were assessed for demographic characteristics, disease duration, HLA-B27, DMARD and biological usage, biological switch ratio. Baseline disease activity was assessed with BASDAI, BASFI VAS (pain, fatigue and patients global assessment), ESR and CRP. Patients were compared according to having uveitis or not. Retention rate of adalimumab assessed by Kaplan-Meier survival analysis.

Results: Total 350 (59.4% male) AS patients analyzed. Mean age was 43 (12), mean disease duration and symptom duration were 10.5 (7.8) and 14.8 (9.6) years, respectively. 52 patients (14.8%) had uveitis. Median adalimumab survival time according to having uveitis were 71.9 (95% CI 25.4–118.6) months vs 36.4 (95% CI 23.3–49.4) months (log-rank $p=0.014$) (figure). Patients with uveitis were more frequently male (18.2% vs 9.8%, $p=0.03$), HLA-B27 positive (75.0% vs 49.5%, $p=0.022$). Patients with uveitis had more frequently SpA family history, as well (23.1% vs 10.8%, $p=0.003$). Age (49 (11) vs 41 (11) years, $p<0.001$), disease duration (14.4 (10.1) vs 9.8 (7.1) years, $p<0.001$), and symptom duration (22 (12) vs 14 (8) years, $p<0.001$) were higher in patients with uveitis. Baseline and last visit disease activities were similar regarding to uveitis.

Conclusions: Determination of possible risk factors for retention of TNFi drugs is an important clinical problem for routine practise. It is well known that adalimumab is one of the treatment option for uveitis whether uveitis related with SpA or not. Our biological cohort supported that AS patients with uveitis had better adalimumab survival. For routine practise, adalimumab could be considered for AS patients with uveitis.

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AB0707 COMPARATIVE EFFECTIVENESS OF SECUKINUMAB AND GOLIMUMAB IN ANKYLOSING SPONDYLITIS ASSESSED BY MATCHING-ADJUSTED INDIRECT COMPARISON USING PIVOTAL PHASE 3 CLINICAL TRIAL DATA

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Background: No data are available from head-to-head RCTs between secukinumab 150 mg (SEC; an anti-IL-17A) and golimumab 50 mg (GOL; a TNFi) in patients with active ankylosing spondylitis (AS). Matching-Adjusted Indirect Comparison (MAIC) can be used to estimate comparative effectiveness and enables treatment outcomes to be compared across effectively balanced trial populations. MAIC is an established method in health technology assessments and NICE have published guidance on appropriate methodology, and especially for addressing imbalances in observed covariates between trials.¹

Objectives: To assess the comparative effectiveness of SEC and GOL up to week 24 using MAIC with pooled individual patient data (IPD) from the RCTs MEASURE 1 (M1) and MEASURE 2 (M2) and published aggregate data from the RCT GO-RAISE.

Methods: Pooled M1 and M2 data were used to maximize the effective sample size (ESS) for SEC. IPD from the SEC arms of M1 and M2 ($n=197$) were weighted to match the published baseline characteristics of the GOL arm of GO-RAISE ($n=138$). Placebo arms were matched in the same way; placebo-adjusted comparisons were possible only until week 16 because patients could receive active treatment from this time onwards. Logistic regression was used to determine weights for age, sex, BASFI, disease duration, CRP and previous TNFi therapy. Recalculated outcomes from M1 and M2 (SEC, ESS=102; placebo, ESS=81) were compared with data from GO-RAISE (GOL, $n=138$; placebo,

$n=78$). Pairwise comparisons – reported as odds ratios (ORs [95% CIs]) – were performed for ASAS 20, ASAS 40 and ASAS PR responses at nearest-equivalent time points across trials: week 12 (SEC)/14 (GOL), week 14 (GOL)/16 (SEC) and week 24 (SEC and GOL). Non-responder imputation (NRI) was available for all binary outcome data. Strict thresholds were avoided when interpreting p values, in line with American Statistical Association 2016 guidance.

Results: There was no evidence of differences in ASAS 20 and ASAS 40 responses between SEC and GOL at weeks 12/14 and 14/16 (both placebo-adjusted). At week 24, non-placebo-adjusted ASAS 20 and ASAS 40 responses using NRI were higher with SEC than GOL (OR [95% CI]: 1.58 [0.93–2.69], $p=0.089$ and 1.58 [0.94–2.64], $p=0.084$, respectively). There was no evidence of differences in ASAS PR responses between SEC and GOL at weeks 12/14, 14/16 and 24. A sensitivity analysis conducted after adding BASDAI score to the matching parameters yielded similar results.

ASAS 20/40 and PR responses are the absolute mean response rate (GO-RAISE) and the predicted mean response rates (MEASURE 1 and MEASURE 2). Error bars shown are 95% CIs. ASAS, Assessment of SpondyloArthritis International Society; ASAS 20/40, at least a 20%/40% improvement according to ASAS response criteria; ASAS PR, ASAS partial remission; CI, confidence interval; ESS, effective sample size; GOL, golimumab; OR, odds ratio; SEC, secukinumab.

Conclusions: There was no evidence of differences in ASAS responses between SEC and GOL in placebo-adjusted analyses. In non-placebo-adjusted analyses, SEC showed higher ASAS 20 and ASAS 40 responses than GOL at week 24.

References:

[1] Phillip DM et al. (2016) NICE DSU Technical Support Document 18. Available from: <http://www.nicedsu.org.uk>.

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AB0708 TRANSITION FROM ONGOING INFlixIMAB REFERENCE PRODUCT TO ITS BIOSIMILAR: CAN WE TALK ABOUT A FAILURE?

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Background: Some recent publications support the fact that there is no clinically meaningful difference between infliximab biosimilar and the originator in naïve patients, but sole a few of them actually assessed the transition itself. Since May 2016, according to the European guidelines, the French Health Authorities have allowed interchangeability between a biopharmacy reference product and its biosimilar. According to the last studies focusing on the safety and efficacy issues, avoiding the transition to biosimilar looks no longer justified.

Objectives: This work aimed to understand to which extent the use of infliximab biosimilar may result in the failure of the switch strategy in spondyloarthritis patients.

Methods: This is a retrospective study conducted from June to December