AB0464 'REAL LIFE' BIOLOGICAL DRUG TAPERING RESULTS IN FEW FLARES OF DISEASE AND SIGNIFICANT COST SAVINGS

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Background: The treatment of rheumatic diseases has been revolutionised in the biologic era. Remission and low disease activity are realistic targets. Several trials have suggested that dose reduction is achievable without loss of clinical effect. However, 'real life' response data is still lacking.

Objectives:

- To increase interval dose of biologic drugs in a standard rheumatology clinic setting
- To assess the clinical response and determine potential cost savings

Methods: Patients were identified by database interrogation and hospital prescription record, from a regional population of 4 00 000 over a 2 year period. All rheumatic conditions treated with anti-TNF and IL-6 blockers were potentially accepted for tapering. Those with low disease activity scores (RA and PsA DAS <2.1, AS BASDAI <4.1) for >1 year were screened and invited to consider dose reduction following discussion in a clinic.

Results: 154 biologic patients were screened and 97 contacted to consider dose tapering. Of these, 40 patients agreed to participate in biologic dose reduction. Demographics: Mean age 51 years, 18 male patients and 22 females, concomitant MTX use in 49%. Diagnosis: RA-24, PsA -9, AS- 7. Drugs tapered included Adalimumab (28), Etanercept (5), Golimumab (5) and Tocilizumab (2). 8 patients flared during the programme and response was recaptured in 2 patients after increasing dose. 32 patients were successfully maintained on reduced dose with no requirement to date to increase dosing frequency. Biologic drug was completely withdrawn in 1 patient and 2 patients were commenced on reduced dose of DMARD. Prior to dose reduction mean DAS was 1.91 and mean BASDAI was 2.45. Low disease activity scores were recorded (mean DAS 2.1, mean BASDAI 2.6) post dose reduction (although incomplete data capture). Estimated cost savings are between 170,000 EUR and 340000 EUR for the 2 years.

Conclusions: Successful tapering of biologic drugs can be achieved and sustained in non-trial settings for patients with low disease activity. Significant cost savings have been confirmed with likelihood of recurrent savings over future years.

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AB0465 SAFETY AND DURATION OF BIOLOGIC TREATMENT IN ELDERLY PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Several differences may be expected between young and elderly patients with rheumatoid arthritis (RA), safety and efficacy results are variable in the different previous studies.^{1,2}

Objectives: To compare the duration and safety of biological treatment in patients with RA depending on the age of onset of therapy, in a Spanish tertiary centre.

Methods: We conducted a retrospective observational study of patients with a diagnosis of RA who were receiving biologic treatment. They were diagnosed between February 1980 and February 2017, on the basis of criteria ACR/EULAR 2010 or 1987 ACR criteria. The information was obtained from review of medical records. We divided the patients in two groups according to age of the onset of treatment: elderly group (≥ 65 years) and young group (< 65 years).

Results: 140 patients were included. At the beginning of the treatment 89 were under 65 years and 51 older (65–74 years: 28 patients, > 75 years: 23). The average duration of the disease from diagnosis until the beginning of the biological treatment was 103 ± 91 months in young patients and $142,86 \pm 109,5$ months in elderly patients ($p: 0,023$). We detected no differences between both groups at baseline characteristics, except for comorbidities and sex. DAS28PCR prior to biologic therapy was 5.20 ± 1.44 in young patients and 5.14 ± 0.813 in elderly ($p: 0,37$).

Duration of the treatment was similar in both groups. Suspension of biologic treatment occurred in 50 young patients (56%) and 30 elderly patients (58%) (table 1). The causes are detailed in table 2. Adverse effects were more frequent in the elderly but without statistical significance. There were 9 cases of cancer in elderly patients (17.3%) and 4 cases in young patients (4.6%) $p: 0.013$. The average diagnosis of cancer prior to the introduction of biologic treatment was 5.8 ± 7.1 years.

Abstract AB0465 – Table 1

	Young patients (< 65 years) n=89	Elderly patients (≥ 65 years) n=51	p
Age diagnostic AR (years)	42,87 (± 11.34)	62 (± 10.65)	0.42
Age biological treatment (years)	51,39 (± 10.32)	73.8 (± 5.30)	$< 0.001^*$
Sex: female	74 (83.1%)	35 (68,65%)	0.04 *
Comorbidities	0	4 (8.3%)	0.006*
Heart failure	2 (2.2%)	5 (9.8%)	0.048*
Renal failure			
Type biological	16 (18%)	11 (21%)	0,013*
Infliximab	31 (34.8%)	10 (19.6%)	
Adalimumab	27 (30.3%)	10 (19.6%)	
Etanercept	3 (3.4%)	2 (3.9%)	
Certolizumab	4 (4.5%)	2 (3.9%)	
Abatacept	7 (7.9%)	8 (15.7%)	
Tocilizumab	0	6 (11.8%)	
Rituximab			
Duration treatment(months)	39.98 ($\pm 41,04$)	46,31 (± 33.28)	0.095
Adverse events	13 (14.6%)	12 (21.56%)	0.7
Serious/recurrentinfection	6 (46%)	6 (54%)	
Active tumour	0	1 (9.1%)	
Cytopenias	1 (7.1%)	1 (9.1%)	
Skin lesions	3 (23%)	0	
Gastrointestinal symptoms	2 (15%)	1 (9.1%)	

Abstract AB0465 – Table 2

	Young patients	Elderly patients	p
Lack of efficacy (< 6 months)	10 (20%)	0	0.015*
Lack of efficacy (> 6 months)	22 (44%)	10 (33%)	0.55
Adverse event	8 (16%)	8 (26.6%)	0.16
Remission	4 (8%)	4 (13.3%)	0.350

Conclusions: Our study corroborate that biologic treatment has similar duration and safety in elderly and young patient.^{1,2}

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AB0466 SAFETY OF RITUXIMAB IN PATIENTS WITH RHEUMATOID ARTHRITIS. ELEVEN-YEAR FOLLOW-UP OBSERVATIONAL STUDY

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Background: Rituximab (RTX) is a chimeric monoclonal antibody approved for the treatment of active rheumatoid arthritis (RA) in patients who failed to respond to tumour necrosis factor inhibitors (TNFi). Due to its effect on induction of B cell depletion, the administration of multiple cycles can lead to a decrease in immunoglobulins (Ig) which may increase the risk of infection.

Objectives: To assess the long-term safety of RTX in patients with RA and to evaluate factors associated with the presence of infections.