Table 1. SLE Medications during 1 year of follow-up period		
	Systemic Lupus Erythematosus (N=30,086)	Lupus Nephritis (N=1,259)
SLE Medications, N (%)		
Corticosteroids ^a	17533 (58.3%)	834 (66.2%)
Number of prescriptions, Mean (SD)	4.5 (5.0)	6.5 (6.0)
Hydroxychloroquine	13061 (43.4%)	513 (40.7%)
Number of prescriptions, Mean (SD)	5.8 (3.6)	6.2 (3.7)
Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) ^b	11342 (37.7%)	271 (21.5%)
Number of prescriptions, Mean (SD)	3.6 (4.0)	3.0 (3.9)
Angiotensin Converting Enzyme Inhibitor (ACE) ^c	3827 (12.7%)	409 (32.5%)
Number of prescriptions, Mean (SD)	5.4 (3.7)	5.4 (3.7)
Angiotensin II Receptor Blockers (ARB) ^d	3376 (11.2%)	318 (25.3%)
Number of prescriptions, Mean (SD)	5.8 (3.7)	5.6 (4.0)
Methotrexate	2884 (9.6%)	62 (4.9%)
Number of prescriptions, Mean (SD)	5.5 (4.1)	4.9 (3.3)
Immunosuppressant ^e	1239 (4.1%)	83 (6.6%)
Number of prescriptions, Mean (SD)	4.8 (3.8)	4.1 (2.9)
Cyclosporine	1090 (3.6%)	40 (3.2%)
Number of prescriptions, Mean (SD)	2.7 (2.6)	3.8 (3.9)
Mycophenolate Mofetil	985 (3.3%)	397 (31.5%)
Number of prescriptions, Mean (SD)	5.2 (3.7)	6.0 (4.0)
Leflunomide	523 (1.7%)	15 (1.2%)
Number of prescriptions, Mean (SD)	4.3 (3.3)	4.7 (4.0)
Belimumab	306 (1.0%)	17 (1.4%)
Number of medical/prescription claims, Mean (SD)	8.8 (6.5)	8.3 (6.7)
Rituximab	275 (0.9%)	26 (2.1%)
Number of medical/prescription claims, Mean (SD)	4.2 (4.0)	4.0 (4.5)
Cyclophosphamide	98 (0.3%)	67 (5.3%)
Number of prescriptions, Mean (SD)	5.0 (5.0)	4.4 (2.7)
SD: Standard Deviation		
^a Corticosteroids: Prednisone, Betamethasone, Budesonide, Cortisone, Desoxycorticosterone, Dexamethasone, Fludrocortisone, Hydrocortisone, Methylprednisolone, Paramethasone, Prednisolone, Triamcinolone		
^b NSAIDs: Diclofenac, Bromfenac, Choline and Magnesium salicylate, Methanamine and sodium salicylate, Fenoprofen, Flurbiprofen, Ketoprofen, Naproxen, Oxaprozin, Sulindac, Piroxicam, Etodolac, Meloxicam, Nabumetone, Celecoxib/Celebrex, Indomethacin, Mefenamic acid, Meclofenamate, Diflunisal, Tolmetin, Salsalate, Aspirin, Ibuprofen, Ketorolac		
^c ACE: Captopril, Enalapril/ Enalaprilat, Fosinopril, Lisinopril, Moexipril, Perindopril, Quinapril, Ramipril, Trandolapril, Benazepril		
^d ARB: Candesartan, Eprosartan, Irbesartan, Losartan, Olmesartan, Telmisartan, Valsartan, Azilsartan		
^e Immunosuppressant: Azathioprine, 6 mercaptopurine		

Conclusion: Our findings indicate a nominal use of biologics (2%) among SLE and LN patients. Corticosteroids and hydroxychloroquine were the most commonly used SLE treatments. These data reveal an unmet need for availability of advanced therapy to treat SLE and LN. Future studies are warranted to understand the underlying causes.

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FRI0202

SHORT AND LONG-TERM FOLLOW-UP OF APREMILAST THERAPY IN REFRACTORY SKIN LUPUS LESIONS

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Background: Treatment of skin lupus lesions (SLL) was based on topical therapy (corticosteroids, calcineurin inhibitors), systemic corticosteroids, antimalarials and immunomodulatory drugs including thalidomide. However, there are refractory patients to conventional treatment. Apremilast, an inhibitor of phosphodiesterase-4 (PDE-4), may be useful in these cases.

Objectives: Our objective was to assess the efficacy and safety of apremilast.

Methods: We set up an observational study of 8 patients with diagnosis of refractory SLL and treatment with apremilast at a standard dose of 30 mg/ 12 hours. The outcome was the presence of improvement and the appearance of side effects.

Results: 8 patients (7 female/1 male) with mean age of 39.9±10.6 years with SLL were studied. Patients were diagnosed as follows: discoid lupus (n=5) and systemic lupus erythematosus (SLE) (n=3). Patients with SLE

were classified as lupus panniculitis (n= 1), polycyclic ring lupus (n=1) and psoriasiform lupus (n=1). All skin lesions were confirmed by biopsy (table).

Before apremilast, all patients had received conventional therapy without improvement: topical corticosteroids (n=8), topical tacrolimus (n=4), oral corticosteroids (n=5), antimalarials (n=8), thalidomide (n=1), belimumab (n=3) and rituximab (n=2).

The time between SLL diagnosis and apremilast beginning was 145.1 ±79.4 months. After a mean follow-up of 14.4±4.8 months, all patients presented improvement of skin lesions (4 of them with complete response). Due to the appearance of gastrointestinal symptoms (diarrhoea, vomiting) it was necessary to reduce the dose of apremilast to 30 mg/ day in one patient and finally, it was discontinued due to no improvement with antiemetic and probiotic treatment.

Conclusion: Apremilast seems useful and relatively safe in patients with refractory SLL to conventional treatment.

Patient	Age/Sex	Skin Lupus Lesions (SLL)	Previous treatment	Months from diagnosis to apremilast onset	Apremilast onset		Follow-up		
					Antimalarial antibody	Combined treatment	Months from apremilast onset	Side effects	Discontinued
1	47 / Female	Polycyclic ring lupus	Prednisone Antimalarials Thalidomide Belimumab, RTX	300	ANA 1/280	Prednisone	12	Diarrhoea	No
2	46 / Female	Lupus panniculitis	Prednisone Antimalarials	156	ANA 1/280	Prednisone Antimalarials	17	No	No
3	37 / Male	Discoid lupus	Prednisone Antimalarials	ND	ANA (-)	Prednisone Antimalarials	16	Diarrhoea Vomiting	Yes
4	38 / Female	Discoid lupus	Prednisone Antimalarials	72	ANA (-)	Prednisone Antimalarials	18	No	No
5	38 / Female	Discoid lupus	Prednisone Antimalarials	120	ANA (-)	Prednisone Antimalarials	20	No	No
6	24 / Female	Psoriasiform lupus	Prednisone Antimalarials Tacrolimus Belimumab, RTX	92	ANA 1/160	Prednisone Antimalarials	15	No	No
7	34 / Female	Discoid lupus	Prednisone Antimalarials	89	ANA 1/320	Prednisone Antimalarials	5	No	No
8	42 / Female	Discoid lupus	Prednisone Antimalarials Tacrolimus Belimumab	187	ANA (-)	Prednisone Antimalarials Tacrolimus	5	No	No

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FRI0203

CONCORDANCE OF DORIS REMISSION CRITERIA WITH THE TREATING PHYSICIAN'S (DORIS-)INDEPENDENT REMISSION JUDGMENT IN A SLE-COHORT AT A TERTIARY CENTER

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Background: The definition of an accurate target for a treat to target (T2T) approach in SLE has been challenging over the past years. Recently four definitions of remission were presented by the international DORIS task force. ¹

Objectives: Aim of this study was to evaluate the frequency of remission in our outpatient SLE cohort and to assess feasibility and concordance of the remission definitions with the treating physician's opinion regarding the patient's state.

Methods: In this monocentric cross-sectional study patients with SLE according to the 1997 American College of Rheumatology (ACR) criteria were enrolled and assessed between September 2016 and December 2017. DORIS remission definitions were applied and demographic and laboratory data as well as disease activity (SLEDAI), steroid dosage and physician global assessment were evaluated. After the clinical consultation, the treating physicians answered the question if his/her patient was in remission.