AB0907  TREATMENT PATTERNS IN PSORIATIC ARTHRITIS IN US AND EUROPE: RESULTS FROM A REAL-WORLD INTERNATIONAL SURVEY

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Background: With the availability of a greater range of Psoriatic Arthritis (PsA) treatment options, it is increasingly necessary to understand their use and impact on disease control in real-world practice.

Objectives: To assess treatment patterns and their clinical outcomes among PsA patients currently receiving conventional/targeted synthetic disease-modifying anti-rheumatic drugs (cs/tsDMARD) or biologic DMARD (bDMARD).

Methods: A point in time survey was conducted in 2015 across the US, France, Germany, Italy, Spain and UK. Patients had physician-confirmed PsA and had to have been receiving their current cs/bDMARD (bio naive) or bDMARD (1st or 2nd line) for ≥6 months. Physicians provided information on demographics, treatment history, disease severity, clinical measures included body surface area (BSA), joint count, flare/remission status. Student t-tests, Pearson chi-squared and Fisher exact tests were used to compare physician-reported patient profile variables, clinical status and treatment outcomes.

Results: 519 physicians (331 rheums, 188 derms) provided data for 2467 PsA patients, 1463 of whom met the inclusion criteria (1136 EU, 327 US). No significant differences were observed between EU and US patients in demographics (male 52.6%, mean age 49.0 years), disease duration 6.3 years; disease severity 29.1% moderate to severe. In the EU, 32.3% patients were on cs/tsDMARDs, 55.4% 1st-line bDMARD, 12.3% 2nd-line bDMARD vs 21.7%, 58.4%, 19.9% respectively in the US. In time (months) from diagnosis to first cs/bDMARD was similar in the EU and US (EU mean 4.7 mo; US 8.1 mo, p=0.24), from 1st cs/bDMARD to 1st bDMARD (EU 37.4 mo; US 29.4 mo, p=0.15). Patients in the EU received more cs/tsDMARDs prior to bDMARD initiation than US patients (mean 1.4 v 0.8; p<0.001). US patients were more likely to have bDMARD without combination cs/tsDMARDs (US 65.1% vs EU 52.3%; p=0.004).

Patients receiving cs/tsDMARDs had a worse clinical profile than those on 1st-line bDMARD in all areas other than joint count. Patients on 2nd-line bDMARD had more symptoms, affected joints and more likely to flare vs 1st-line bDMARD. They had more affected joints but were less likely to flare vs cs/tsDMARD. These findings were directionally similar in the EU and US (table 1). BSA was higher for cs/tsDMARD patients than for any bDMARD patients.

Conclusions: Only 39%-60% of patients were considered by physicians as in remission, revealing a considerable unmet need in both the EU and US in patients treated with cs/tsDMARDs and bDMARDs. Further research is needed to identify patients on cs/tsDMARDs who may be a candidate for advanced therapy and to recognise patients who might fail on bDMARD who therefore may benefit from a different therapeutic alternative.


AB0908  ABILITY OF THE REDUCTIVE X-RAY SCORE FOR PSORIATIC ARTHRITIS (REXSPA) TO DETECT CHANGE IN AN OBSERVATIONAL COHORT OF PATIENTS WITH PSA

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Background: The measurement of radiographic joint damage is important in characterising disease severity, progression, and prognosis in psoriatic arthritis (PsA). Existing radiographic measures are time-consuming to perform, leading to limited data collection from existing longitudinal observational studies.

Objectives: We have previously proposed a Reductive X-Ray Score for Psoriatic Arthritis (ReXSPA) as more feasible method, and in this study set out to examine the sensitivity of ReXSPA in a new cohort of patients.

Methods: A retrospective sample of 28 patients who had hand and foot radiographs at 3 time points (5 years before [T0], at the time of [T1], and 5 years post [T2]) using the Standardised Response Mean (SRM) and Smallest Detectable Change (SDC).

Results: The patients’ mean age (SD) at T0 was 61 years (13.4), the mean disease duration was 11.2 years (11.14). Patients were followed up for a mean (SD) of 10.2 years (2.76). Overall inter- and intra-rater reliability for ReXSPA and VDH were 0.80 and >0.92 and 0.91 and >0.90 respectively. The median (IQR) of ReXSPA score was 8.5 (1–14), 12.5 (5–20) and 14.5 (8–36) at T0, T1, and T2 respectively. The percentage SDC was 0.91 for the ReXSPA method and 0.77 for the VDH method, and the SRMs were 0.92 and 0.87 respectively (table 1), demonstrating the sensitivity of both methods in detecting change. There was a trend towards slowing in radiographic progression following the initiation of TNF-inhibitors, but ReXSPA was less sensitive compared to the VDH and was not able to detect a significant change in the rate of progression post-TNF inhibition (p 0.08) (Graphical 1).

Conclusions: Only 39%-60% of patients were considered by physicians as in remission, revealing a considerable unmet need in both the EU and US in patients treated with cs/tsDMARDs and bDMARDs. Further research is needed to identify patients on cs/tsDMARDs who may be a candidate for advanced therapy and to recognise patients who might fail on bDMARD who therefore may benefit from a different therapeutic alternative.


Abstract AB0908 – Table 1. Sensitivity to change of each scoring method

<table>
<thead>
<tr>
<th>Method</th>
<th>Mean Change</th>
<th>SD of change</th>
<th>SEM</th>
<th>SRM</th>
<th>SDC</th>
<th>SDC as% of total score</th>
</tr>
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<tbody>
<tr>
<td>VDH</td>
<td>22.11</td>
<td>19.14</td>
<td>3.62</td>
<td>0.87</td>
<td>4.09</td>
<td>0.77</td>
</tr>
<tr>
<td>Erosion</td>
<td>7.29</td>
<td>10.62</td>
<td>2.01</td>
<td>1.46</td>
<td>2.27</td>
<td>0.71</td>
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<tr>
<td>JSN</td>
<td>16.96</td>
<td>15.17</td>
<td>2.87</td>
<td>0.89</td>
<td>3.24</td>
<td>1.56</td>
</tr>
<tr>
<td>ReXSPA</td>
<td>10.9</td>
<td>10.0</td>
<td>1.89</td>
<td>0.92</td>
<td>2.14</td>
<td>0.91</td>
</tr>
<tr>
<td>Erosion</td>
<td>3.21</td>
<td>5.31</td>
<td>1.00</td>
<td>1.65</td>
<td>1.13</td>
<td>1.03</td>
</tr>
<tr>
<td>JSN</td>
<td>6.36</td>
<td>5.11</td>
<td>0.97</td>
<td>0.80</td>
<td>1.09</td>
<td>1.24</td>
</tr>
<tr>
<td>Proliferation</td>
<td>0.96</td>
<td>2.32</td>
<td>0.44</td>
<td>2.40</td>
<td>0.50</td>
<td>1.39</td>
</tr>
</tbody>
</table>

Sharp-van der Heijde modified method (VDH), Standard deviation (SD), Standard error of mean (SEM), Standardised response mean (SRM), Smallest detectable change (SDC).
Conclusions: The RexSPA is a reliable and sensitive alternate scoring method for the detection of radiographic progression in an observational cohort of patients with PsA, but not as sensitive to change as the VDH method.

REFERENCE:

Disclosure of Interest: None declared

CERTOLIZUMAB PEGOL’S EFFECTIVENESS, RETENTION RATE AND SAFETY IN PSORIATIC ARTHRITIS. ROUTINE CLINICAL PRACTICE DATA


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Background: Certolizumab pegol (CZP) is the only antiTNF pegylated without Fc fragment in clinical trials is known, but there are few published data on the effectiveness of CZP in a real in PsA patients. CZP retention rate and biologics exposure (n° of previous biologics) was not affected by the number of previous biological treatments.

Methods: Multicentric cohort of PsA patients treated with CZP according routine clinical practice. Study approved by local Ethics Committee. Maximum time of observation was 12 months. Effectiveness variables: SJC, TJC, PtGA (Patient Global Assessment) and DAS28-CRP. Safety variables: discontinuation rate.

Results: 262 patients with PsA were included: 43.5% male, mean (SD) age 49.9 (11.9) years, mean (Q1-Q3) disease duration 6.9 (1.9–9.3) years, 14.9% of patients HLAB27 positive, mean (SD) IMC (kg/m2) 26.9 (4.7), never smokers 70.3%. Extra-articular manifestations ever: Psoriasis (90%; PASI 70.3%), enthesitis (44.4%), dactylitis (41.9%), nail disease (32%), inflammatory bowel diseases (4.9%). 37.3% of the PsA patients had bone erosions and 3% arthritis mutilans. 48.9 patients received 1 prior csDMARD and 52.1% at least 2 csDMARD. Prior bDMARD: 28.4% none; 38.1% 1, 33.5% 2. 29.6% of PsA patients received CZP in monotherapy. Mean time on treatment with CZP 10 months.

Abstract AB0909 – Figure 1. CZP retention rate and biologics exposure (n° of previous biologics)

Statistically significant differences in SJC, TJC and DAS28-CRP were observed at the last visit comparing with baseline (table 1). Percentage of patients with enthesitis at baseline (25.4%) decrease to 9.5% at the last visit; 73.2% of the patients had a resolution of the enthesitis (MASES=0). The percentage of patients with dactylitis at baseline (29.1%) decrease to 8.6% in the last visit; 82.5% of these patients had a resolution of the dactylitis. Statistically significant reduction of patients with nail disease was observed from 30.6% to 16.4%. According to Kaplan-Meier analysis, the drug survival of CZP was 78.2%, and no differences were observed in patients who received CZP as first/second biologic or after more than 1 failure to other biological agents (Figure 1).

262 patients were included in the safety analysis, 21.8% withdrawn treatment: 12.6% due to lack of effectiveness, 5.3% due to intolerance and 3.8% other reasons.

Abstract AB0909 – Table 1. Effectiveness

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Last visit</th>
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<tbody>
<tr>
<td>DAS28; mean (SD)</td>
<td>4.6 (0.9)</td>
<td>3.8 (1.0)*</td>
</tr>
<tr>
<td>TJC; mean (SD)</td>
<td>7.2 (5.1)</td>
<td>4.0 (4.0)*</td>
</tr>
<tr>
<td>SJC; mean (SD)</td>
<td>5.0 (3.7)</td>
<td>2.8 (2.8)*</td>
</tr>
<tr>
<td>PGA; mean (SD)</td>
<td>6.9 (1.7)</td>
<td>4.3 (2.0)</td>
</tr>
</tbody>
</table>

*p<0.001, Wilcoxon’s test

Conclusions: In this study of routine clinical practice CZP was effective in patients with PsA, with a significant decrease in DAS28-CRP and the percentage of patients with enthesitis and dactylitis. The retention rate of certolizumab pegol was not affected by the number of previous biologic treatments.

Follow-up time was 89.25 patients-year. Mean survival time was 40.3 months (95% CI: 32.0–48.5). Age, mean evolution time and previous biological use were significant in the univariate analysis. Concomitant sDMARD had no influence on golimumab retention rate (HR: 1.3; 95% CI: 0.5–3.2; p=0.6). Figure 1. When golimumab was used as first or second biologic treatment, it had a better retention rate than when it was used as third or fourth, but did not reach statistical significance (HR: 2.3; IC 95%: 0.8–5.0). Concomitant sDMARD (%) 24 (50%). SJC mean (SD) 4.1 (4.1) SJM mean (SD) 2.9 (2.7) CRP mg/dL mean (SD) 0.6 (0.7) Concomitant DMARD (%) 24 (50%) Biological Therapy naïve (%) 25 (52.1%)