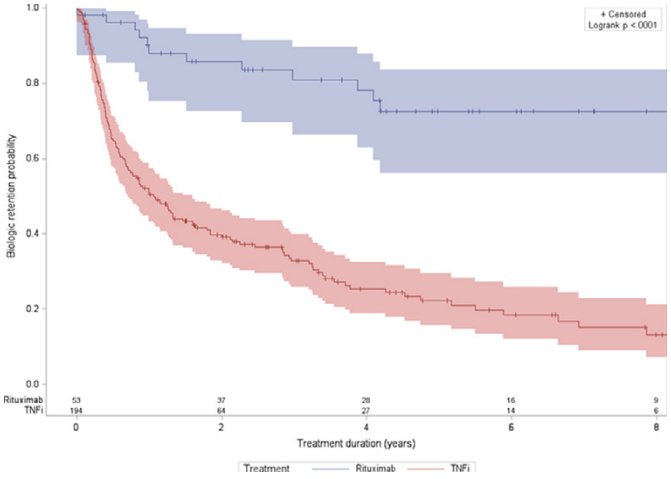
but recent registry data point to better responses and retention if a drug with a different mode of action is prescribed.
Objectives: Assess the long-term retention of rituximab (RTX) and TNFi following first biologic (b)DMARD inadequate response in RHUMADATA® registry patients (pts) with RA.
Methods: Data from RHUMADATA® pts with RA prescribed either RTX or TNFi as the second bDMARD after 1 January 2006 were analysed. Pts were followed until treatment discontinuation or 9 January 2017 cut-off. Pt characteristics were compared using descriptive statistics, bDMARD discontinuation rates using Kaplan-Meier methods, and proportional hazard models were used to identify predictors of treatment discontinuation.
Results: Data for 53 and 194 pts prescribed RTX or a TNFi, respectively, as second-line treatment were extracted. No clinically significant differences in baseline characteristics were noted between treatment groups. Most pts were women (74.9%), average age (SD) was 45.2 (12.9) years at diagnosis and disease duration 10.5 (8.7) years. Most pts were stopping an anti-TNF agent: 100% of those who were switched to RTX and 83% of those who were prescribed a second anti-TNF. Overall, 77.3% of pts stopped their first bDMARD after >6 months of treatment (secondary failure). Significant differences in retention between RTX and TNFi groups (log-rank p≤.0001) were observed (Table, Figure). Results remained unchanged for pts treated with TNFi only in first line, and primary/secondary failure of the first bDMARD did not affect sustainability of the second agent. Lack of efficacy (54.4%) and AEs (16.5%) were the most commonly cited reasons for treatment discontinuation.



Conclusions: Rituximab has better sustainability over a second line TNFi in RA patients having failed one prior bDMARD.
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SAT0196 REPEATED RITUXIMAB INFUSIONS FOR THE THERAPY OF RHEUMATOID ARTHRITIS IS NOT ASSOCIATED WITH INCREASED RATES OF SERIOUS INFECTIONS

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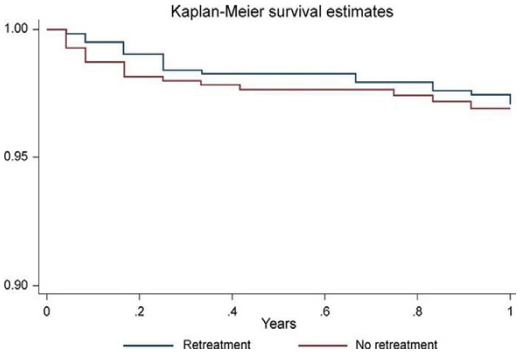
Background: Extended observations in clinical trials have not demonstrated an increased risk of serious infection events (SIE) in patients with rheumatoid arthritis (RA) treated with rituximab.[1] However, continuous surveillance using large-scale observational data is of importance.
Objectives: To evaluate the rate of SIEs among patients with RA who received only an initial rituximab infusion vs those retreated with ≥1 rituximab infusion during the first year of therapy, and also to describe characteristics of rituximab-treated patients who experienced an SIE vs those who did not.
Methods: Patients with RA enrolled in the Corrona registry and treated with rituximab were followed until their most recent Corrona registry visit, first SIE, switch to another biologic or targeted synthetic disease-modifying antirheumatic drug, or 12 months after the most recent infusion with no further retreatment – whichever occurred first. The rate of SIEs was estimated in the overall population as well as in patients retreated with ≥1 infusion every 12 months after rituximab initiation and in those who did not receive a repeat infusion in the first 12 months. Patient characteristics were compared between those who experienced an SIE and those who did not.
Results: A total of 1361 patients with 1821 patient-years (PY) of follow-up were included; there were 59 SIEs for a rate of 3.24 SIE/100 PYs. 637 patients (46.8%) received ≥1 rituximab retreatment during the first 12 months and 724 (53.2%) received only the initial infusion. In the retreatment population there were 40 SIEs per 1312.8 PY for a rate (95% CI) of 3.05/100 PY (2.18–4.15), and in the no retreatment population there were 19 SIEs per 508.71 PY for a rate (95% CI) of 3.73/100 PY (2.25–5.83). The Kaplan-Meier curve depicting the occurrence of SIEs in the 2 cohorts during the first year of follow-up is shown (Figure). In the 59 patients (4.3%) who experienced an SIE, the mean (SD) number of rituximab infusions was 1.88 (1.18), compared with 2.07 (1.70) in the 1302 patients (95.7%) who did not experience an SIE. Patients who experienced an SIE vs those who did not were older (mean age [SD]: 62.9 [9.9] vs 58.1 [12.55] years), had longer disease duration (19.1 [13.1] vs 13.6 [10.4] years), were more frequently diabetic (16.9% vs 8.3%) and more frequently had cardiovascular disease (25.4% vs 12.8%), prior history of SIEs (18.6% vs 5.8%) and pulmonary disease (10.2% vs 4.8%). There were no differences in other clinical, demographic and medication history characteristics; steroid therapy was similar between the groups.



Conclusions: Retreatment with rituximab infusions was not associated with a higher rate of SIEs in this study. Patients who experienced an SIE had a higher prevalence of risk factors for infections.
References:
[1] Van Vollenhoven RF et al. J Rheumatol. 2015;42:1791–6.
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SAT0197 TREATMENT OUTCOMES WITH ANTI-TNF AND NON-ANTI-TNF DISEASE-MODIFYING THERAPY BY BASELINE BODY MASS INDEX

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Background: Recent studies have indicated that being overweight or obese could reduce the effect of anti-TNF treatment in patients (pts) with RA.[1,2] Other data show that certain biologic (b)DMARDs, such as abatacept, work independently of BMI.[3,4] Additional data on the role of BMI on treatment outcomes in clinical practice settings is required to inform clinical practice.
Objectives: To evaluate the impact of BMI on outcomes of disease activity in pts with RA treated with TNF and non-TNF agents (conventional or other bDMARDs).
Methods: Pts enrolled in a tertiary care centre RA registry, established in 2003, were analysed. The registry mostly comprises pts with established RA who were evaluated semi-annually for multiple clinical patient-reported outcomes and resource utilization parameters, and annually for composite disease activity measures such as DAS28 (CRP), CDAI and SDAI. The current analysis is based on pts enrolled in the RA registry with BMI values at time of enrolment. Pts were classified into groups based on BMI: normal (BMI <25 kg/m^2), overweight (BMI ≥25 to <30 kg/m^2) and obese (BMI ≥30 kg/m^2). Outcomes evaluated included change from baseline in DAS28 (CRP), CDAI, SDAI and joint counts at 12 months