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Background: Classification criteria for SLE need validation and selection of the most advanced ones for clinical practice

Objectives: To validate Systemic Lupus International Collaborating Clinics (SLICC)-12, American College of Rheumatology (ACR)-97 and 2019 European League against Rheumatism/American College of Rheumatology (EULAR/ACR-2019) for Systemic

Lupus Erythematosus classification criteria on a patient cohort from V.A. Nasonova Scientific Research Institute of Rheumatology (Moscow)

Methods: This prospective study included 252 (n=152 with SLE and n=100 non SLE: 74 – with systemic sclerosis (SC) and 26 – with primary antiphospholipid syndrome (pAPS)) patients who were sequentially admitted to the 4th Rheumatology Department from December 2018 to June 2020. All of the patient records were reevaluated by expert rheumatologist in order to determine if they agree with the diagnosis. For every patient, a check-list of SLE-related features was filled out. The association between clinical diagnosis and diagnosis generated on the basis of ACR-97, SLICC-12 and EULAR/ACR-2019 classification criteria was assessed. The overall sensitivity and specificity of ACR-97, SLICC-12 and EULAR/ACR-2019 classifications, as well as the sensitivity and specificity according to disease duration was calculated. The predictive value of every criterion in ACR-97, SLICC-12 and 2019 EULAR/ACR classification was assessed using logistic regression analysis and receiver operating characteristic (ROC) curves.

Results: According to ACR-97 criteria, reliable SLE was diagnosed in 131 (86%), according to SLICC-2012 – in 145 (95.3%) and according to EULAR/ACR-2019 – in 144 (94.7%) of 152 patients, respectively. We identified the criteria that were significantly more represented in the SLE-group. The sensitivity and specificity (Table 1) did not change depending on the ANA titers (1/160 and 1/320) and the duration of the disease.

Table 1. The sensitivity and specificity of SLE criteria in 152 SLE patients and 100 non SLE patients

SLE classification criteria	AUC, 95% CI	Cut point	Sensitivity	Specificity
ACR-97	0.654 (0.550-0.758)	4	89.7	36
SLICC-12	0.616 (0.505-0.728)	4	93.1	43
2019 EULAR/ACR	0.609 (0.492-0.727)	10*	97.4	48

Note. ACR-97 – American College of Rheumatology classification from 1997; SLICC-12 – Systemic lupus International Collaboration Clinics classification from 2012; 2019 European League Against Rheumatism/American College of Rheumatology. ANA – anti-nuclear antibody more than 1/320 n=116; ANA < 320 n= 36. AUC – area under the ROC curve; Cut point – reference point for the number of criteria, * number of points ≥ 10.

When excluding patients with SC in a single-factor logistic model of patients with SLE and pAPS, indicating the number of criteria, the sensitivity was for ACR-97 – 86, for SLICC-12 – 95, for 2019 EULAR/ACR – 95, the specificity was 100, 62 and 62, respectively.

Conclusion: Evaluation of the criteria by level ANA revealed the highest sensitivity for 2019 EULAR/ACR and SLICC-12, the specificity was low for all three criteria. In the analysis of patients with SLE and pAPS, the sensitivity was highest for 2019 EULAR/ACR and SLICC-12, the specificity was 100 for ACR-97.

Disclosure of Interests: None declared

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AB0304 LEVELS AND TRENDS IN PREMATURE MORTALITY BURDEN DUE TO SYSTEMIC LUPUS ERYTHEMATOSUS IN CUBA

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Background: Analysis of the causes of premature mortality is an essential function of public health surveillance. A variety of methods have been used to accurately assess and report the level and trends of premature mortality; however, many have significant limitations, particularly in capturing actual early deaths. Years of life lost (YLL) has been recognized as a robust and comprehensive measure of premature mortality.¹ Systemic lupus erythematosus (SLE) is among the leading causes of premature mortality burden in young women in the United States and premature mortality from SLE is increasing in Latin America.^{2,3} However, the premature mortality burden from SLE has not been fully characterized in Cuba.

Objectives: To identify levels and trends in premature mortality burden due to SLE in Cuba during 2001-2018.

Methods: Data were obtained from the mortality database of the Ministry of Public Health of Cuba (International Classification of Diseases-10, code 32 as underlying cause of death). YLL were calculated using the standard life expectancy of the WHO's global health estimates. Age- and sex-specific YLL rates were calculated using the Cuban mid-year population estimates and the age-standardized YLL rate (ASYR) was estimated by the direct method using the WHO's standard population. The 2001-2018 temporal trends were analyzed using Joint-point software.

Results: During 2001-2018, 1 475 patients died from SLE. These deaths contributed 66 605 YLL (women= 59 166; men=7 433), with a mean of 45.1 YLL per death (women= 45.2; men= 44.5). The 40-44 age group was the most affected in both sexes with 9 266 YLL (women=8 177; men=1 086). The ASYR was higher in 2018 than in 2001 for both sexes (Figure 1). A significantly increasing trend in ASYR due to SLE was identified throughout the period (average annual percent change [AAPC] =1.9; 95% confidence interval [CI] = 0.9 to 3.0), more pronounced in men (AAPC = 7.0; 95% CI = 3.5 to 10.6) than in women (AAPC = 1.3; 95% CI = 0.3 to 2.3).

Conclusion: The high levels and growing trends in premature mortality burden from SLE in Cuba, demands its recognition as an important health problem and immediate actions that help mitigate it.

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AB0305 IS THERE HYPERCOAGULATION IN PATIENTS WITH ANTIPHOSPHOLIPID SYNDROME AND BEHCET'S DISEASE?

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Background: Whereas antiphospholipid syndrome (APS) is a non-inflammatory vasculopathy and is associated with thrombosis in 98% of cases, Behcet's disease (BD) is a systemic vasculitis of unknown etiology, characterized by vascular damage of any calibre. Both venous and arterial thromboses occur in 45% of BD patients and are associated not with hypercoagulable disease but with inflammatory changes in the vascular wall mediated by hypersecretion of pro-inflammatory cytokines and endothelial cells dysfunction. Thrombodynamics (TD) is a new global test for diagnosing plasma haemostasis disorders, identifying bleeding and thrombosis risks, and can be used to detect a prothrombotic state and assess the influence of disease activity and course on the hypercoagulation process.

Objectives: comparative assessment of TD in patients with APS and BD before anticoagulant therapy (AC).

Methods: The study included 20 patients (9 APS and 11 BD) and 8 age and sex-matched healthy controls (HC). None of the subjects received AC. Thromboses