achieved LLDAS at least once; 59 patients achieved LLDAS for 50% of observations. Multivariate logistic regression analysis showed that age at disease onset < 30 years (OR=0.05, 95%CI [0.01-0.59], p=0.017), 24-hour urine total protein (UTP) level at recruitment (OR=0.9992, 95%CI [0.9987-0.9998], p=0.007), and C3 level (OR=1.004, 95%CI [1.001-1.008], p=0.024) had independent associations with achieving LLDAS for ≥ 50% of all observations (Table 1). During follow-up, 56 (37.6%) patients experienced disease flare measuring 14 (9.4%) patients with severe flare. Kaplan-Meier analyses showed significant differences in flare rates according to whether LLDAS was achieved and the percentage follow-up time in LLDAS (Figure 1). Multivariate cox analysis revealed that the percentage time of time in LLDAS was an independent negative determinant of disease flare (HR=0.18, 95% CI [0.07-0.48], p=0.001) (Table 2). There were 16 (15.0%)/107 patients who had damage accrual after one year of follow-up. Multivariate logistic analysis showed a trend for achieving LLDAS during follow-up being protective for damage accrual (OR=0.27, 95%CI [0.07-1.00], p=0.050).

Conclusion: In this Chinese early disease cohort, LLDAS was an attainable goal in clinical practice. Age at onset, UTP and C3 level at recruitment influenced achievement of LLDAS. LLDAS was negatively associated with disease flare and damage accrual; this needs to be confirmed by future longer follow-up.

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