Assessment (PGA) (0-3 points, 10 cm scale), SLEDAI-2K and SLE-DAS. A senior rheumatologist expert in SLE, blinded to the disease activity scores, classified each patient in 1 of 4 categories: (i) remission, (ii) low disease activity (LDA), (iii) mild disease activity and (iv) moderate/severe disease activity. The best cut-off values of SLE-DAS to define these categories were estimated using Receiver Operating Characteristic (ROC) curve analysis. Accuracy, precision, sensitivity and specificity values for these cut-off values were then calculated. The agreement between the SLE-DAS and physician's classification was measured using Kappa coefficient. Statistical significance was set at 0.05.

Results: We included 221 patients (84.2% female, mean age of 45.4 ± 13.5 years, mean disease duration of 15.4 ± 9.5 years). In this preliminary study, the proposed cut-off values of SLE-DAS to define each disease activity category were: remission $\text{SLE-DAS} \leq 2.08$, LDA $2.08 < \text{SLE-DAS} \leq 3.77$, mild disease activity $3.77 < \text{SLE-DAS} \leq 7.64$, and moderate/severe disease activity $\text{SLE-DAS} > 7.64$ for (Table 1). The overall accuracy of these SLE-DAS cut-off values to identify each disease activity state was 96.4%. The agreement between SLE-DAS and physician's classification was very high ($k=0.925$, $p<0.001$). Distribution of SLE-DAS and SLEDAI-2K scores in each disease activity state is presented in Figure 1. According to the SLE-DAS cut-offs, 68.8% of the patients were in remission, 2.3% in LDA, 10.9% in mild disease activity and 18.1% in moderate/severe disease activity.

Abstract THU0267 – Table 1. Performance of SLE-DAS to assess each disease activity state.

Disease activity state	Sensitivity (%)	Specificity (%)	Precision (%)
Remission ($\text{SLE-DAS} \leq 2.08$)	99.3	97.1	98.7
Low Disease Activity ($2.08 < \text{SLE-DAS} \leq 3.77$)	66.7	99.5	80
Mild Disease Activity ($3.77 < \text{SLE-DAS} \leq 7.64$)	88.0	99.0	91.7
Moderate/Severe Disease Activity ($\text{SLE-DAS} > 7.64$)	94.9	98.4	92.5

Conclusion: The SLE-DAS has a high precision in identifying remission, LDA, and other disease activity states in SLE. These results suggest that the SLE-DAS is an accurate tool in defining achievable targets in SLE management.

Figure 1. SLE-DAS and SLEDAI-2K boxplots for each disease activity state according to the physician's classification. The superiority of SLE-DAS to separate the disease activity levels is indicated by the clear separation of its boxplots, in contrast to the overlap of the SLEDAI-2K boxplots.

Abstract THU0267 – Figure 1

REFERENCES:

- [1] Jesus D, Matos A, Henriques C, et al. Derivation and validation of the SLE Disease Activity Score (SLE-DAS): a new SLE continuous measure with high sensitivity for changes in disease activity. *Ann Rheum Dis* 2019, Epub ahead of print 9 January 2019. DOI: 10.1136/annrheumdis-2018-214502.

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THU0268

CLINICAL AND LABORATORY FEATURES OF PRIMARY SJÖGREN'S SYNDROME ASSOCIATED WITH ANTICENTROMERE ANTIBODIES

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Background: The prevalence of ACA among patients with pSS varies from 2% to 27%. Among experts, there is a lot of controversy about whether primary Sjögren's syndrome with ACA is a separate disease subtype or overlap-syndrome with systemic sclerosis.

Objectives: To evaluate clinical and laboratory features of anticentromere antibody-positive (ACA) primary Sjögren's syndrome (pSS); to evaluate the spectrum of autoantibodies in patients of this group; to evaluate conformity of the patients to the pSS and systemic sclerosis (SSc) classification criteria; to evaluate prevalence of salivary MALT-lymphoma in this group of patients; to evaluate prevalence of primary biliary cirrhosis (PBC)/biliary lesions in this group of patients.

Methods: From 2012 to 2018, we examined 83 patients with pSS and ACA. Inclusion criteria were conformity to the 2001 Russian Sjögren's syndrome criteria and high ACA titer. We used ACR 2012 and ACR/EULAR 2016 criteria to evaluate conformity to the pSS, and ACR 2013 criteria to evaluate conformity to the SSc. Diagnosis of salivary MALT lymphoma was established on the basis of histological, immunohistochemical and PCR studies of biopsy specimens of parotid salivary glands. Diagnosis of PBC/biliary lesions was made on the basis of histological and immunohistochemical studies of liver biopsy specimens.

Results: We found a low detection rate of anti-Ro antibodies (32.5%), anti-La antibodies (7.2%), RF (21.7%), increased ESR (14%), leukopenia (7%), hypergammaglobulinemia (17.6%), increased IgG (9.5%), increased IgA (18.7%) hypocomplementemia (16.1%) in the group of patients with pSS and ACA. Despite the low frequency of detection of the RF, some patients of this group had MALT-lymphoma: 14 patients had salivary MALT-lymphoma (16.8%), one patient had tonsil MALT-lymphoma with nodal involvement (1.2%). In addition, patients of this group are characterized by a high frequency of detection of AMA antibodies 17/52 (32.7%), increased IgM (29.7%) and increased risk of biliary lesions (14.4%). According to our data increased risk of developing biliary lesions (28.5%), primary biliary cirrhosis (28.5%), autoimmune hepatitis (AIH) (28.5%), overlap-syndrome between PBC and AIH (14.5%) was observed in patients with functional signs of liver damage (ALT/AST, GGT, ALP >2N), AMA-positivity, high levels of IgM. Only two patients, who were diagnosed with liver disease according to studies of biopsy specimens, lacked AMA-antibodies. Damage to the nervous system, kidneys, antiphospholipid syndrome, rheumatoid arthritis, hypergammaglobulinemic purpura and cryoglobulinemic vasculitis were much less common and were single. Also patients with pSS and ACA often have Raynaud's phenomenon (54.9%) with capillaroscopic changes of the scleroderma type (68%) and an increased risk of developing limited form of systemic scleroderma (24%).

Conclusion: pSS associated with ACA is a subtype of the disease, significantly different from the "classic" in a number of clinical and laboratory signs and characterized by an increased risk of SSc and PBC/biliary lesions which in some cases leads to the underdiagnosis of pSS. ACA should be considered as pathogenetically related to pSS antibodies and all ACA-positive patients should be examined for pSS and PBC/biliary lesions regardless of whether they have SSc or not. Patients with a significant enlargement of salivary glands should be biopsied to confirm the presence of MALT-lymphoma before initiating hormonal, antilymphoproliferative and anti-B-cell therapy.

Disclosure of Interests: None declared

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THU0269

SERUM IL-6 AND CIRCULATING IMMUNE COMPLEXES AS BIOMARKERS OF DISEASE ACTIVITY IN MULTI-ETHNIC ASIAN SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: IL-6 plays an important role in B cell hyperactivity and immunopathology of systemic lupus erythematosus (SLE), and may have a direct role in mediating tissue damage [1]. Elevated levels of serum