conventional DMARD-experienced ABA- and TOF-treated pts. Treatment-related death was not analysed in an NMA due to insufficient data.

Results: Thirty-one randomised controlled trials ($n=13,978$) were included for data extraction. Of these, ABA and TOF were examined in 16 and 15 trials, respectively. There were no head-to-head comparisons of ABA vs TOF. Most of the trial population were Caucasian (48%–98% across trials), had an average age ranging from 40 to 60 years and were predominantly female (60%–90%). Of the trials, 26 included a US population and 5 a non-US population. Out of 11 studies reporting treatment-related mortality, one study reported four deaths for pts on TOF 5 mg ($n=321$) within a 1 year follow-up. No such deaths were reported for ABA pts. The NMAs showed no significant differences in the risk of TrAEs for pts on TOF 5 or 10 mg compared with ABA with/without MTX (TOF 5 mg +MTX vs ABA+MTX: risk ratio [RR] 1.1, 95% CI: 0.77, 1.5; TOF 10 mg vs ABA: RR 1.1, 95% CI: 0.78, 1.6). These findings remained consistent for the risk of total AEs and serious infections.

Abstract AB0427 – Figure 1. PRISMA Diagram Showing Study Selection

*One reference identified manually from a ClinicalTrials.gov record

[†]Wrong publication date cut-off: meeting abstract published before 2015

Conclusions: Without head-to-head trials, the data available to make comparisons between abatacept and TOF are limited. Even after conducting an SLR and NMAs, precision is lacking in estimating differences. Additional studies, such as real-world observational analyses with larger patient samples and higher incidence of measured outcomes, are needed to further examine the safety differences of abatacept vs TOF.

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AB0428 PREFERENCES IN THE USE OF BIOLOGIC DRUGS AND ADVERSE EVENTS IN PATIENTS WITH RHEUMATIC DISEASE FROM A NATIONAL BIOLOGICS REGISTRY IN MÉXICO

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Background: National registries of biologic drugs have proven to be valuable tools in following patients with rheumatic disease and some outcomes in real-life situations.

Objectives: The objective of this study was to describe Mexican Rheumatologists' preferences when treating patients with biologic drugs and to analyse factors associated to the use of this therapy.

Methods: Data from patients undergoing biologic treatment in México is gathered into the BIOBADAMEX online database, which is part of the BIOBADAMERICA

initiative and based on the BIOBADASER Phase 3 platform. Phase 3 in México started gathering patient data in April 2016 and to date has information on 216 patients. The database collects information such as gender, age, diagnosis, disease duration, biologic treatment, DMARD treatment, concomitant therapy, motives for discontinuation of biologics, comorbidities, adverse event (AE) severity, infection site and germ involved. Descriptive statistics were applied on the data collected from April 2016 to January 2018.

Results: We analysed data on the use of 267 biologic treatments in 216 patients. Most of them receive biologic therapy through socialised medical insurance programs which may have led to bias. 89.1% of patients were female, mean age 49 ± 15.2 (4–85) years, 42.5% belonging to the <50 group. 69.9% of patients in the registry have RA, 12.5% AS and 5.5% PsA. Mean disease duration is 11 ± 8.9 (0–58) years. The most commonly used biologic overall is Abatacept (15.3%), followed by Adalimumab (13.8%), Tocilizumab (11.2%), Certolizumab (10.1%), Golimumab (8.6%), Rituximab (8.2%), Etanercept biosimilar (7.4%), Etanercept (6.3%), Infliximab (4.1%) and Benlystia (1.1%). All others, including JAK inhibitors, are used in <1% of patients. The preference for first biologic drug was Etanercept (32.4%), followed by Adalimumab (12%), Infliximab (8.3%), Rituximab and Tocilizumab (5.5% each) and Abatacept (2.7%). Most treatments were stopped due to lack of efficacy (60.4%), disease remission (7.4%), other causes (20.1%), AE (4.4%), with the rest of the causes each affecting <5% of patients. The most commonly used DMARD were Methotrexate (49.8%), steroids (33.3%) and leflunomide (23.2%). Comorbidities were present in 87 patients (40%), the most common being Hypertension (13.4%), Diabetes (7.8%) and Dyslipidemia (6.9%). Non-lymphoma neoplasms were reported in 1.3%. 25% of AE were considered serious but most (70%) were mild. Only 6 patients reported infections with the most common sites being the skin (33.3%), urinary tract (16.6%) and middle-ear (16.6%). The causal germ was often undetermined (60%).

Conclusions: When using biologic drugs, TNF inhibitors are the most commonly used initial mechanism of action for the treatment of rheumatic diseases in the BIOBADAMEX registry. Upon treatment failure, patients undergo a switch to another mechanism of action, mainly using Abatacept. Adverse events and infections related to the use of biologics are infrequent, but 40% of patients present chronic comorbidities.

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AB0429 NO DIFFERENCE IN EFFECTIVENESS WITH EITHER ETANERCEPT ORIGINATOR OR BIOSIMILAR AS FIRST LINE BIOLOGIC TREATMENT FOR RHEUMATOID ARTHRITIS

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Background: Biosimilars and their reference agents have been shown to be equivalent in clinical trials. In the United Kingdom, etanercept biosimilars (ETA-B) are, since 2016, a first-line treatment option for the management of severe rheumatoid arthritis (RA) defined as no response to 2 or more csDMARDs. However, real world data, including how it compares to the etanercept originator (ETA-O) are lacking.

Objectives: This study aims to compare the short-term effectiveness of etanercept originator with its biosimilar in patients with RA when used as a first biologic following csDMARDs.

Methods: This study included patients with RA registered with the British Society for Rheumatology Biologics Registers for RA (BSRBR-RA) at the point of starting either ETA-O or an ETA-B since 2011 as their first biologic. Baseline information is collected at drug start and includes demographic and clinical data. Follow-up (FU) data are captured every 6 months and include details on therapy changes, current disease activity, and development of any adverse events. The primary outcome of this study is effectiveness as calculated by change in the 28 joint count disease activity score (DAS28). Only patients with a complete DAS28 at baseline and their 1st FU were included in the final analysis of this study. Hazard ratios (HR) comparing drug survival and risk of first serious adverse event (SAE) between ETA-O and ETA-B patients were calculated using Cox regression.

Results: Between January 2010 and 11 December 2017, 1217 and 412 patients starting ETA-O or ETA-B respectively were recruited and had ≥ 1 FU available. Complete DAS28 data at baseline and 1st FU were available for 740 ETA-O patients and 177 ETA-B patients. Patient characteristics were similar between the 2 cohorts (Table). After adjusting for baseline differences, no difference between groups was seen in DAS28 ($p=0.1$) or remission status ($p=0.1$) at 1st FU.