used to evaluate Δ CDAI. Subgroup analyses were conducted by line of therapy, after excluding switch pts.

Results: Overall, 3959 pts met inclusion criteria and 2045 had data on PPF; 344 and 814 pts received ABA and anti-TNF. Mean (SD) age of ABA pts was 60.3 (12.5) yrs and median (interquartile range; IQR) CDAI was 25.5 (18.1). Mean (SD) age of anti-TNF pts was 56.4 (13.3) yrs and median CDAI (IQR) was 19.8 (18.1). PPF+ pts treated with ABA (vs all other ABA pts) had a better CDAI outcome at 6M (-9.7 [16.1] vs -7.5 [14.4]). In sensitivity analyses, the difference persisted (-10.4 vs -8.4 ; Fig). PPF+ pts treated with ABA as first-line therapy (vs all other ABA pts) had a better CDAI outcome (-13.4 vs -10.3). Similar trends were not observed in the anti-TNF cohort (Fig). Adjusted mean (SE) Δ CDAI in PPF+ vs PPF- pts treated with ABA was -12.1 (2.01) vs -9.5 (0.79); covariates included in the model were age, sex and BL CDAI ($p=0.24$). During follow-up, more PPF+ pts treated with ABA changed from high/medium to LDA or remission vs all other pts (34% vs 25%), while this was not seen in anti-TNF pts (45 vs 42%).

Conclusions: Pts with RA treated with abatacept had higher disease activity at BL and a greater reduction in disease activity was observed in seropositive pts with RA and erosions compared with all other abatacept pts. Similar trends were not observed in anti-TNF pts. No direct comparisons between treatments were conducted in these cohorts.

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FRI0233

THE RETENTION RATES OF ABATACEPT IN ELDERLY RA PATIENTS (65 YEARS AND ABOVE) WHO CANNOT BE TREATED WITH METHOTREXATE: COMPARISON WITH ETANERCEPT AND TOCILIZUMAB; A SINGLE-CENTER, RETROSPECTIVE, CASE-CONTROL STUDY

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Background: There are many elderly rheumatoid arthritis (RA) patients who cannot be treated with methotrexate (MTX) for many reasons, but data about the therapeutic strategies by biologic agents for the patients are insufficient.

Objectives: To analyze the retention rate of abatacept in elderly patients with RA who cannot be treated with MTX.

Methods: Data were retrospectively collected from the medical records of patients with rheumatoid arthritis at our center. Abatacept (ABT), etanercept (ETN), or tocilizumab (TCZ) was administered to 68 elderly RA patients who could not be treated with MTX. We analyzed the retention rate of each group by Kaplan-Meier curves and the log-rank test. The primary end point was the 24-month retention rate of the biologics without discontinuation due to adverse events, loss or primary lack of effectiveness.

Results: In the ABT group (26 cases: a mean age of 77.8 ± 6.3 years, ACPA positive 92.3%, oral steroid use 34.6%), the cumulative retention rates for both 12 and 24 months were 0.699. In the ETN group (26 cases: a mean age of 75.8 ± 5.1 years, ACPA positive 92.0%, oral steroid use 73.1%), the cumulative retention rates for 12 and 24 months were 0.450 and 0.315, respectively. In the TCZ group (16 cases: a mean age of 73.7 ± 5.6 years, ACPA positive 87.5%, oral steroid use 56.3%), the cumulative retention rates for 12 and 24 months were 0.433 and 0.325, respectively.

There was a significant difference in the retention rates between ABT groups and the other two groups [log-rank test, $p=0.018$ (ABT vs. ETN), 0.047 (ABT vs.

Kaplan-Meier drug survival estimates for abatacept (ABT), etanercept (ETN), Tocilizumab (TCZ) in elderly RA patients (≥ 65 years) who cannot be treated with methotrexate

(endpoint: discontinuation due to adverse events, loss or primary lack of effectiveness)

TCZ)]. There are no significant retention rates between ETN groups and TCZ groups.

Three cases (11.5%) in the ABT group were discontinued the biologic agents by hospitalization for severe infection within 24 months. Five cases (19.2%) in the ETN group, six cases (37.5%) in TCZ group were hospitalized for severe infection, respectively.

Conclusions: Our data suggested that abatacept can be used for a period longer than etanercept or tocilizumab for elderly RA patients who cannot be treated with methotrexate.

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FRI0234

CHOICE OF BIOLOGIC THERAPY FOLLOWING RITUXIMAB: INFLUENCING FACTORS IN A FRENCH MULTICENTER COHORT OF RHEUMATOID ARTHRITIS

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Background: In rheumatoid arthritis (RA), the long lasting effect of rituximab (RTX) on B lymphocyte depletion may influence the choice of biologic after RTX failure but there is currently no specific recommendation about the optimal strategy.

Objectives: We assessed factors which may have influenced the choice of biologic following failure to RTX in RA patients and analysed the effectiveness of these biologics.

Methods: A retrospective study of RA patients, who had started a new biologic during the year after RTX discontinuation, was conducted between 2009 and 2016 in 5 French rheumatology centers. We collected at baseline (at the time the biologic was introduced after RTX) and during follow-up (3, 6 and 12 months), data about patients and disease. Characteristics of the patients receiving tocilizumab (TCZ), abatacept (ABA) or anti-TNF following RTX, the EULAR response and retention rate were compared using univariate and multivariate analyses.

Results: 152 RA patients (117 women, mean age 56.9 ± 13 years) were analysed. RA duration was 14.3 years [IQR 7.8–19.8], mean DAS28 ESR at baseline 4.8 ± 1.3 . 57 patients (37.5%) received TCZ, 47 (31%) anti-TNF and 48 (31.2%) ABA following RTX. 87% had received anti-TNF prior to RTX. No significant difference in the biologics prescription profile was noted across centers. At baseline, sex, disease characteristics and activity, use of concomitant DMARDs or prednisone were not different between the 3 groups. There was no difference in the number of cycles or dose of RTX received and the number of previous anti-TNF treatment. Patients receiving ABA were slightly older (59.8 years vs 54 years for TCZ and 57.8 years for anti-TNF, $p=0.06$). Multimorbidity index (MMI) assessing the number of comorbidities was higher in the group ABA but not significantly (MMI count 2 ± 1.7 for ABA, 1.6 ± 1.5 for TCZ, 1.7 ± 1.4 for anti-TNF, $p=0.5$). At 3, 6 and 12 months, DAS28ESR was lower in patients with TCZ as compared to those with anti-TNF or ABA (Table) but tender and swollen joint counts did not differ. The EULAR good-or-moderate response rates were similar across groups (Table). After adjustment on age, sex, disease duration, MMI count,

Table 1. Change in DAS28-ESR score and EULAR response at 3, 6, 12 months according to the biologic following RTX treatment

	TCZ (n=57)	Anti TNF (n=47)	ABA (n=48)	p
DAS28 ESR (mean±SD)				
M3	2,7±1,2	3,5±1,7	3,7±1,3	0.002
M6	2,6±1,5	3,5±1,7	3,5±1,2	0.01
M12	2,5±1,2	3,1±1,7	3,3±1,3	0.04
EULAR Good-Moderate response n (%)				
M3	29 (76)	12 (63)	17 (52)	0.09
M6	22 (79)	8 (57)	19 (73)	0.34
M12	21 (75)	7 (70)	16 (73)	0.95

Figure 1: Retention rate of ABA, TCZ, antiTNF treatments after failure of RTX.