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FRIDAY, 14 JUNE 2019

15:30:00 – 17:00:00

Remission – the holy grail? Looking across diseases

SP0162 REMISSION IN RA: DOES THE DEFINITION MATTER?

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Remission is the ultimate target for chronic inflammatory rheumatic disease, and so also for rheumatoid arthritis (RA). In this presentation, we will review the challenges in defining and assessing remission. Further, we will discuss if remission should be a clinical target, or whether imaging results, e.g. from ultrasound or MRI examinations, should be included in the concept of remission. Many symptoms in patients with RA may mimic RA disease activity, while they are not directly a consequence of the disease process, with secondary pain syndromes being a typical example. Finally, patients are the most important stakeholders on the question of whether or not a musculoskeletal disease is in remission. Patient reported outcomes have been criticised for their subjectivity and their role in remission indices has been questioned. We will also explore the influence and Pro's and Con's of these measures on remission assessment.

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SP0163 REMISSION IN SLE: WHAT TO AIM FOR?

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It is generally acknowledged that, in SLE, disease activity is associated with poor prognosis, high glucocorticoid use, damage development and increased mortality; therefore reaching low level of disease activity or remission are main treatment targets for SLE.

Definitions for disease remission and low disease activity are being proposed and validated as meaningful targets to be pursued in SLE management.

In detail an international task force has recently developed a definition of remission in SLE (DORIS) taking in consideration four different domains: clinical activity, serological activity, treatment and duration. This approach led to the development of different levels of remission i.e. clinical remission on/off treatment and complete remission on/off treatment.

Recently data from different cohorts have been published, showing that remission is an achievable target in SLE. Achieving remission appears associated with reduced damage accrual, however persistence in remission is rare being maintained in an average of 7% of patients over 5 years. In addition, the more stringent is the definition, the more difficult is to achieve remission and a longer time to remission is observed in patients with high activity, high therapy, hematological activity, African-American ethnicity.

Low disease activity may represent another target in SLE treatment and a definition of (lupus low disease activity state (LLDAS) has been developed by Franklyn et al. LLDAS is defined based on three domains which are SLEDAI-2k 4, physician global assessment (PGA) 1, absence of new manifestations and stable and well tolerated treatment with a prednisolone (or equivalent) dose of 7.5 mg/day. Interestingly, LLDAS is achieved by a high percentage of patients over follow up, ranging between 33 and 88% in different cohorts and it is maintained over follow up in up to 50% of patients for 50% of follow up time. Predictive factors for LLDAS attainment are shorter disease duration, lower disease activity score, lower mean PGA, lower mean SLEDAI, older age; while persistent LLDAS is less frequent in

patients with vasculitis, neurological, renal, cardiopulmonary and mucocutaneous manifestations.

Achievement and persistence of LLDAS are associated with lower prednisone dose during follow up, reduction of disease flares, lower damage accrual, better quality of life.

In conclusion, definitions of remission and low disease activity in SLE have been proposed and validated against outcomes such as glucocorticoids usage, damage accrual, quality of life.

Both targets are associated with improved outcomes, however at present persistence in remission is not common. The achievement of LLDAS is not rare, persistence in LLDAS is achievable.

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Laboratory course – from the clinic to the lab and back (from translation to prescription)

SP0164 ANA DIAGNOSTIC AND ANTIPHOSPHOLIPID SYNDROME (APS) AS INHERITED COAGULATION DISORDER

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Use of ANA diagnostic is key for systemic autoimmune diseases. ANA is an overarching term and the underlying specificities are important for defined diagnosis of SLE, Sjögren's, systemic sclerosis etc. Diagnostic algorithms of ANA and new semi-automated procedures are discussed in the context of case discussions. Subsequently, the value and limitations of the diagnostics of lupus anticoagulant and antiphospholipid antibodies as key serologic findings in antiphospholipid syndrome are discussed in the context of instructive cases.

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