Response to: Correspondence on "New EULAR/ACR 2019 SLE classification criteria: defining ominosity in SLE" by Whittall Garcia et al

We thank Dr Pons-Estel and colleagues[1] for their interest in our[2] paper proposing that a score of 20 or more in the 2019 European League Against Rheumatism/American College of Rheumatology (EULAR/ACR) classification criteria[3 4] predicts more severe disease activity in the following 5 years after the systemic lupus erythematosus (SLE) classification.[2]

Pons-Estel *et al*[1] demonstrated that 98 (15.31%) patients who were classified by 1982/1997 ACR criteria, but not classified as SLE with the 2019 EULAR/ACR classification criteria, having a score of less than 10 points, accrued less damage compared with those who had a score of ≥10.[5] In our cohort of patients with SLE, only 16 (1.8%) had a EULAR/ACR score of less than 10. The 1997 ACR domain involvement of this subgroup of patients was predominated by skin, musculoskeletal and haematological involvement, and only rarely had severe organ-threatening disease (figure 1). We did not specifically assess their disease course compared with those who did score 10 or more. We recognise the possible utility of this analysis and congratulate the authors on their interesting results.[5]

The findings from Ugarte-Gil *et al*[5 6] and Carneiro *et al*[7] suggest an association between the EULAR/ACR score and damage accrual. In our recent work[2] we did not find a correlation between the EULAR/ACR score at baseline and damage at 5 years after SLE classification. We acknowledge that 5 years is too early to adequately establish damage accrual and are currently looking into the possible implications of a higher EULAR/ACR score at diagnosis and long-term outcomes.

We agree with the authors regarding the possible novel use of the new 2019 EULAR/ACR SLE classification criteria. Indeed, taking together the results from Ugarte-Gil *et al*,[5] Carneiro *et al*[7] and our findings,[2] using these criteria as a predictor of outcomes in patients with SLE is possible. This concept is certainly of interest as it could facilitate upfront patient stratification, leading to early recognition of patients at higher risk of an 'ominous' outcome.

We also agree that further studies on separate cohorts are needed to corroborate the results and cut-offs.
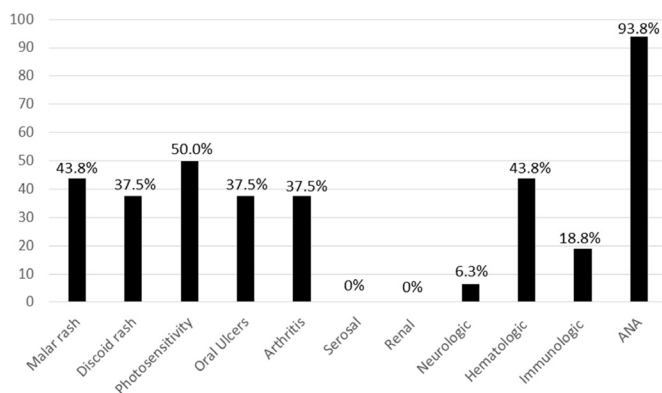

Figure 1 Distribution of the 1997 ACR criteria domains in patients with a score <10 in EULAR/ACR (n=16). ACR, American College of Rheumatology; ANA, antinuclear antibodies; EULAR, European League Against Rheumatism.

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