prior biologic exposures. Importantly, MPC infusions were well-tolerated with no adverse infusion reactions or serious adverse events (SAE) noted over 12 weeks. At 4 and 8 weeks, both MPC groups achieved higher ACR20 levels than placebo, with the placebo group reaching similar levels by 12 weeks. Notably, at 12 weeks both ACR50 rates (31, 27, 19%) and ACR70 rates (27, 20, 0%) were higher for the 2M/kg and 1M/kg MPC groups than placebo (Figure 1); $p=0.04$ for ACR70 in 2M/kg vs. placebo. The MPC groups showed dose-related greater improvement in pain, patient global assessment (PGA) of disease and physical function vs. placebo with greater efficacy in the 2M/kg group (Table 1). At 12 weeks PGA and Pain were significantly reduced in 2M/kg MPC group vs. placebo (both $p=0.04$). MPC treatment was associated with significantly improved health-related physical function by the HAQ. Minimal clinically important difference in HAQ defined as reduction of at least -0.22 points was achieved in 93% of 2M/kg MPC vs. 25% of placebo at 12 weeks ($p=0.003$).

Table 1 Summary of Week 12 Efficacy Assessments

	Placebo N=16	MPC 1M/kg N=16	MPC 2M/kg N=16
ACR20 (%)	50%	47%	50%
ACR50 (%)	19%	27%	31%
ACR70 (%)	0%	20%	27%*
DAS-28 CRP (%)			
Response: ≤ 3.2	19%	27%	36%
Remission: < 2.6	13%	20%	21%
HAQ Change from baseline ≤ -0.22 (%)	37.5%	53%	93%**
ACR Core Components [Change (SE) from baseline]			
Tender joints	-9.8 (1.9)	-5.8 (1.9)	-11.2 (1.9)
Swollen joints	-7.7 (1.6)	-6.1 (1.6)	-10.1 (1.6)
Investigator global assessment	-21.6 (6.5)	-32.6 (6.5)	-35.6 (6.6)
Patient global assessment	-6.7 (6.5)	-17.5 (6.5)	-25.7 (6.5)*
Patient pain	-8.4 (6.6)	-16.2 (6.6)	-28.6 (6.7)*

* $p < 0.05$; ** $p < 0.005$

Conclusions: A single infusion of MPCs was well-tolerated in RA patients. While the efficacy results are encouraging, further assessment including dose optimization is needed. The current trial is a unique early phase trial that shows promise of a future role for MPCs as a therapeutic option in biologic-refractory RA patients, a subset of the RA population with substantial remaining medical need.

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FRI0221 DOES SEROPOSITIVITY INFLUENCE DIFFERENTIALLY DRUG DISCONTINUATION OF BIOLOGIC ANTIRHEUMATIC AGENTS WITH NON-ANTI-TNF MODE OF ACTION?

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Background: Rheumatoid factor (RF) and anti-citrullinated protein antibodies (ACPA) are used as diagnostic tools, but may also be used as prognostic factors or as predictors of response to therapy, as these biomarkers have been associated with better clinical responses to some bDMARDs.

Objectives: To examine whether seropositivity has a similar impact on drug discontinuation of different bDMARDs with a non-anti-TNF mode of action (non-aTNF bDMARDs).

Methods: This is a pooled analysis of 10 observational European RA registries

(FR, CZ, DK, NO, PT, RO, ES, SE, CH, NL). Inclusion criteria were a diagnosis of RA, initiation of treatment with abatacept (ABA), rituximab (RTX) or tocilizumab (TCZ) and available information on RF and/or ACPA status. The exposure of interest was seropositivity, which was defined as positive if RF or ACPA was positive and negative if both were negative. The primary endpoint was overall drug discontinuation, defined as the period between treatment initiation and treatment discontinuation. Because national differences may constitute a potential confounder, we only included national registries with information for all 3 bDMARD and pooled data across registries only after excluding significant effect modification by country. Drug discontinuation was analyzed using a Cox proportional hazard model, including drug, seropositivity, and their interaction, adjusting for age, gender, disease duration, baseline DAS28, concomitant synthetic DMARD (sDMARDs), number of previous sDMARDs and bDMARDs, and stratifying by country and calendar year.

Results: We found no effect modification by country, allowing us to pool data from 12040 patients (Table). In crude analyses, seropositivity was associated with a lower drug discontinuation with all 3 bDMARD (p -value interaction 0.22), with a hazard ratio for seropositive vs. seronegative (HR) 0.89 (95% CI: 0.82–0.97). In adjusted analyses, seropositivity remained associated with a lower drug discontinuation, but the effect differed by drug (p interaction 0.01): ABA: HR for seropositive vs. seronegative: 0.76 (95% CI 0.66–0.88), RTX: 0.88, (95% CI: 0.70–1.10), and TCZ: 1.08, (95% CI: 0.89–1.31). Two-by-two drug to drug comparisons showed that the effect of seropositivity differed between ABA and TCZ ($p=0.004$), but not between ABA and RTX ($p=0.29$), or between TCZ and RTX ($p=0.16$). Other factors associated with discontinuation were higher baseline disease activity and more previous bDMARD.

Table 1: Baseline demographic and treatment characteristics

	ABA N=3089	RTX N=5539	TCZ N=3412
Seropositivity, N (%)	2602 (84.2%)	5176 (93.4%)	2920 (85.6%)
• RF+	2234 (73.0%)	4655 (84.1%)	2682 (79.3%)
• ACPA+	1861 (60.5%)	3703 (66.9%)	1826 (53.7%)
Female sex, N (%)	2463 (79.7%)	4543 (82.0%)	2692 (78.9%)
Age [yr], mean (SD)	56.8 (13.2)	58.9 (12.1)	55.9 (12.8)
Disease duration [yr], mean (SD)	11.8 (9.3)	12.5 (9.3)	11.2 (9.6)
DAS28 at baseline, mean (SD)	4.9 (1.5)	5.2 (1.5)	4.7 (1.4)
N previous sDMARD, N (%)			
≤ 1	917 (32.3%)	1988 (40.1%)	1245 (39.2%)
≥ 2	1925 (67.7%)	2972 (59.9%)	1928 (60.8%)
N previous bDMARD, N (%)			
≤ 1	1903 (62.1%)	3818 (69.2%)	1733 (52.5%)
≥ 2	1163 (37.9%)	1699 (30.8%)	1569 (47.5%)
Concomitant sDMARD, N (%)	1657 (53.6%)	3899 (70.5%)	2251 (66.1%)
Median follow-up time [yrs]	0.96	2.00	1.12
Calendar year of treatment initiation, 10 th - 90 th percentile	2008-2014	2006-2012	2009-2015

Conclusions: Data from this pooled European registry analysis suggests that seropositivity is associated with lower drug discontinuation of non-aTNF bDMARDs. This effect differed between drugs and was significant for ABA, but not for TCZ or RTX. The impact of seropositivity on other measures of effectiveness still needs to be investigated.

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FRI0222 SUSTAINED RESPONSE FOLLOWING DISCONTINUATION OF METHOTREXATE IN PATIENTS WITH RHEUMATOID ARTHRITIS TREATED WITH SUBCUTANEOUS TOCILIZUMAB: RESULTS FROM A RANDOMIZED CONTROLLED TRIAL (COMP-ACT)

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Background: Methotrexate (MTX) is frequently administered in combination with biologics for the treatment of rheumatoid arthritis (RA). MTX may be subsequently discontinued due to intolerance or nonadherence, and/or to reduce medication burden once disease control is achieved. Previous studies have established the efficacy of tocilizumab (TCZ) initiated as monotherapy (MONO), but the impact