prednisone 5 mg/day or less, and stable antimalarials, immunosuppressives and biologics.

Table 1.

	Vote in favor	LoE	SoR	Agreement
1. Inclusion of serology [anti-DNA, complement] in the DORIS definition of remission-on-treatment does not meaningfully alter the construct validity and therefore it is not recommended to include it	90%	2a	B	8.38
2. While the goal of treatment is sustained remission, a definition of remission should be able to be met at any point in time; therefore, duration should not be included in the definition	100%	5	C	9.02
3. To date, the SLEDAI-based definitions of remission have formally been investigated more extensively than BILAG or ECLAM-based definitions. The SLEDAI-based definitions can therefore more confidently be recommended	91%	2a	B	9.25
4. Remission off treatment, while the ultimate goal for many patients and providers, is achieved very rarely. In clinical research and as an outcome in clinical trials, the definition for remission-on-treatment is recommended	92%	2a	B	9.52
5. In clinical trials, the LLDAS definition for low disease activity and the DORIS definition of remission are both recommended as outcomes	100%	5	C	9.25

The 2021 DORIS definition of remission in SLE:

The 2021 DORIS definition of remission in SLE:

- cSLEDAI=0 and
- PhGA <0.5 (0-3)
 - irrespective of serology
 - the patient may be on antimalarials, low-dose glucocorticoids (prednisolone ≤5 mg/day), and/or stable immunosuppressives including biologics

Conclusion: The 2021 DORIS definition of remission in SLE was established. It is recommended for use as an aspirational treatment target in clinical care, a clear concept in education, and a key outcome in research including clinical trials and observational studies.

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OP0297

THE SLE-DAS ENABLES ACCURATE AND USER-FRIENDLY DEFINITIONS OF REMISSION AND CATEGORIES OF LUPUS DISEASE ACTIVITY: DERIVATION AND VALIDATION STUDY IN 1190 SLE PATIENTS

D. Jesus^{1,2}, M. Larosa³, C. Henriques^{4,5}, A. Matos^{4,6}, M. Zen³, P. Tomé^{4,6}, V. Alves^{4,6}, N. Costa⁴, V. Le Guern⁷, L. Iaccarino³, N. Costedoat-Chalumeau⁷, A. Doria³, L. Inês^{2,8}. ¹Centro Hospitalar de Leiria, Rheumatology Department, Leiria, Portugal; ²University of Beira Interior, Faculty of Health Sciences, Covilhã, Portugal; ³University of Padova, Division of Rheumatology, Padova, Italy; ⁴Institute of Viseu, Technology and Management, Viseu, Portugal; ⁵University of Coimbra, Centre for Mathematics, Coimbra, Portugal; ⁶Research Centre in Digital Services, CISEd, Viseu, Portugal; ⁷Cochin Hospital, Internal Medicine Department, Paris, France; ⁸Centro Hospitalar e Universitário de Coimbra, CHUC Lupus Clinic, Rheumatology Department, Coimbra, Portugal

Background: Treatment of systemic lupus erythematosus (SLE) is tailored according to the intensity of SLE disease activity and aims to achieve remission. Current definitions of remission and disease activity categories are mostly based on the SLE Disease Activity Index (SLEDAI), which has important limitations. The SLE Disease Activity Score (SLE-DAS) is a validated continuous disease activity score with higher accuracy in measuring SLE activity and higher sensitivity-to-change as compared to SLEDAI¹. SLE-DAS is user-friendly with its online calculator.

Objectives: To derive and validate the SLE-DAS cut-off values for defining SLE disease activity categories and SLE clinical remission state.

Methods: Derivation study was conducted at the Padova Lupus Clinic. Validation was performed prospectively in patients from the Cochin Lupus Clinic and by post-hoc analysis of BLISS-76 (NCT00410384) trial. Gold-standard for clinical remission state was fulfillment of Definition Of Remission In SLE (DORIS). In Padova and Cochin Clinics, at time of inclusion, a senior clinician classified each patient as presenting: (i) remission, (ii) mild, or (iii) moderate/severe disease activity. Derivation of the SLE-DAS cut-offs for disease activity categories was performed using ROC curve analysis against this expert clinical classification. Performance of these SLE-DAS categories of disease activity was assessed as compared with: (i) expert classification (in Cochin cohort); (ii) British Isles Lupus Assessment Group (BILAG) index (in BLISS-76). An index-based and a Boolean definition of remission were tested applying decision trees, using CHAID (chi-square automatic interaction detection) algorithm and their performance estimated.

Results: We included 1190 SLE patients (221 in Padova, 150 in Cochin and 819 from BLISS-76 cohorts). In the derivation cohort, best SLE-DAS cut-off values for disease activity categories were: (i) remission, SLE-DAS≤2.08; (ii) mild activity, 2.08<SLE-DAS≤7.10; (iii) moderate/severe activity, SLE-DAS>7.10. Table 1 shows the performance of these SLE-DAS cut-offs. The SLE-DAS Boolean-based definition of remission (all SLE-DAS clinical items scores = 0 and prednisone ≤5mg/day) showed sensitivity and specificity of 100% in the derivation (Padova) and validation (Cochin) clinical cohorts. The SLE-DAS index-based definition of remission (SLE-DAS ≤2.08 and prednisone ≤5mg/day) presented sensitivity =100% and specificity =97.4% in the derivation and validation clinical cohorts. The SLE-DAS definitions of remission were fully substantiated by CHAID.

Table 1. Performance of SLE-DAS cut-offs for remission and disease activity categories compared to physician's classification and BILAG (n =1190).

	Disease activity category	Sensitivity (%)	Specificity (%)	Accuracy (%)
Derivation Padova Cohort	Remission (SLE-DAS≤2.08)	99.3	97.1	98.6
	Mild Disease Activity (2.08<SLE-DAS≤7.10)	74.2	98.9	95.5
	Moderate and Severe Disease Activity (SLE-DAS>7.10)	97.4	96.7	96.8
Validation	Remission (SLE-DAS≤2.08)	99.1	93.9	98.0
Cochin Cohort	Mild Disease Activity (2.08<SLE-DAS≤7.10)	82.6	99.2	96.7
	Moderate and Severe Disease Activity (SLE-DAS>7.10)	100.0	98.6	98.7
Validation	Remission and Mild Disease Activity [§] vs. Moderate and Severe Disease Activity ^{§§} (SLE-DAS≤7.10 vs. >7.10)	91.4	84.1	90.8

§ Remission/Mild: No BILAG B or A scores §§ Moderate/severe: ≥1 BILAG B or A scores

Conclusion: The SLE-DAS is an accurate and easy to use tool for defining clinical remission state and SLE disease activity categories, validated with both the expert assessment and BILAG.

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Difficult to treat RA: definitions and mechanisms_____

OP0298

ARE PATIENTS WITH PSORIATIC ARTHRITIS BEING TREATED OPTIMALLY ACROSS THE WORLD? DISPARITIES IN HEALTH CARE FOR PATIENTS WITH PSORIATIC ARTHRITIS ACROSS COUNTRIES WITH DIFFERENT GDP'S, AN ANALYSIS OF 429 PATIENTS FROM 13 COUNTRIES

F. Lucasson¹, U. Kiltz², J. D. D. Cañete³, A. M. Orbai⁴, Y. Y. Leung⁵, P. Palominos⁶, A. Balanescu⁷, S. Meisalu⁸, A. Ruysen-Witrans⁹, M. Soubrier¹⁰, L. Eder¹¹, I. Gaydukova¹², U. Kalyoncu¹³, P. Richette¹⁴, M. De Wit¹⁵, E. Lubrano¹⁶, J. S. Smolen¹⁷, L. C. Coates¹⁸, R. Scrivo¹⁹, E. Dernis²⁰, S. Aydin²¹, M. E. Husni²², L. Gossec¹. ¹Sorbonne Université and Hôpital Pitié Salpêtrière, Department of Rheumatology, Paris, France; ²Ruhr University Bochum, Rheumazentrum Ruhrgebiet, Herne, Germany; ³Hospital Clínic, Barcelona, Department of Rheumatology, Barcelona, Spain; ⁴Johns Hopkins University School of Medicine, Division of Rheumatology, Baltimore, MD, United States of America; ⁵Singapore General Hospital, Department of Rheumatology and Immunology, Singapore, Singapore; ⁶Hospital de Clínicas de Porto Alegre, Universidade Federal do Rio Grande do Sul, Serviço de Reumatologia, Porto Alegre, Brazil; ⁷Sf Maria Hospital, University of Medicine and Pharmacy Carol Davila, Internal Medicine and Rheumatology, Bucharest, Romania; ⁸East Tallinn Central Hospital, Department of Rheumatology, Tallinn, Estonia; ⁹Toulouse University Hospital, UMR 1027, Inserm, Université Paul Sabatier Toulouse III, Rheumatology Unit, Toulouse, France; ¹⁰CHU Gabriel Montpied, Service de rhumatologie, Clermont-Ferrand, France; ¹¹University of Toronto, Women's College Hospital and the Department of Medicine, Toronto, Canada; ¹²North-Western State Medical University, Department of Therapy And Rheumatology, Saint Petersburg, Russian Federation; ¹³Hacettepe University, Department of Rheumatology, Ankara, Turkey; ¹⁴AP-HP Lariboisière Hospital, Department of Rheumatology, Paris, France; ¹⁵Amsterdam Public Health (APH), Amsterdam University Medical Centre, Department of Medical Humanities, Amsterdam, Netherlands; ¹⁶Dipartimento di Medicina e Scienze della Salute "Vincenzo Tiberio", University of Molise, Academic Rheumatology Unit, Campobasso, Italy; ¹⁷Medical University of Vienna, Rheumatology, Vienna, Austria; ¹⁸University of Oxford, Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences, Oxford, United Kingdom; ¹⁹Sapienza Università di Roma, Rheumatology Unit, Department of Internal Medicine and Medical Specialties, Roma, Italy; ²⁰Le Mans Central Hospital, Rheumatology Department, Le Mans, France; ²¹University of Ottawa Faculty of Medicine, Ottawa Hospital Research Institute, Rheumatology, Ottawa, Canada; ²²Cleveland Clinic, Department of Rheumatologic and Immunologic Diseases, Cleveland, OH, United States of America

Background: In psoriatic arthritis (PsA), EULAR recommendations are to aim for remission or low disease activity(1). Many treatments are now available, though some are costly and not widely available in all countries. Country of patient care, and in particular Gross Domestic Product (GDP) may be linked to PsA outcomes(2). Although patients with high disease activity are eligible for targeted therapies such as biologic disease-modifying anti-rheumatic drugs (bDMARDs), they may not be able to get the benefits from these efficacious treatments in all countries equally.

Objectives: The objective was to explore the rate of PsA patients with high to moderate disease activity, not receiving bDMARDs across countries, and to assess the consequences on functional incapacity.

Methods: This was a cross-sectional analysis of an observational study (ReFlap, NCT03119805)(3), which included adult patients with PsA with ≥ 2 years disease duration from 14 countries. One country was excluded from this analysis since only 7 patients were included. We explored the rate of patients with significant disease activity (i.e based on DAPSA > 14) and no ongoing bDMARD prescription. Countries of inclusion were analysed separately, and classified into tertiles by GDP/capita (lowest tertile: Brazil, Turkey, Russia, Romania, Estonia; middle tertile: Spain, Italy, UK, France; highest tertile: Canada, Germany, USA and Singapore). The rate of no bDMARDs - DAPSA > 14 patients was analysed by country and compared between the 3 tertiles of GDP/capita by parametric tests. Functional capacity (HAQ) was compared between no bDMARDs - DAPSA > 14 patients and the other patients (pooling patients with moderate or high disease activity with bDMARD, low disease activity and remission with or without bDMARD). There was no imputation of missing data.

Results: Of the 459 patients, 429 had complete data available and were analysed: mean age 52.3 (SD 12.6) years, mean disease duration 10.2 (SD 8.2) years, 215 (50.1%) males. The rate of no bDMARDs - DAPSA > 14 patients was 18.4% (76/414). The rate ranged from 7.4% (UK and Spain) to 40% (Russia): Figure 1. A link was seen with the country and the tertiles of countries according to GDP/capita, with higher rate of no bDMARDs - DAPSA > 14 patients in the lowest GDP/capita countries (28.8%, 15.3% and 14.3% in the 3 GDP/capita tertiles, respectively, $p=0.005$; Figure 1). Of note, 40/76 no bDMARDs - DAPSA > 14 patients received a treatment intensification during the visit. Among no bDMARDs - DAPSA > 14 patients, functional incapacity was higher than in the other patients, as expected (mean HAQ 0.96 (SD 0.64) vs 0.57 (SD 0.63), $p<0.001$).

Figure 1. The size of the bubbles represent the number of patients per country (range, 13 to 89). The horizontal lines represent the mean proportion of patients with no bDMARDs - DAPSA > 14 for each tertiles of countries by GDP/capita.

Conclusion: In this exploratory comparison of disease patterns and treatments choices in 13 countries, we observed that more PsA patients with high or moderate disease activity and living in low GDP/capita countries were less likely to be treated with bDMARDs. As a consequence, no bDMARDs - DAPSA > 14 patients had worse functional incapacity. Equitable access to bDMARDs should be aimed for all patients regardless of their country of origin.

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