SAT0292

EVALUATION OF RADIOGRAPHIC PROGRESSION AFTER 4 YEARS OF ETANERCEPT (ETN) IN ANKYLOSING SPONDYLITIS (AS): RESULTS FROM THE OPEN-LABEL EXTENSION (OLE) OF THE PHASE 3 CLINICAL TRIAL

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Background: ETN was well tolerated and showed clinical efficacy (ASAS 20: ETN 59%, placebo 28%, $p < 0.0001$) through 24 wks in a phase 3 AS trial;¹ efficacy was sustained up to 2 years in pts who completed the study and continued ETN in an OLE.² No significant difference was found in change in modified Stoke AS Spine Score (mSASSS) from baseline (BL) to yr 2 of the OLE among ETN-treated pts vs a historic cohort not treated with tumour necrosis factor inhibitors (TNFi).³

Objectives: Report radiographic progression through 4 years in ETN-treated pts with AS.

Methods: In the double-blind, placebo-controlled phase 3 study, pts with active AS were randomised to ETN 25 mg BIW or placebo for 24 wks. Pts who completed the study could enrol in a 168-wk OLE and were treated with ETN 25 mg BIW (amended after 17 months to 50 mg QW). The primary radiographic endpoint was change in mSASSS from BL to yr 2 vs change in mSASSS from yr 2 to yr 4.

Results: 257 pts were treated in the OLE, of whom 126 (49.0%) completed the study and 131 (51.0%) withdrew prior to 168 wks (most common reasons [$>5\%$]: pt refusal [10.1%]; adverse event, infection, or injection-site reaction [8.2%]; lack of efficacy [7.8%]). ETN resulted in sustained improvement in signs and symptoms of active disease for up to 168 wks beyond the 24-wk double-blind study. Of 267 pts who received ≥ 1 dose of ETN in the phase 3 study or OLE, 124 were included in the 4 year primary radiographic endpoint analysis (8 received a prohibited TNFi and were excluded). BL characteristics were similar between these pts and all pts who received ≥ 1 dose of ETN in the phase 3 study. Mean change in mSASSS among completers was 1.96 from BL to yr 4 ($n=110$) while change in mean mSASSS between yr 2 and yr 4 was 0.66 ($n=109$). The nominal p -value for change in mSASSS from BL to yr 2 vs change from yr 2 to yr 4 was 0.0536. Radiographic data suggest disease progression continued in pts receiving ETN continuously over 4 years; however, mean mSASSS increased from BL to year 2 and not from yr 2 to yr 4 (figure 1) due to a few outlier patients with large mSASSS values at yr 2 but missing 4 year data.

Abstract SAT0292 – Table 1. Baseline Demographic and Disease Characteristics

Pts Who Received ≥ 1 Dose of ETN in the Phase 3 Study or Its Extension and Had Baseline, 2 year, and 4 year X-rays ($n=127$)	
Mean (SD) age, yrs	42.43 (9.63)
Male, n (%)	89 (70.1)
HLA-B27 positive, n (%)	100 (78.7)
Used NSAIDs, n (%)	115 (90.6)
Used DMARDs, n (%)	43 (33.9)
Used corticosteroids, n (%)	16 (12.6)
Mean (SD) mSASSS	16.7 (16.3)
Mean (SD) disease duration, yrs	10.61 (8.67)

Abstract SAT0292 – Figure 1. Mean mSASSS

Conclusions: This is the first report of 4 year radiographic ETN data in AS, and these data suggest that disease progression continued in pts who received ETN continuously throughout, but that disease progression may be slower after longer-term treatment with ETN vs shorter term. This adds to the already-existing data that demonstrate TNFi seem to reduce radiographic progression in pts with AS.

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- [2] Davis Ann Rheum Dis 2005.

- [3] van der Heijde Arthritis Rheum 2008.

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SAT0293

SAFETY AND EFFICACY OF TOFACITINIB, AN ORAL JANUS KINASE INHIBITOR, UP TO 36 MONTHS IN PATIENTS WITH ACTIVE PSORIATIC ARTHRITIS: DATA FROM THE THIRD INTERIM ANALYSIS OF OPAL BALANCE, AN OPEN-LABEL, LONG-TERM EXTENSION STUDY

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Background: Tofacitinib is an oral Janus kinase inhibitor for the treatment of psoriatic arthritis (PsA).

Objectives: To report the safety, tolerability and efficacy of tofacitinib in patients (pts) with active PsA from an ongoing, open-label, long-term extension (LTE) study (OPAL Balance, NCT01976364; November 2017 data-cut; database not locked).

Methods: Eligible pts from 2 Phase (P)3 tofacitinib PsA studies (OPAL Broaden, NCT01877668; OPAL Beyond, NCT01882439) entered a 3 year LTE ≤ 3 months after completing the P3 study or discontinuing for reasons unrelated to study drug. Pts received tofacitinib 5 mg BID to Month (M)1, after which dose adjustments between 5 and 10 mg BID were permitted to improve efficacy, or for safety reasons. Pts receiving a csDMARD at P3 study entry continued the same csDMARD in the LTE. Primary endpoints were incidence and severity of adverse events (AEs) and changes from baseline (Δ) in laboratory values. Safety data are reported up to M36. Efficacy was evaluated up to M30 (when $n > 50$) as a secondary endpoint.

Results: 686 pts were treated in OPAL Balance; 468 (68.2%) remained in the study at data cut-off. Mean (range) LTE tofacitinib exposure was 614 (1–1032) days. On Day 1, 675 pts (98.4%) received a csDMARD, which was discontinued in 86 pts (12.7%). To M36, 2189 AEs were reported in 546 pts (79.6%), 95 pts (13.8%) had serious AEs and 59 pts (8.6%) discontinued due to AEs. Serious infections occurred in 12 pts (1.7%), herpes zoster (HZ) in 20 pts (2.9%; 1 serious event), major adverse cardiovascular events in 5 pts (0.7%), malignancies in 24 pts (3.5%; including 12 pts with NMSC) and uveitis in 2 pts (0.3%). No AEs of gastrointestinal perforation or inflammatory bowel disease were reported. There were 5 deaths (not attributed to treatment, as assessed by the investigator) due to metastatic pancreatic carcinoma, acute cardiac failure/hypertensive heart disease, chronic obstructive pulmonary disease, pulmonary embolism and cardiovascular insufficiency. Four AEs of latent tuberculosis were reported in pts whose previously negative QuantiFERON response became positive. ALT was elevated $\geq 3 \times$ ULN in 27 pts (4.0%), and AST $\geq 3 \times$ ULN in 15 pts (2.2%). Changes in laboratory values observed in P3 studies were generally stable in the LTE, except for a modest decrease in absolute lymphocyte count over time. Eight pts (1.2%) discontinued (protocol-mandated) due to laboratory value changes. ACR responses, Δ HAQ-DI, PASI75 response, Δ Leeds Enthesitis Index, Δ Dactylitis Severity Score and Δ Pain were maintained up to M30.

Conclusions: Over 36 months in the LTE, the safety profile of tofacitinib in active PsA pts was generally similar to that of the P3 studies. No new safety risks were identified. Efficacy across various PsA disease domains was maintained over time.

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SAT0294

ASSOCIATION OF ENTHESITIS WITH ACHIEVEMENT OF NORMAL QUALITY OF LIFE AND CLINICAL RESPONSE IN PATIENTS WITH NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS TREATED WITH ADALIMUMAB

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Background: Enthesitis, a key pathology in axial spondyloarthritis (axSpA), has been difficult to treat with conventional therapies and may take longer to resolve than other disease manifestations. It is unknown if failure to attain resolution of enthesitis affects achievement of normal quality of life (QoL) and clinical response.

Objectives: To assess if enthesitis at baseline (BL) and after 12 wks of adalimumab (ADA) treatment in the ABILITY-3 study associates with achieving normal QoL and clinical response in patients (pts) with non-radiographic axSpA (nr-axSpA).

Methods: ABILITY-3 enrolled adult pts with nr-axSpA with objective evidence of inflammation (MRI positive or elevated hsCRP), active disease at BL (ASDAS ≥ 2.1 , BASDAI ≥ 4 , and Patient's Assessment of Total Back Pain score ≥ 4), and an inadequate response to ≥ 2 NSAIDs. Pts received ADA 40 mg every other wk during a 28-wk open-label lead-in. Pearson's correlation coefficients were used to assess the relationship between total enthesitis count (sum of Maastricht Ankylosing Spondylitis Enthesitis Score [MASES] and plantar fascia enthesitis score) and QoL and disease activity at BL. Multivariable stepwise logistic regression was used to evaluate the relationship between total enthesitis count or enthesitis location and normal QoL (EQ-5D ≥ 0.898 or SF36 MCS/PCS ≥ 50) and clinical response (ASDAS-ID [ASDAS < 1.3], ASAS40, or BASDAI50) at wk 12.

Results: At BL, 74% (501/673) of pts had enthesitis, and mean (95% CI) total enthesitis count was 3.7 (3.42, 3.98). Enthesitis resolved in 39% (196/501) of pts, and total enthesitis count was 1.9 (1.68, 2.12) at wk 12 of ADA treatment. At BL, total enthesitis count significantly correlated with all QoL and disease activity measures (Table). Each 1-unit increase in BL total enthesitis count was associated with 7% lower odds of ASDAS-ID (OR [95% CI]: 0.93 [0.88, 0.99], $p=0.018$) and 6% lower odds of BASDAI50 (0.94 [0.89, 0.99], $p=0.024$) at wk 12 and was not associated with normal QoL or ASAS40 at wk 12. Total enthesitis count at wk 12 was associated with lower odds of normal QoL and clinical response at wk 12 (Table). Achievement of normal QoL at wk 12 was less likely if pts had BL enthesitis at the posterior (EQ-5D ≥ 0.898) or anterior superior iliac spine (SF36 PCS ≥ 50), and pts with BL enthesitis at the 7th costochondral joint were less likely to achieve clinical response at wk 12 (Table).

Abstract SAT0294 – Table 1. Association of Total Enthesitis Count With QoL and Disease Activity at BL and Clinical Response at Wk 12

Baseline			
Measure	n	Pearson Correlation Coefficient	
EQ-5D	672	-0.23*	
SF-36 PCS	672	-0.18*	
SF-36 MCS	672	-0.15*	
BASDAI50	673	0.27*	
ASDAS	673	0.18 [†]	
Patient Global Assessment	673	0.14*	
Physician Global Assessment	671	0.17*	
Wk 12			
Measure	n	Odds Ratio (95% CI)	
EQ-5D ≥ 0.898	658	0.62 (0.48, 0.78)*	
SF-36 PCS ≥ 50	658	0.70 (0.61, 0.81)*	
SF-36 MCS ≥ 50	658	0.85 (0.80, 0.91)*	
ASDAS-ID	628	0.82 (0.75, 0.91)*	
ASAS40	632	0.82 (0.76, 0.88)*	
BASDAI50	632	0.74 (0.69, 0.81)*	
Enthesitis Location at baseline			
Measure at wk 12	n	Location	Odds Ratio (95% CI)
EQ-5D ≥ 0.898	660	Posterior superior iliac spine L/R	0.58 (0.34, 0.99) [‡]
SF-36 PCS ≥ 50	660	Anterior superior iliac spine L/R	0.60 (0.37, 0.96) [‡]
SF-36 MCS ≥ 50	663	—	—
ASDAS-ID	630	7th costochondral joint L/R	0.57 (0.36, 0.91) [‡]
ASAS40	637	7th costochondral joint L/R	0.62 (0.42, 0.91) [‡]
BASDAI50	634	7th costochondral joint L/R	0.60 (0.40, 0.91) [‡]

Locations evaluated included 1st costochondral joint L/R, 7th costochondral joint L/R, anterior superior iliac spine L/R, posterior superior iliac spine L/R, iliac crest L/R, 5th lumbar spinous process, proximal insertion of Achilles tendon L/R, and plantar fascia L/R. ASAS40, Assessment of SpondyloArthritis international Society 40% improvement; ASDAS-ID, Assessment of SpondyloArthritis international Society inactive disease; BASDAI, Bath Ankylosing Spondylitis Disease Activity Index; EQ-5D, EuroQol 5 dimension; MCS, mental component summary; PCS, physical component summary; QoL, quality of life; SF-36, short form health survey.

* $P<0.001$; † $P<0.01$; ‡ $P<0.05$.

Conclusions: 39% of pts achieved complete resolution of enthesitis after 12 wks of ADA treatment. Total enthesitis count at BL was not associated with normal QoL and inversely associated with clinical response at wk 12. Total enthesitis count at wk 12 was negatively associated with normal QoL and clinical response. Our exploratory analysis suggested possible inverse associations of specific BL enthesitis sites with achievement of normal QoL and clinical response; however, additional research is needed to further define these relationships.

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SAT0295

TOOL FOR THE PRESCRIPTION OF EXERCISE IN SPONDYLOARTHRITIS WITH MULTIMEDIA ANIMATIONS (EJES-3D): PILOT STUDY

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Background: Exercise is a basic pillar in the management of axial spondyloarthritis (SpA-axe), together with pharmacological treatment^{1,2}. Since it has been shown to improve pain, inflammation, mobility, physical and respiratory function. The information provided to the patient on paper on exercises has limitations of understanding. To this must be added the barriers to exercise that patients perceive, such as the lack of adaptation of the exercises according to the SpA phases