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AB0829

PERSISTENCE ON GOLIMUMAB AS SECOND LINE BIOLOGICAL THERAPY IN PATIENTS WITH SPONDYLOARTHRITIS (AXIAL SPONDYLOARTHRITIS AND PSORIATIC ARTHRITIS). GO-BEYOND, A RETROSPECTIVE STUDY

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Objectives: In this retrospective study we assess the 1 to 3 year probability of persistence on golimumab in patients with spondyloarthritis (SpA), axial SpA or psoriatic arthritis (PsA) who started treatment with golimumab as second biological (after withdrawal of a first anti TNF-alpha drug)

Methods: GO-BEYOND was a retrospective study undergone in 20 Spanish rheumatology clinics. Information was collected on all axial SpA and PsA patients who initiated golimumab between January 2013 and December 2015 as second anti TNF-alpha (i.e. after discontinuation of a first anti TNF-alpha drug). Centres in which all the patients could not be included were excluded from the analysis. The probability of persistence was calculated with a Kaplan-Meier test and comparisons were done with the log-rank test.

Results: 210 patients were included (131 with axial SpA and 79 with PsA, mean age 49 years [SD=12], 40% women, median duration of disease at the initiation of golimumab 80.5 months). Reasons for discontinuation of the first anti TNF-alpha were loss of efficacy (71.4%), poor tolerability or adverse event (11.0%) and patient or physician preference (17.6%). During a median follow-up of 29.3 months, 72 of 210 patients (34.3%) discontinued golimumab, due to primary failure (n=21), disease reactivation or secondary failure (n=29), poor tolerability (n=4), adverse events (n=10), inactive disease or patient-physician agreement (n=8). The probability of persistence on golimumab since treatment initiation was 80% at year 1 (95% CI 75–86), 70% at year 2^{64–77} and 65% at year 3 [59–72]. The figures were similar in patients with axial SpA or PsA, and in patients who discontinued the first anti TNF-alpha due to loss of efficacy or to other reasons (p=0.121 and p=0.835, table 1).

Abstract AB0829 – Table 1

		Baseline disease			Reason for discontinuation of the first anti TNF-alpha			
		Axial SpA patients		PsA patients	Loss of efficacy		Other	
	N	Probability of persistence	N	Probability of persistence	N	Probability of persistence	N	Probability of persistence
Baseline	210		131		79		150	
Year 1	166	80%	102	80%	65	81%	119	81%
Year 2	132	70%	83	72%	49	67%	94	69%
Year 3	82	65%	52	69%	30	59%	60	64%
Year 4	43	65%	30	69%	13	59%	30	64%

n=number at risk, SpA=Spondyloarthritis; PsA=Psoriatic arthritis

Conclusions: After discontinuation of a first anti TNF-alpha, patients with spondyloarthritis showed a high probability of persistence on golimumab. The probability of persistence was similarly high in patients with axial SpA or PsA, and in

patients who discontinued the first anti TNF-alpha due to loss of efficacy vs other reasons. Real life effectiveness of golimumab as second anti TNF-alpha is high and durable in SpA patients.

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AB0830

MRI EVALUATION OF THE EFFECT OF ANKYLOSING SPONDYLITIS TREATMENT ON HIP JOINTINVOLVEMENT

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Background: Coxitis is one of the leading causes of early disability in ankylosing spondylitis (AS) patients. There's no mild course of the disease as soon as hip joints (HJ) are involved, but epidemiological surveys in Russia show that only 7% of AS associated hip damage require total hip replacement.

Objectives: To evaluate case follow-up data in treated AS patients with hip involvement using hip MRI and radiography for dynamic assessment.

Methods: 30 AS patients (mean age of 27.7±17 y.) meeting modified 1984 N-Y criteria with MRI signs of HJ inflammation were followed up for 2 years. Patients' mean age at the onset of the disease was 22.3±18.3 years, 77% of the population were HLA-B27 positive. Median AS duration was 47 (12–144) months, and median BASDAI score was 5.9±3.1. The median duration of clinically manifest coxitis by the time of the study was 45 months. [25%; 75%], and pain intensity by numeric ranking scale (NRS) was 6 (2; 8). HJ MRI using T1 and STIR modes was performed in all participants in addition to clinical and radiological examinations. All patients were grouped into three arms based on therapeutic regimens: Group I was administered non-steroidal anti-inflammatory drugs (NSAIDs), Group II – genetically engineered biological agents (GEBA) +NSAIDs, and Group III was treated with a combination of NSAIDs+DMARD (methotrexate or sulfasalazine). In case of baseline regimen failure patients from Group III were switched to NSAIDs+DMARD+ GEBA combination at Mo 6 after initiation of treatment.

Results:

Abstract AB0830 – Table 1

Parameters	Group (I) n=5		Group (II) n=17		Group (III) n=8	
	Baseline	2 years FUP	Baseline	2 years FUP	Baseline	2 years FUP
AS duration, mo, Me [25%; 75%]	27 [12;32]	51 [36;56]	32 [18;40]	56 [42;64]	38 [18;42]	62 [42;66]
BASDAI, Me [25%; 75%]	2,5 [2;0;3,7]	2,4 [1,8;3,5]	5,6 [4,1;8,2]	1,8 [0,4;2,6]	4,1 [3,6;5,2]	3,2 [2,4;4,6]
BASFI, Me [25%;75%]	1,7 [0,8;3,2]	2,8 [1,8;4,2]	3,2 [2,6;4,7]	2,8 [1,8;3,6]	3,6 [2,2;5,0]	3,2 [1,9;4,8]
HLA-B27, n (%)	95%	95%	93%	93%	75%	75%
ASDAS (CRP) Me [25%; 75%]	2,0 [1,8;3,0]	2,3 [1,9;3,4]	4,3 [3,8;5,6]	2,6 [1,3;3,7]	3,9 [2,6;4,2]	2,3 [1,8;3,6]
ESR, mm/h, Me [25%; 75%]	10 [3;15]	12 [5;15]	30 [15;60]	10 [0,8;4,5]	18 [12;28]	12 [6;18]
CRP, mg/mL, Me [25%; 75%]	7,0 [4,3;10,7]	6,8 [4,2;11,0]	36 [15;47]	10,8 [0,8;34]	15,8 [8,4;28,9]	6,9 [4,7;17,8]
NRS, Me [25%; 75%]	4 [2;6]	4 [2;6]	6 [4;8]	5 [2;6]	4 [2;7]	2 [0;4]
MRI Synovitis n (%)	5 (100%)	5 (100%)	17 (100%)	4 (24%)	8 (100%)	1 (12,5%)
Osteitis n(%)	0	0	6 (35%)	2 (12%)	2 (25%)	0 (0%)
BASRI (0-I) n(%)	4 (80%)	1 (20%)	12 (70%)	9 (53%)	7 (88%)	7 (88%)
BASRI (II-IV)	1 (20%)	4 (80%)	5 (30%)	8 (47%)	1 (12%)	1 (12%)

Conclusions: 1. Long-standing MRI symptoms of HJ synovitis should be viewed as the factor predisposing to radiographic progression of coxitis in AS patients.

2. NSAIDs therapy does not modify the radiographic progression of coxitis.

3. GEBA+NSAIDs in combination with DMARDs reduce the risk of further radiographic progression.

4. Future studies are warranted to better understand potential factors contributing to radiographic progression of coxitis.

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