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FRI0204 COMPARISON THE LONG-TERM CLINICAL OUTCOMES BETWEEN NONTNF-INHIBITORS VERSUS TNF-I IN RA PATIENTS WHO FAILED TO A FIRST TNF-I

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Background: There are many biological therapies for Rheumatoid Arthritis (RA) with different mechanisms of action and good efficacy rate; however, up to 40% of patients (pts) fail to respond to the 1st biologic agent, and it is still not clear what strategy to follow after showing inadequate response to tumor necrosis factor α inhibitors (TNF-i)
Objectives: To assess the clinical response and survival (SVV), in our cohort of RA pts that discontinued the 1st TNF-i, of a 2nd TNF-i vs a nonTNF-i, both in the global cohort and in the subpopulation that dropped out the 1st TNF-I due to inefficacy
Methods: This observational study included 110 pts in the RA-Paz cohort who previously suspended Ifx (68%) or Ada (32%) between 1999–2016. Two groups were established as they switched to a TNF-i or nonTNF-i. Clinical response was evaluated by DAS28, Delta-DAS28 (∆DAS28) and EULAR response (E-resp). The assessments were performed at 6 (v-6) and 12 months (v-12) since initiating 2nd biological agent and during the last visit prior to drug discontinuation or ending of the study for those who did not interrupt the drug (v-end). Statistical analysis was performed using SPSS version 20.0
Results: Of the 110 pts who had stopped Ifx or Ada as 1st TNF-i, 65% changed to a 2nd TNF-i. The 84% of the overall pts were women. The mean age was 64±14 years and the mean time of 2nd biologic drug was 3.71±3.51 years. 61% associated methotrexate at the beginning of 2nd biologic agent and 56% at the v-end, without differences between those who switched to TNF-i and those who did to nonTNF-i. At v-6 and v-12, there was no difference in ∆DAS28 [at v-6:1.3±1.4 in TNF-i and 1.2±1.2 in nonTNF-i (p=0.919), at v-12: 1.3±1.5 in TNF-I and 1.2±1.1 in nonTNF-i (p=0.852)]. In contrast, at v-end, pts with nonTNF-i showed a higher clinical improvement (∆DAS28: 0.68±1.7 in TNF-i, 1.8±1.1 in nonTNF-i, p=0.002). At v-6, the TNF-i group achieved higher good E-resp rate (41% vs 18%, p=0.035), but there was no difference at v-12 (36% in TNF-I vs 23% in nonTNF-i, p=0.435). However, at v-end, the nonTNF-I group achieved better E-resp (good resp: 38% in nonTNF-i vs 25% in TNF-I, no resp 18% in nonTNF-i vs 50% in TNF-i, p=0.01). Likewise, 100% (n=7) of the pts that finished 2nd biologic agent by remission, had changed to a nonTNF-i (p<0.00001). There were no differences regarding 2nd biologic drug SVV (mean SVV time of 5.7±0.66 in TNF-I, 4.3±0.59 in nonTNF-i, p=0.797). When analyzing the cohort that discontinued 1st TNF-I because of inefficacy, at v-6 and v-12 there were no differences between switchers to TNF-I and nonTNF-i in ∆DAS28 [v-6: 1.4±1.4 vs 0.9±1 p=0.164); v-12: 1.5±1.4 vs 1±1, p=0.192)], but at v-end, the nonTNF-i group reached a higher ∆DAS28 (0.9±1.5 in TNF-i, 1.6±1 in nonTNF-i, p=0.031)

Demographic characteristics	
Age (years)	64±13,9
Sex (female)	92 (84%)
Smokers	18 (16%)
BMI	26,6±7,7
Disease duration (years)	16,7±8,04
RF +	94 (85%)
Anti-CCP +	96 (89%)
Duration of treatment 1st biological (years)	3,2±3,1
Basal DMARDs (2º biological)	99 (90%)
Basal MTX (2º biological)	67 (61%)
v-Final FAMEs (2º biological)	93 (86%)
v-Final MTX (2º biological)	60 (56%)
Basal CPR (2º biological)	15,2±18,7
Basal ESR (2º biological)	42±24,1
Basal DAS (2º biological)	5,55±1,3

Conclusions: In our sample of RA patients who suspended Ifx/Ada as 1st TNF-i, switching to a 2nd biologic agent did not show relevant clinical differences between a TNF-i and a nonTNF-i within the 1st year of treatment. However, in the long-term, switching to a nonTNF-i shows enhanced clinical benefits with no impact on survival vis-à-vis a 2nd TNF-i. Despite the efficacy of TNF-i, new therapeutic targets are needed for those who fail to respond to these biological agents
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FRI0205 CORRELATION OF PATIENT PREFERENCES TO TREATMENT OUTCOMES IN PATIENTS WITH RHEUMATOID ARTHRITIS (RA) TREATED WITH ANTI-TNF AGENTS IN GREECE. THE PANORAMA STUDY

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Background: Route and frequency of administration of treatment options may be an important differentiator between drugs that are used to treat RA and patient preferences may influence adherence to and outcomes of therapy.
Objectives: The objective of this study was to assess the correlation between the fulfillment of patient preferences and clinical and patient reported outcomes.
Methods: PANORAMA was a non-interventional, prospective, multicenter, cohort study. Patients were either biologic naïve or experienced who initiated/switched to anti-TNF at enrollment. Post physician's anti-TNF choice, patients completed a preferences questionnaire over attributes related to anti-TNF treatment. Satisfaction with treatment was assessed with the TSQM questionnaire and compliance (proportion of full doses/planned) was recorded via the use of a patient diary. Persistence was defined as the time period between first and last anti-TNF administration. The observational period was 12 months, with study visits every 3 months.
Results: A total of 254 patients were enrolled in the study. The mean patient age was 58.3±13.4 years, 82.7% were female, 65.4% were biologic naïve and 66.1% had severe disease (DAS-28 ESR>5.1).The mean DAS-28 and HAQ-DI scores at enrollment were 5.5±1.1 and 1.4±0.6 respectively, while mean disease duration was 6.7±6.2 years with 53.2% of patients being seropositive (RF (+):49.2%, Anti-CCP (+): 40.5%). A monthly administration was most preferred by patients (65.7% vs. 20.1% for twice per month, 11.8% for once per week and 3.9% for twice per week), and the large majority of patients (75.2%) preferred the subcutaneous mode of administration. The mean compliance and 12-month persistence rates were 97.0% and 72.3% respectively. At 12 months, good EULAR response rate was achieved by 56.5% of patients and 40.8% were in DAS-28 remission. Univariate analysis demonstrated that fulfillment of patient preferences was correlated to good EULAR response (p<0.001), increased probability of being persistent (p=0.019) and satisfaction with treatment (p=0.063). Multivariate logistic regression analysis revealed that a good EULAR response was associated with satisfaction of patient preferences (OR 5.560, p<0.001), good patient knowledge of the disease (OR 1.327, p=0.006), absence of history of comorbidities (OR 2.42, p=0.014) and lower SJC (OR 1.10, p=0.021), whereas anti-TNF persistence at 12 months was associated (Cox regression analysis) with seropositivity (HR 0.566, p=0.047) and a high baseline ESR (>35 mm/h (HR 0.587, p=0.071)).
Conclusions: In anti-TNF treated RA patients, fulfillment of expressed treatment preferences was independently associated with a good EULAR response and correlated with drug persistence at 12 months, emphasizing the importance of patient preferences in treatment outcomes.
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FRI0206 CORRELATION BETWEEN THE SERUM ETANERCEPT LEVEL AND RESPONSE TO ETANERCEPT TREATMENT IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: It is well documented that the blockade of TNF-α significantly reduces disease activity in patients with rheumatoid arthritis (RA). However, at least one third of patients receiving etanercept either do not respond to treatment, or lose initial responsiveness [1]. Recent findings indicate that lack of clinical response may be related with lowering the serum drug levels.
Objectives: To investigate the relationship between serum etanercept levels and response to etanercept treatment in patients with RA.
Methods: The study population consisted of fifty eight patients with rheumatoid arthritis (RA), all treated with etanercept. Disease activity was assessed according to the 28-joint count *Disease Activity* Score (*DAS28*) at baseline and 6 months of