0.84, p<0.001, respectively). Improvements in all SF-36 subscales were observed in the GLM group at Wks 8 & 16 compared to PBO (p<0.01, with the exception of the role-emotional subscale [p=0.058]). The percentage of pts achieving clinically meaningful change (5 points or greater) in SF-36 PCS & MCS were higher in GLM than PBO in Wks 8 & 16 (PCS: 58.1 vs. 27.2, 67.6 vs. 35.9, respectively; MCS: 48.6 vs. 34.0, 54.3 vs. 29.1, respectively; p<0.05 for all). Mean EQ-5D VAS improvements were greater (p<0.001) in GLM than PBO at Wks 8 & 16 (17.61 vs. 6.63, 20.32 vs. 4.79, respectively). Greater improvements in ASQoL were observed in GLM compared to PBO at Wks 8 & 16 (-4.5 vs. -1.5, p<0.001, -5.4 vs. -1.8, p<0.001, respectively). By Wk 28, after PBO crossed-over to GLM, improvement in PCS, MCS, EQ-5D VAS, & ASQoL were similar between the two treatment arms.

Table: Summary of mean (standard deviation) changes in SF-36, EQ-5D, and ASQoL.

		IV GOLIMUMAB 2mg/kg	PLACEBO
Patients		105	103
Mean (SD) change from baseline in SF-36 PCS:	Week 8	6.83 (6.90) (p<0.001)	2.07 (5.66)
	Week 16	8.52 (7.54) (p<0.001)	2.87 (6.11)
	Week 28	9.08 (8.02)	9.29 (7.09)
Mean (SD) change from baseline in SF-36 MCS:	Week 8	5.56 (9.26) (p=0.006)	1.67 (8.80)
	Week 16	6.47 (9.12) (p<0.001)	0.84 (9.82)
	Week 28	6.16 (10.91)	5.60 (9.70)
Mean (SD) change from baseline in EQ-5D VAS:	Week 8	17.61 (24.02) (p<0.001)	6.63 (19.881)
	Week 16	20.32 (24.59) (p<0.001)	4.79 (23.47)
	Week 28	20.52 (27.86)	22.45 (23.08)
Mean (SD) change from baseline in ASQoL:	Week 8	-4.5 (4.71) (p<0.001)	-1.5 (3.90)
	Week 16	-5.4 (5.01) (p<0.001)	-1.8 (4.50)
	Week 28	-5.3 (5.24)	-5.3 (4.84)

Conclusions: Adult pts w/active AS treated w/IV GLM showed marked improvements in physical functioning, mental health functioning, health state, & HRQoL.

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AB0693 PATIENTS WITH CHRONIC INFLAMMATORY ARTHROPATHIES TREATED WITH GOLIMUMAB ACHIEVE A HIGHER SERUM LEVEL OF DRUG IF USED AS THE FIRST OR SECOND BIOLOGICAL DRUG

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Objectives: To know the influence of the order of introduction of Golimumab (GLM), on clinical efficacy in ankylosing spondylitis (AS), psoriatic arthritis (PSA) and rheumatoid arthritis (RA).

Methods: A prospective, observational study, in 46 consecutive patients with AS, APS and RA, treated with GLM. Data: epidemiological, concomitant DMARD, time of disease evolution, HLA-B27, RF and ACPA; from GLM: order of introduction, time in treatment, serum level and anti-GLM Ab. The clinical response was assessed in AS patients using BASDAI, BASFI, ASDAS-VSG. In patients with RA or peripheral APS, DAS28-VSG, DAS28-PCR and SDAI. Serum levels of GLM and anti-GLM Ab were determined by ELISA (Progenika, Grifols SA, Spain). Serum cutoff levels for serum GLM levels: 36 ng/mL and for anti-GLM Ab: UA>20 AU/mL. Samples were extracted just prior GLM administration (trough level) and stored frozen at -80ºC until analysis.

Results: Of 33 (72%) AS patients: 52% were males, mean age 53±12 years, mean BMI 28±4, disease mean evolution 16±12 years and in GLM: 1.3±1.1 years, 30% received DMARD, being GLM the first anti-TNF in 25%, second 37%, third 25% and fourth in 13%. The mean GLM level was 0.77±0.62 mg/mL and the prevalence of anti-GLM antibodies was 6%. In the 5 patients with RA and 8 with APS: 23% were men, mean age of 55±11 years, mean BMI 28±6, mean disease evolution of 10.5±8 years and in GLM of 2±1.5 years, the 85% of patients received DMARD, being GLM the first anti-TNF in 31%, second 15%, third 31% and fourth 23%. The mean GLM level was 0.703±0.53 mg/L. No anti-GLM Ab were detected.

Table 1. Characteristics of patients with receiving GLM, according to the order of introduction

Golimumab (GLM) RA-APS (n: 13)	1°–2° anti-TNF (n: 7)	3°–4° Anti-TNF (n: 6)	p
BMI, kg/m^2: mean (SD)	28,72 (6,62)	28,93 (6,66)	0,95
Disease evolution (years): mean (SD)	10,1 (7,64)	11,53 (10)	0,78
DMARD, n (%)	7 (100)	4 (67)	0,13
Years on GLM: mean (SD)	2,27 (1,86)	2,5 (2,04)	0,84
anti-GLM Ab, U/L, n (%)	0	0	–
DAS28-VSG, mean (SD)	1,74 (0,83)	2,12 (0,94)	0,47
DAS28-PCR, mean (SD)	1,82 (0,85)	2,28 (0,93)	0,39
SDAI, mean (SD)	3,92 (5,17)	7,67 (6,58)	0,30
Golimumab (GLM) AS (n: 33)	**1°–2° anti-TNF (n: 21)**	**3°–4° anti-TNF (n: 12)**	**p**
BMI, kg/m^2: mean (SD)	27,46 (4,20)	29,26 (3,09)	0,16
Disease evolution (years): mean (SD)	14,25 (10,55)	20,65 (14,27)	0,21
DMARD, n (%)	8 (38%)	2 (17)	0,57
Years on GLM: mean (SD)	1,75 (1,47)	1,13 (0,89)	0,14
GLM level, mg/dL: mean (SD)	0,919 (0,63)	0,448 (0,47)	**0,025**
anti-GLM Ab, U/L, n (%)	0	2 (17)	–
BASDAI: mean (SD)	5,96 (2,48)	6,10 (2,23)	0,86
ASDAS: mean (SD)	2,92 (0,87)	3,79 (2,68)	0,64

Conclusions: 1. The overall prevalence of anti-GLM Ab was 6% and 17% in AS patients. Not detecting in patients with RA or PSA. 2. Serum GLM level was higher among the patients receiving it as the 1st or 2nd anti-TNF. 3. In AS GLM as 3rd or 4th anti-TNF were able to achieve clinical remission, similar to that achieved as 1st or 2nd drug.

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AB0694 RHEUMATOLOGISTS' ATTRIBUTION OF PATIENT-REPORTED SYMPTOMS IN AXIAL SPONDYLOARTHRITIS (AXSPA): IMPACT ON RESPONSE TO TNF-INHIBITORS (TNFI) IN 508 PATIENTS

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Background: In axSpA, treatment decisions are mainly based on patient-reported symptoms: recommendations are to initiate TNFi in patients with active disease and with physician conviction that treatment is needed (ref). However, the attribution of symptoms to inflammation is difficult to establish in axSpA.

Objectives: The objective of the present analysis was to explore the link between physician-attributed causality for symptoms and treatment response to TNFi.

Methods: The PredictSpA study (ClinicalTrials.gov: NCT03039088) was a longitudinal observational multicenter study in France in 2015. Patients with physician-defined definite axSpA and starting a TNFi treatment were included, a TNFi was prescribed according to usual practice and efficacy was assessed at 12 weeks by BASDAI50 response. At baseline, symptoms levels including BASDAI and ASDAS were collected and the physician evaluated the causality of symptoms by answering the following 3 questions: how convinced are you that the symptoms of this patient are due to (A) inflammatory axSpA activity (B) to axSpA severity (eg syndesmophytes, kyphosis) and NOT to disease activity and (C) to other diseases and NOT axSpA. Each question was assessed 0–10 (not convinced at all to absolutely convinced). The link between a score ≥4/10 on each of the 3 questions and BASDAI50 response was assessed by univariate logistic regression. Patients interrupting the TNFi before 3 months were considered as non-responders and missing data were imputed using non-responder imputation.

Results: In all, 519 patients were included and 508 had data over 3 months: mean age 41.3 (SD 11.6) years, mean disease duration 6.1 (SD 8.4) years, 237 (46.7%) were women, 424 (83.5%) satisfied the ASAS criteria for axSpA of whom 379 (74.6%) were in the imaging arm and 45 (8.9%) in the clinical arm. Symptom levels were high: mean BASDAI was 5.7 (SD 1.8) and mean ASDAS-CRP was 3.3 (SD 0.9) with only 6 (1.2%) patients in inactive disease state according to ASDAS. The physician-attributed causality of symptoms was mostly related to inflammatory activity: mean scores for (A), (B) and (C) were respectively, 7.4 (SD 2.0), 2.3 (SD 2.5) and 2.1 (SD 2.2). When physicians attributed causality to non-axSpA (score (C) ≥4/10), BASDAI50 response was less frequent: 45/118 (38.4%) vs 213/390 (54.6%), odds ratio 0.5 [95% CI 0.3, 0.8].

Conclusions: In axSpA patients starting a TNFi with high symptom levels, physician-attributed causality of symptoms was mainly related to inflammatory activity of the axSpA. When physician-attributed causality was more oriented towards non-axSpA causes, BASDAI50 response after 3 months of a TNFi was lower. This confirms the validity of the ASAS-EULAR recommendations for starting a TNFi which rest on a level of symptoms but associated to physician conviction of the indication.

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AB0695 DOSE TAPERING OF INFIXIMAB IN PATIENTS WITH SPONDYLOARTHRITIS

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Background: Infliximab have proven to be effective in spondyloarthritis. Previous studies suggest that patients in clinical remission may benefit from dose reduction or pharmacological tapering without relapse.
Objectives: To study the evolution of clinical activity and physical function in patients with spondyloarthritis, ankylosing spondylitis (AS) and psoriatic arthritis (PsA) under Infliximab (IFX) tapering strategy.
Methods: This is a prospective single-centre observational study of patients diagnosed with AS and PsA treated with IFX (5 mg/kg/infusion) between January 1, 2012 and December 31, 2015. We included patients who achieved clinical remission or low activity index (expressed with BASDAI and BASFI) and decided to lower the dose of 5 to 4 mg/kg/infusion, maintaining the periodicity of the treatment in each patient. Demographic data (age, gender, time with IFX) daily activities, physical activity (BASDAI and BASFI) and laboratory data (ESR and CPR) were collected at the baseline visit prior to tapering, at the next infusion following dose reduction and the last infusion (between November 1st 2014 and December 31st, 2016).
Results: We included 18 patients (16 men) on IFX treatment with EA (16) or axial APs (2). The medians of age and time of evolution were 50.79 years (41.8–55.1) and 9.5 years (7.2–11.5), respectively. Table 1 shows the clinical and laboratory data obtained at the baseline visit, the next infusion and the last infusion. Fourteen patients (87.9%) continued with the dose of 4 mg/kg/infusion and are maintained in clinical remission. Four patients returned to the dose of 5 mg/kg/infusion due to loss of efficacy at dose reduction, with a mean follow-up of 17.6 months (17.0–19.1). Clinical remission was again achieved in the 4 patients, although one of them changed biological therapy due to loss of efficacy of IFX after 3 infusions with 5 mg/kg/infusion.

Table 1. Clinical and laboratory data during follow-up

	Baseline	Next Infusion	Last Infusion
BASDAI median (RI)	3,1 (1,45–4,45	4 (1,4–4,25)	4,1 (1,65–6,15)
BASFI median (RI)	2,8 (1,1–4,5)	3,6 (1,8–4,25)	2,8 (1–5)
ESR (mm/h) median (RI)	6,5 (3–11,25)	4,5 (3–11,5)	12,5 (6,5–16,75)
CPR (mg/dl) median (RI)	0,2 (0,2–0,55)	0,3 (0,1–0,4)	0,2 (0,1–0,72)

Conclusions: In our patients with spondyloarthritis dose reduction of IFX was well tolerated and safe, maintaining the clinical response measured by BASDAI and BASFI. In 3 out of 4 patients who worsened upon dose reduction, the 5 mg/kg/infusion dose recovered clinical remission.
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AB0696 RETENTION RATES OF ADALIMUMAB, ETANERCEPT, AND INFLIXIMAB AS FIRST- OR SECOND-LINE BIOTHERAPIES FOR SPONDYLOARTHRITIS PATIENTS IN DAILY PRACTICE IN AUVERGNE (FRANCE)

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Background: The use of tumour necrosis factor alpha (TNF-α) inhibitors – or anti-TNFs – has considerably improved the treatment of spondyloarthritis (SpA). The first three of these available anti-TNFs (infliximab, adalimumab, and etanercept) are the most widely used in the treatment of SpA. Their efficacy and safety have been demonstrated in extensive randomised controlled trials (RCTs).Nevertheless, the randomized studies were of short duration and included a selected population that differed from patients treated in daily practice
Objectives: To compare, in real-life settings, the retention rates of the initial anti-TNF treatment (etanercept [ETN], adalimumab [ADA],and infliximab [IFX]) used as first-line biotherapy for spondyloarthritis (SpA), and to evaluate treatment switches to another anti-TNF inhibitor in the event of treatment failure.
Methods: Monocentric retrospective cohort including all SpA patients starting an initial anti-TNF therapy between 2001 and 2015.
Results: Of the 249 SpA patients analysed (135 radiographic cases, 114 non-radiographic), 102 were given ETN, 62 ADA, and 85 IFX. In total, 103 discontinued treatment. The median retention duration was 69.7 months (17–∞) (ETN: 55.4 [17.6–94.6], ADA 57.6 [13.9–∞], and IFX: not reached). Retention was longer for IFX compared with ETN (HR=0.62 [0.39–0.99]) but non-significant compared with ADA (HR: 0.91 [0.56–1.48]). The percentage of patients continuing treatment after 5 years was 47% for ETN, 46% for ADA, and 62% for IFX. In multivariate analysis, the predictive factors for retention were a low BASDAI score (HR: 1.02 [1.01–1.04]), high CRP levels (HR 0.98 [0.97–0.99]), the concomitant use of disease-modifying therapy (HR: 0.4 [0.21–0.75]), and radiographic SpA (HR: 1.5 [1.0–2.52]). In total, 61 patients switched to another anti-TNF therapy. No difference was observed among the three anti-TNF therapies with regard to the median retention duration, but the retention rate was higher in the event of treatment switches from one monoclonal antibody to another.
Conclusions: The retention rate in SpA patients proved high, and retention for IFX was superior to that of ETN.
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AB0697 IMPACT OF THE BASELINE BATH ANKYLOSING SPONDYLITIS RADIOLOGY HIP INDEX ON THE STRUCTURAL HIP JOINT PROGRESSION AFTER TNFα BLOCKING THERAPY IN SPONDYLOARTHRITIES PATIENTS

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Background: One of the major goals of treatment of spondyloarthrites (SpA) is to prevent or slow the radiographic damage.The results of clinical trials raised expectations that TNFi are effective not only on clinical and biological parameters of the disease but may also have structural effect.
Objectives: We assessed whether the baseline Bath Ankylosing Spondylitis Radiology (BASRI) hip index had effect on structural hip progression under TNFα blockers in SpA patients with hip disease.
Methods: This was a multicentric longitudinal study including SpA patients (ASAS2009) with hip disease under TNF α blockers. Anteroposterior X-rays of the pelvis obtained at baseline were compared with X-rays obtained after 5 years [3–10] of continuous TNF α blockers treatment. Radiographic progression of the hip was evaluated by the Bath Ankylosing Spondylitis Radiology Hip Index (BASRI-h), scoring system (min 0 = no change, 1 = focal joint space narrowing, 2 = circumferential joint space narrowing >2 mm, 3 = circumferential joint space narrowing ≤2 mm or bone-on-bone apposition of <2 cm and max 4 = bone deformity or bone-on-bone apposition of ≥2 cm) and the hip joint space width (assessed by the average of measurements at three distinct sites between the acetabulum and femoral head)[1]. The median progression of the hip joint space was chosen as cut-off to define the structural evolution, it was 0.3mm. A good response of the hip was defined by a stabilization or a decrease of the hip joint space less than 0.3 mm (RH+).A poor response was defined by a decrease of the hip joint space >0.3mm (RH-).
Results: 48 patients were included (81% male). The average age was 40.7±11years. The mean age at the onset of the disease was 25.8±10 years. Hip involvement was bilateral in 77% of cases. At baseline, the mean BASRI hip index was 2±0.8. The BASRI hip score was 1 in 26%, 2 in 51%, 3 in 18% and 4 in 5% of patients. The average of hip joint space width at baseline was 3.4±1.2mm. Infliximab was the most prescribed TNFα blocker (48%) followed by Etanercept (37.5%) and Adalimumab (14.5%).After 5years, the mean BASRI hip index remained stable 2±0.8, the BASRI hip score was 1 in 23%, 2 in 50%, 3 in 14% and 4 in 13% (p=ns). The variation of hip joint space width was-0.294 mm (p=ns). 29 patients were RH+. The BASRI hip index 2±0.8 and 2.1±0.9 in RH+ and RH- patients respectively with no statistically significant difference.
Conclusions: According to our study the structural hip joint progression under TNFα blockers is not influenced by the baseline BASRI hip index.
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AB0698 COMPLEMENTARY AND ALTERNATIVE MEDICINE USAGE AND ASSOCIATED FACTORS IN ANKYLOSING SPONDYLITIS: PRELIMINARY RESULTS OF A CROSS-SECTIONAL STUDY

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Background: Several surveys indicate that the complementary and alternative medicine (CAM) use is especially prevalent in patients with chronic painful