six main PROs: body pain, patient global and fatigue score on a 0-10 visual analogue scale, as well as a functional impact score, self-report joint count and symptom checklist which have a range of 0-10, 0-48 and 0-60 respectively. Composite indices consisting of either two or three of patient pain score 6, self-report joint count 16 and symptom checklist 16 or three of four of the same measures plus a fatigue score 6 have been described previously to provide clues to comorbid FM in other rheumatic diseases [3,4]. Individual PROs and these composite indices were compared between patients with and without FM by student's unpaired t-test and Area Under the Curve (AUC) analysis. The physician's diagnosis of FM was analysed against the FM criteria using Cohen's kappa. Physicians were blinded to the results of the 2016 FM criteria.

Results: 88 patients with SLE were studied, of whom 23 (26%) satisfied FM criteria. Those with FM reported higher scores in all PROs. A patient global of 6 could correctly classify 90% of patients and provided the highest AUC of 0.95, followed by the symptom checklist and body pain. An index of three measures (pain score, self-report joint count and symptom checklist) gave an AUC of 0.90. An index of four measures (additional fatigue criterion) gave an AUC of 0.93. Both indices correctly classified 89% of patients with a cut-off of 2 and 3 respectively. The physician's diagnoses had moderate agreement with the FM criteria (kappa = 0.43).

	AUC	Sensitivity	Specificity	Correctly classified
3 PROs (≥ 2)	0.90	78%	92%	89%
4 PROs (≥ 3)	0.93	74%	94%	89%
Patient global (≥ 6)	0.95	91%	89%	90%

Conclusion: Comorbid FM is prevalent in SLE yet often missed by physicians. In busy clinical settings, composite indices provide useful clues to coexisting FM in SLE, although a simple MDHAQ patient global is quick and potentially just as valuable in this patient group. These findings require further validation in a larger cohort.

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THU0266 ULTRASONOGRAPHY IN THE DIAGNOSIS OF LOWER LIMB ENTHESEOPATHY IN A COHORT OF SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS: RELATION TO THE DISEASE ACTIVITY

Reem A. Habeeb, Maryam A. Abdel Rahman, Dalia Abdel Hamid Elsherbiny, Safaa A. Hussein, Heba A. Mustafa. *Internal Medicine Department, Division of Rheumatology, Ain Shams University, Cairo, Egypt*

Background: Systemic lupus erythematosus (SLE) is a chronic inflammatory autoimmune disease characterized by variable clinical manifestations due to different organ involvement¹. Musculoskeletal involvement is extremely common in patients with SLE. Musculoskeletal ultrasound (MSUS) is an important tool for evaluation of patients with inflammatory arthritis and early detection of subclinical inflammation at the joint, tendon and enthesal level².

Objectives: To investigate the presence of enthesal abnormalities in SLE patients and correlating it with parameters of disease activity.

Methods: In this cross-sectional study we evaluated 50 patients with SLE who fulfilled the 2012 ACR/SLICC criteria³. Patients underwent clinical,

laboratory and ultrasonographic examination of both lower limbs at the sites of entheses. Disease activity was assessed by using the SLE disease activity index (SLEDAI)⁴. The scanned entheses were those included in the Glasgow Ultrasound Enthesitis Scoring System (GUESS)⁵. The anatomical sites were scanned bilaterally, both in longitudinal and transverse planes, in grey-scale (GS) and power Doppler (PD) mode. Ultrasonography was performed using (esaote) MyLab™Six ultrasound machine, equipped with a 6-18 MHz linear probe.

Results: In our cohort of 50 SLE patients we found 29 patients had clearly evident MSUS features of enthesopathy (58%) and 16 patients with minimal and isolated enthesal abnormalities (32%). Five patients had normal MSUS findings with no evidence of enthesal affection (10%). The mean of total GUESS score of all patients was 3.54 ± 2.6 . MSUS examination of the quadriceps tendon insertion at the patella revealed mean thickness of 5.89 ± 0.7 mm, the patellar tendon attachment at the patella (proximal) was 4.26 ± 0.84 mm and the mean thickness of the patellar tendon at the tibial insertion (distal) was 4.08 ± 0.7 mm. The Achilles tendon insertion at the superior pole of calcaneus and the plantar fascia insertion at inferior pole of calcaneus were 4.2 ± 0.7 and 3.7 ± 0.7 mm respectively. Age, body mass index (BMI), SLEDAI score, and ESR; had a highly significant positive correlation with GUESS score. The increase in BMI, SLEDAI score and creatinine; had an independent effect on increasing GUESS score.

Conclusion: Lower limb enthesopathy is common in SLE patients and considered one of the important causes of knee and ankle joints pain. Enthesal involvement in SLE patients is affected by variable parameters, mainly disease activity. Enthesal abnormalities can be early detected by ultrasonography even in clinically asymptomatic SLE patients without evidence of clinical symptoms and/or signs of enthesal affection.

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THU0267 THE SLE DISEASE ACTIVITY SCORE (SLE-DAS) ENABLES ACCURATE DEFINITIONS OF SLE REMISSION AND LDA AS ACHIEVABLE TARGETS IN DISEASE MANAGEMENT

Diogo Jesus^{1,2}, Ana Matos^{3,4}, Carla Henriques^{3,5}, Margherita Zen⁶, Maddalena Larosa⁶, Luca Iaccarino⁶, Andrea Doria⁶, Luís Inês^{1,2}. ¹Centro Hospitalar e Universitário de Coimbra, Rheumatology Department, Coimbra, Portugal; ²University of Beira Interior, Faculty of Health Sciences, Covilhã, Portugal; ³Polytechnic Institute of Viseu, School of Technology and Management, Viseu, Portugal; ⁴Polytechnic Institute of Viseu, Center for Research in Digital Services, Viseu, Portugal; ⁵University of Coimbra, Centre for Mathematics, Coimbra, Portugal; ⁶University of Padova, Division of Rheumatology, Padova, Italy

Background: The treat-to-target strategy in Systemic Lupus Erythematosus (SLE) aims to achieve remission. However, to define a target based on the SLE Disease Activity Index (SLEDAI) is questionable, due to its limitations (especially its dichotomous nature). The SLE Disease Activity Score (SLE-DAS) is a recently validated continuous disease activity score which has a higher accuracy in measuring SLE activity and a higher sensitivity-to-change compared to SLEDAI.¹

Objectives: To assess the ability of SLE-DAS to define SLE remission and other disease activity states.

Methods: Cross-sectional study of SLE patients fulfilling the ACR'97 and/or SLICC'12 classification criteria and followed at the Padua Lupus Clinic from March to June 2018. At each outpatient visit, the attending clinician scored SLE disease activity (in the last 30 days) using Physician Global