTHEMATOSUS MANAGEMENT

A. Floris, M. Piga, G. Cappellazzo, E. Chessa, M. Congia, A. Cauli, A. Mathieu. *Chair of Rheumatology and Rheumatology Unit, University and AOU of Cagliari, Monserrato, Italy*

Background: In the view of applying a treat to target (T2T) strategy in the management of systemic lupus erythematosus (SLE), a novel definition of minimal acceptable disease activity – the lupus low disease activity state (LLDAS) ^[1] – and clinical remission (CR) ^[2] were recently proposed.

Objectives: To compare attainability and outcomes of LLDAS and CR as treatment targets in the early stages of SLE management.

Methods: LLDAS and CR prevalence were analysed at 6 (T1) and 18 (T2) months after treatment initiation (T0) in a monocentric cohort of 107 (median disease duration 9.7 months) prospectively followed Caucasian SLE patients. LLDAS was defined as SLE disease activity index 2000 (SLEDAI-2K)≤4 without major organ activity and no new disease activity, physician global assessment (0–3)≤1, prednisone ≤7.5 mg/day and well-tolerated immunosuppressant dosages. CR was defined as clinical SLEDAI-2K=0 (increased anti-dsDNA and low complement were excluded) and prednisone ≤5 mg/day in patients treated with/without stable immunosuppressants and/or antimalarials. Multivariate models were built to identify factors associated with failure to achieve LLDAS and CR, as well as to investigate relationship between the latter and early damage accrual (defined as SLICC/Damage Index≥1 at T2).

Results: LLDAS was achieved significantly more frequently than CR both at T1 [47 (43.9%) vs. 25 (23.4%); p<0.001] and T2 [48 (44.9%) vs. 35 (32.7%); p<0.001]. Out patients achieving LLDAS, 25 (53.2%) and 35 (66.7%) concomitantly fulfilled the criteria for CR at T1 and T2, respectively. A prednisolone (PDN) dose exceeding the minimal acceptable range set in the respective definitions was the most frequent reason for failure to achieve both LLDAS and CR (in 83.0% of no-LLDAS patients at T1% and 95.1% of no-CR at T1). The disease manifestations with the highest persistence rate during follow-up were: increased anti-dsDNA (persistently present in 85.7% and 67.5% of cases at T1 and T2, respectively), low complement (73.2% and 66.3%) and renal abnormalities (46.4% and 28.6%). Renal involvement at baseline significantly associated with failure to achieve LLDAS both at T1 (OR: 7.8, 95% CI: 1.41–43.40; p=0.019) and T2 (OR: 3.87, 95% CI 1.41–10.6; p=0.008) and CR at T2 (OR 9.46, 95% CI 1.13–78.8). High PDN dosage was significantly associated with no-CR achievement both at T1 (OR 6.23, 95% CI 2.2–18.3; p=0.01) and T2 (OR 1.11, 95% CI 1.02–1.20; p=0.02). Early damage was recorded in 23 (21.5%) patients and was significantly associated, on multivariate analysis, with older age at diagnosis (OR 1.05 95% CI 1.01–1.09; p=0.016) and failure to achieve LLDAS (OR 4.82, 95% CI 1.44–16.09; p=0.11) at T1. No significant association was found between early damage and failure to achieve CR, possibly due to its low prevalence among this cohort of early SLE patients.

Conclusions: During the early stages of SLE, LLDAS and CR overlap definitely less frequently than reported in long-standing disease (53.2%–66.7% vs 83.9%–96.5% ^[2]). Although remission is recommended as the primary treatment target in SLE, LLDAS may represent a valid alternative in the first stages of disease management, being more attainable compared to CR and negatively associated to early damage.

REFERENCES:

- [1] Franklyn K, et al. *Ann Rheum Dis* 2016;75:1615–21.
- [2] Zen M, et al. *Ann Rheum Dis* 2017;76:562–5.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.2774