with oral acyclovir. Secondary bacterial infection occurred in 9% of the episodes. Disseminated disease or mortality was not reported in any patients. Significant post-herpetic neuritis developed in 9% of the episodes. Patients with HZ reactivation were more likely to have first-time renal disease (78% vs 58%; p=0.02) and a shorter SLE duration at LN (31.4±50 vs 62.7±72 months; p=0.02) than those without HZ. A trend of higher SLEDAI score, higher anti-dsDNA titer, lower C3 and albumin level but higher rate of refractory renal disease was also observed in HZ-infected patients. Other clinical parameters such as histological classes of LN, neutrophil, lymphocyte counts and immunoglobulin levels at baseline and 6 months post-treatment were not significantly different between HZ-infected and control patients. HZ-infected patients had been treated with a significantly higher dose of prednisolone (0.7±2.0 vs 0.6±0.3 mg/kg/day) as induction therapy. Dosages of other immunosuppressive drugs were not associated with HZ reactivation. Logistic regression revealed first-time renal disease (OR 2.25[1.08-4.71]; p=0.003), peak MMD daily dose (OR 1.24[1.00-3.07]; p=0.02) and cumulative CYC dose (OR 1.41[1.01-1.28]; p=0.04) during induction therapy were significantly associated with HZ within 2 years.

**Conclusion:** HZ reactivation is fairly common in LN patients undergoing immuno-suppressive therapies but unpredictable from histological and laboratory parameters. Higher doses of prednisolone, MMF and CYC were associated with a higher risk of HZ reactivation within 2 years.

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**THU0280 IMPACT ON PHYSICIAN GLOBAL ASSESSMENT ON REMISSION RATES IN SLE. ANALYSIS FROM A GERMAN SLE-COHORT.**

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**Background:** Defining remission for SLE as a suitable target for a treat to treat target (T2T) approach has been a major challenge in the past years. A few years back, four definitions of remission were presented by the international DORIS task force.[1] Parameters included in the definition are clinical activity (cSLEDAI), steroid dose, immunosuppressive therapy, serology and physician global assessment (PGA). In particular the PGA, its threshold and general utility have been and still are discussed controversially.

**Objectives:** It was our aim to evaluate the added value of PGA in remission assessment.

**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. Two different definitions of remission were applied. The internationally accepted DORIS remission and a modified DORIS remission excluding PGA. Factors influencing PGA were assessed in the entire cohort. Regression analyses were used to assess differences between patients in DORIS and modified DORIS remission.

**Results:** A total of 233 patients were included (87.6% female). 98 patients (41.9%) fulfilled any of the four DORIS remission definitions, while 154 patients (66.1%) were in any modified remission in which PGA was excluded. In general, PGA rating was associated with disease activity (clinical SLEDAI: p=0.001), depression (Centers for Epidemiologic Studies Depression Scale: p=0.049), pain reported by the patient (numeric rating scale: p=0.0001) and hypocomplementemia (p=0.0001). Damage (SLICC damage index, SIDI) did not influence PGA (p=0.98). Both, DORIS and modified DORIS remission were associated with lower damage (p=0.025; p=0.003), lower pain on NRS (p=0.001; p=0.013), normal complement (p=0.0005; p=0.005) and better illness perception (p=0.006; p=0.023). Patients in modified DORIS remission had a tendency for more immunosuppressive therapy (p=0.046).

**Conclusion:** Exclusion of PGA in remission assessment led to an increased number of patients in remission. Clinical parameters and factors associated with DORIS remission vs. modified DORIS remission were similar, hence the added value of PGA in our cohort regarding remission assessment is questionable. The use and especially the correct threshold of PGA for remission still is to be discussed.

**References:**[1] van Vollenhoven, Ronald; Voskuyl, Alexandre; Bertiasia, George; Aranow, Cynthia; Aringer, Martin; Arnaud, Laurent et al. (2017): A framework for remission in SLE: consensus findings from a large international task force on definitions of remission in SLE (DORIS), In: Annals of the rheumatic diseases 76 (3), S. 554–561. DOI: 10.1136/annrheumdis-2016-209519.

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