POS0758 DOES EXPERIENCE IN SYSTEMIC LUPUS ERYTHEMATOSUS INFLUENCE THE PHYSICIAN GLOBAL ASSESSMENT SCORING? A CROSS-SECTIONAL STUDY ON TWO EUROPEAN COHORTS

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Background: The Physician Global Assessment (PGA) is an outcome instrument based on physician judgement of disease activity in patients with Systemic Lupus Erythematosus (SLE). Due to the subjectivity of the score and lack of standardization, the PGA could represent a source of heterogeneity, because the same manifestations could be rated differently by physicians with different backgrounds (1).

Objectives: The purpose of this study was to evaluate the inter-rater reliability of PGA between a rheumatology trainee and rheumatologists expert in SLE from 2 european countries.

Methods: SLE patients classified according to SLICC 2012 criteria were enrolled between May 2019 and December 2019 during a SLEuro traineeship program. Demographic, clinical (SLEDAI-2k, PGA), serological and ongoing medication data were collected. PGA was evaluated before (pre-lab) and after (post-lab) knowledge of laboratory exams, using a Visual Analogue Scale (VAS) ranging from 0 to 3, anchored at point 1 (mild), 2 (moderate) and 3 (severe activity). A trainee in Rheumatology (EC) and three rheumatologists experts in SLE (LA, MP, FS) independently scored the PGA for each patient.

The trainee preliminarily received a standardization training with her tutor (MP), consisting of a shared discussion about 10 consecutive SLE outpatients to increase reliability in PGA scoring.

Inter-rater reliability was analysed using the intraclass correlation coefficient (ICC) with a two-way single-rating model (2,1); 95% confidence interval (CI) was calculated.

Results: Fifty-seven patients (86% female) affected from SLE (29 belonging to a French cohort and 28 to an Italian cohort) with a mean (SD) age 43.2 (15.9) years and a median [IQR] disease duration 6.4 [2.0-15.4] years were enrolled. Clinical features are presented in table 1. Pre-lab PGA scores were obtained from all patients and ranged from 0 to 2.3; post-lab PGA scores were obtained from 51 patients and ranged from 0 to 2.9. Inter-rater reliability of the PGA among the trainee was good to excellent for each lupus expert comparison: a) pre-lab PGA ICC 0.94, 95% CI 0.87-0.97; post-lab PGA ICC 0.94, 95% CI 0.87-0.97 (MP); b) pre-lab PGA ICC 0.84, 95% CI 0.63-0.93; post-lab PGA ICC 0.96 CI 0.88-0.99 (LA); c) pre-lab PGA ICC 0.91, 95% CI 0.65-0.98; post-lab PGA ICC 0.91, 95% CI 0.65-0.98 (FS).

Conclusion: After an adequate standardization, PGA scoring reaches good to excellent reliability between trainee and experts.

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Clinical Data	
Caucasian	44 (77.2%)
anti-dsDNA titre (median,IQR)	14 (0-75)
Hypocomplementemia (n,%)	30 (54%)
SLEDAI≥6 (n,%)	18 (31.6%)
SLEDAI (median,IQR)	4 (2-6)
Flares (n,%)	18 (31.6%)
Ongoing prednisone treatment (n,%)	41 (71.9%)
Prednisone dose mg (mean±sd)	5 (0 - 8.9)
Hydroxychloroquine (n,%)	44 (77.2%)
Immunosuppressant (n,%)	35 (61.4%)

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POS0759 THE JOURNEY OF PATIENTS FROM FIRST SYMPTOMS TO DIAGNOSIS OF SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): AN OBSERVATIONAL STUDY

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Background: The lack of pathognomonic features poses a considerable challenge in SLE diagnosis. The time from symptom onset to diagnosis has been reported to range from two to six years[1].

Objectives: To document the initial symptoms of the disease and the time lapse until its diagnosis.

Methods: We examined 438 patients from the "Attikon" SLE cohort[2]. For diagnosis, we used the classification criteria (ACR, SLICC, EULAR-ACR) or in few cases clinical diagnosis (n=32, 7.3%). Data were collected using patient interviews, in-person clinical visits and medical charts review. Initial symptoms were recorded and determined chronologically using prespecified forms with a list of typical manifestations (skin, joints, renal, nervous system, pleuropulmonary, cardiovascular, anti-phospholipid syndrome) as well as characteristic disease features (Raynaud's phenomenon, fatigue, fever, sicca symptoms). Questions also included the time between symptom onset and initial physician visit, the time from first medical consultation until first rheumatologist assessment, the time from rheumatologist assessment to SLE definite diagnosis, the number of physicians seen before SLE diagnosis, the specialty of first physician and of diagnosing physician. Information on demographic and clinical characteristics, disease activity and disease damage, was collected both at enrolment and at last follow-up visit.

Results: 88.5% of patients were females, mean (±SD) age at diagnosis was 41.9 years ± 15.4 and disease duration was 6.7 ± 7 years. Most common systems involved were joints (94.5%), skin (73.7%), blood (39.2%) and renal (17.5%). At diagnosis, 9.8% of patients were ANA negative. The most common initial symptoms at disease onset were arthritis/arthralgia (74.4%), followed by fatigue (53.1%) and photosensitive rash (50.9%) (Table 1). Among non-criteria features, Raynaud's phenomenon was reported by 146 patients (33.3%) prior the diagnosis. The median interval between symptoms onset and the SLE diagnosis was 16 months (IQR 5-60). SLE was diagnosed earlier in ANA-positive than -negative patients [median time 14 months (IQR 5-60) vs 36 months (IQR 10.5-84); P=0.1, t-test]. Approximately half of the patients (52.5%) were diagnosed after 12 months from disease onset with only 15.9% diagnosed within 3 months of symptoms presentation. The median lag time between onset of symptoms and the first medical consultation was 2 months (IQR 1-12). Internists were the most common first consultants (27.8%) followed by orthopedists (15.9%), dermatologists (13.6%) and rheumatologists (13.4%). The median interval between the first medical assessment and first rheumatologist evaluation was 3 months (IQR 0-11.5) while the median time from rheumatologist assessment to definite diagnosis was 0 months (IQR 0-4). SLE patients consulted an average of 3 different physicians before the definite diagnosis, which in 95.8% was established by rheumatologists.

Conclusion: Approximately 50% of patients were diagnosed with SLE after 12 months from symptom onset with a mean time from symptoms to definite diagnosis almost 4 years. Increasing awareness of internists to SLE and avoidance of strict adherence to ANA as a requirement for diagnosis may improve early diagnosis.