No-Switch pts respectively. The improvement of initial DAS28-ESR category or maintenance in remission/LDA was comparable in both groups at M6 and M12 (table 1).

Abstract AB0444 – Table 1. DAS28-ESR improvement or maintenance in remission/LDA category

% of pts*, 95% CI	Switch, n=94	No Switch, n=220
M6, n/N	66/90	137/195
	73.3% [63.0–82.1]	70.3% [63.3–76.6]
M12, n/N	63/91	118/204
	69.2% [58.7–78.5]	57.8% [50.8–64.7]

* Permanent discontinuation of TCZ considered as failure.

Using the IPTW for balancing on baseline characteristics between groups, similar proportions were observed at both M6 and M12. TCZ retention rates at M12 were 78% (95% CI[68–85] and 80% (95% CI: 74–85 p=0.555 for Switch and No-Switch groups respectively. In the 208 pts with a DAS28 ≤3.2 at inclusion, multivariate analysis showed no parameters associated to the switch. Conversely in the 106 pts with a DAS28 >3.2 at inclusion, rheumatoid nodules (OR=4.78, 95% CI [1.23–18.55], p=0.024) and duration of IV TCZ before inclusion (OR=1.37, 95% CI [1.08–1.73], p=0.009) were significantly associated to the switch.

Conclusions: The RoSwitch study showed the maintenance of efficacy at 6 and 12 months in RA pts switching from IV to SC TCZ. Similar efficacy and therapeutic retention rates were observed for No-Switch pts. No factor was associated with the switch in pts in remission/LDA at inclusion suggesting that patient's personal appreciation was preponderant in the choice of the switch.

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AB0445 THERAPEUTIC MAINTENANCE OF ABATACEPT IN RHEUMATOID ARTHRITIS: RESULTS OF THE RIC-ABA STUDY (517 PATIENTS)

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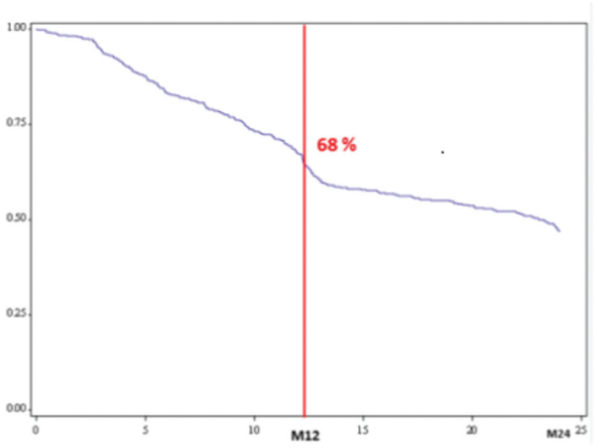
Objectives: Study the therapeutic maintenance, associated factor with maintenance at 12 months and reasons for abatacept (ABA) stop in daily practice.

Methods: Retrospective multicentric study, from the RIC Nord de France network, of patients treated for rheumatoid arthritis who received at least one ABA treatment between January 2008 and July 2016. We studied the therapeutic maintenance at 12 months, according to the number of previous bDMARDs and according to the date of initiation (group 1: from 2008 until 31/07/2010 (ABA authorised in anti-TNFfailure) and group 2 from 01/08/2010 (ABA authorised in the first line)). Therapeutic maintenance was evaluated using the Kaplan-Meier method.

Results: Of the 517 patients (74% women) who were included, the mean age was 61.4±13.3 years. There were 76% positive anti-CCP. ABA was used as monotherapy in 176 patients (34%) and 22% of patients were naïve to bDMARDs. The mean DAS 28-VS at initiation of ABA was 4.7±1.3.

Therapeutic maintenance at 12 months was 68%. Among the 166 patients (32%) stopped ABA, the reason for discontinuation was primary ineffectiveness (n=54, 32.5%), loss of efficacy (n=40, 24%), adverse events (n=43, 26%) and other (n=29, 17.5%). On multivariate analysis CRP <10 mg/L was associated with better maintenance at 12 months.

No significant difference in therapeutic maintenance was found at 12 months according to the date of initiation and according to the number of previous bDMARDs.



Abstract AB0445 – Figure 1. Therapeutic maintenance of Abatacept at 12 months

Conclusions: Therapeutic maintenance at 12 months was 68%, this rate is similar to Pan-European Registry. The rate of CRP at initiation seems to have an impact on the maintenance of ABA at 12 months.

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AB0446 PHYSICIAN-REPORTED BEHAVIOURS AND TREATMENT TRENDS OF TUMOUR NECROSIS FACTOR INHIBITOR USE: CYCLING VERSUS SWITCHING IN FIVE EUROPEAN COUNTRIES: FRANCE, GERMANY, ITALY, SPAIN AND THE UK

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Background: Previously, most biologics prescribed for treating rheumatoid arthritis (RA) were tumour necrosis factor inhibitors (TNFi) and it was common practice to prescribe a second TNFi after failure of the first. Biologics with different mechanisms of action (MOA) have become available and 2016 European League Against Rheumatism guidelines recommend cycling to another TNFi or switching to a biologic with a new MOA following failure of the first TNFi.

Objectives: Describe the proportion of patients in 5 EU countries who, after failure of a first TNFi, cycle to a second TNFi ('TNFi cycling') vs switch to a treatment with a different MOA ('Switch'), and identify patient characteristics and physician attitudes associated with TNFi cycling vs switching.

Methods: Data were from the Adelphi Disease Specific Programme (DSP), a cross-sectional survey conducted in 2017 in France, Germany, Italy, Spain and the UK. Rheumatologists prospectively completed records about the next 10 patients with RA who consulted them during the study period; records captured treatment history and clinical details. Patients were included in the analysis if they had been prescribed at least 2 different biologics, their first was a TNFi and their second was known. Patients were assigned to 2 cohorts: 'TNFi cycling' patients received a TNFi at first- and a different TNFi at second-line; 'Switch' patients received a TNFi at first-line and a non-TNFi at second-line. Bi-variate comparisons of groups were conducted using nonparametric tests as appropriate.

Results: All physicians in the DSP sample (n=301) were questioned on their beliefs around TNFis; 86.4% believed that there is a class effect with TNFis regarding efficacy and/or safety (table 1). Data from 359 patients were included in the analysis (75.8% female; mean [SD] age 56.5 [12.7]), of whom 167 (46.5%) were TNFi cycling, and 192 (53.5%) were Switch patients (female: 70.7% vs 80.2%, respectively; p=0.04; age: 55.8 [13.1] vs 57.1 [12.4], respectively; p=0.42). The most common reasons for discontinuing first-line therapy among the TNFi cycling and Switch cohorts were worsening condition (36.3% vs 45.3%,