was considered sufficient to record global data by 6 central readers in all cases. An additional reader assessed only images in DICOM format (n=175). Comparison of active and structural lesion frequencies typical of axSpA was assessed descriptively according to individual and majority of central readers data.

Results: Active lesions typical of axSpA were recorded in about 30% of cases in the cohort. Active or structural lesions typical of axSpA were recorded in about 40% of patients (table 1). Similar data was observed when active sacroiliitis was defined using the ASAS definition of a positive MRI. Structural lesions alone, without any active lesions typical of axSpA, were recorded in 6.6% of cases. Active lesions alone, without any structural lesions typical of axSpA, were recorded in 7.8% of cases. Both active and structural lesions typical of axSpA were recorded in 23.1% of cases. The frequencies of these categories were only slightly lower when majority reader data was analysed.

Abstract OP0249 – Table 1 Contribution of structural MRI lesions to detection of sacroiliitis in the ASAS-CC. (*Individual data from 6reader; *majority reader (≥4) data)

Variable	Mean% (Range)*	Number (%) of Cases#
Active lesions typical of axSpA	31.5 (24.5-38.5)	79 (28.4%)
Active lesions typical of axSpA but not structural lesions typical of axSpA	7.8 (4.6-11.8)	7 (2.9%)
Structural lesions typical of axSpA	31.4 (23.5-39.9)	68 (28.6%)
Structural lesions typical of axSpA but not active lesions typical of axSpA	6.6 (4.2-12.7)	7 (2.9%)
Active and structural lesions typical of axSpA	23.1 (16.0-29.0)	51 (21.4%)
Active or structural lesions typical of axSpA	39.2 (28.2-48.7)	99 (41.6%)
Active lesions typical of axSpA and meets ASAS definition for positive MRI	30.0 (22.6-37.4)	79 (28.4%)
ASAS positive MRI but not structural lesions typical of axSpA	7.2 (3.4-11.3)	7 (2.9%)
Structural lesions typical of axSpA but not ASAS positive MRI	8.8 (5.0-13.0)	7 (2.9%)
ASAS positive MRI and structural lesions typical of axSpA	22.6 (15.6-28.6)	51 (21.4%)
ASAS positive MRI or structural lesions typical of axSpA	38.4 (27.7-47.9)	99 (41.6%)

Conclusions: Structural lesions typical of axSpA may be observed without any active lesions typical of axSpA in 5%–10% of cases presenting with undiagnosed back pain in the ASAS-CC. This is the same proportion of the cohort for which active lesions typical of axSpA are seen without any structural lesions typical of axSpA. In view of the concomitant presence of both lesions, contextual interpretation seems optimal.

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.7249

FRIDAY, 15 JUNE 2018

Present and future treatments for SLE, Sjögren's and APS

OP0250 A RANDOMISED, DOUBLE-BLIND STUDY TO ASSESS THE SAFETY, TOLERABILITY AND PRELIMINARY EFFICACY OF LENIOLISIB (CDZ173) IN PATIENTS WITH PRIMARY SJÖGREN'S SYNDROME

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Background: Primary Sjögren's syndrome (pSS) is a systemic and progressive autoimmune disease characterised by lymphoid infiltration and progressive alteration of exocrine glands secretory function. Ectopic germinal center-like structures harbour plasma cells that generate autoantibodies leading to immune complex formation. Leniolisib (CDZ173) is an oral low molecular weight compound that selectively inhibits the lipid kinase PI3Kδ. In animals, leniolisib blocks PI3Kδ-dependent B cell functions, disrupts germinal centre formation and immune cell trafficking, supporting the rationale for a PI3Kδ–targeted therapy in pSS

Objectives: To evaluate the safety, tolerability, pharmacokinetics (PK) and preliminary clinical efficacy of multiple oral doses of leniolisib, after 12 weeks of treatment, in pSS patients

Methods: Double-blind, randomised, placebo-controlled, parallel-design study recruited 30 seropositive pSS patients with moderate to severe disease activity as determined by EULAR Sjögren's Syndrome Disease Activity Index (ESSDAI)≥6, EULAR Sjögren's Syndrome Patient Reported Index (ESSPRI)≥5 and stimulated whole salivary flow rate >0 mL/min. Patients were randomised in a 2:1 ratio to receive leniolisib (70 mg b.i.d) or placebo. The primary outcome was change in ESSPRI at week 12. Secondary outcomes included PK, changes in ESSDAI, the Short Form-36 (SF-36), Multidimensional Fatigue Inventory (MFI) and global Visual Analogue Scales (VAS) completed by patients and physicians. Additional assessments included lacrimal gland function and biomarkers relevant to pathway and disease

Results: Overall safety and tolerability profile of leniolisib was acceptable, but appeared less favourable than placebo. In particular, rash occurred more frequently in the leniolisib group (11/20 patients) compared to placebo (1/10 patients). There was a slight improvement (not statistically significant) in ESSPRI scores (dryness, pain and fatigue) favouring leniolisib. Similar trends were observed in secondary endpoints (SF-36/mental and physical, MFI, VAS completed by patients and physicians). After 12 weeks of treatment, there was a slight improvement (not statistically significant) in the lacrimal gland function in the leniolisib group compared to placebo. The observed PK profile was as expected based on healthy volunteer data. Biomarker results suggest a strong and sustained target and pathway engagement, as evidenced by inhibition of phosphorylated Akt in *ex-vivo* stimulated B cells, significant decrease in serum CXCL13 and reduced frequency of circulating Follicular T helper-like cells. There was a trend of decreasing autoantibody levels in leniolisib-treated patients

Conclusions: Leniolisib had an acceptable safety and tolerability profile, but caused rashes a known class effect of PI3K inhibitors. Target and pathway engagement were confirmed, however no clear efficacy signal for leniolisib was seen based on ESSPRI and ESSDAI in this Proof-of-Concept study at the studied dose.

Disclosure of Interest: T. Dörner: None declared, M. Zeher: None declared, U. Laessing: None declared, F. Chaperon: None declared, S. De Buck: None declared, A. Hasselberg: None declared, M.-A. Valentin Shareholder of: Novartis stock option, Employee of: Novartis, S. Ma: None declared, M. Cabanski: None declared, C. Kalis: None declared, C. Burkhart: None declared, P. Gergely: None declared

DOI: 10.1136/annrheumdis-2018-eular.3111

OP0251 ATTAINMENT OF LOW DISEASE ACTIVITY AND REMISSION IN SYSTEMIC LUPUS ERYTHEMATOSUS PATIENTS WITH HIGH DISEASE ACTIVITY IN THE ATACICEPT PHASE IIB ADDRESS II STUDY AND ITS LONG-TERM EXTENSION

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Background: Low disease activity (LDA) and remission are consummate goals of SLE treatment.[1] Lupus Low Disease Activity State (LLDAS) is associated with reduced damage accrual,[2] and has been shown to be a feasible clinical trial endpoint.[3] In the Phase IIb ADDRESS II study,[4] atacicept improved SRI-6 response rates and flare prevention at Week (Wk) 24 vs placebo (PBO), in patients with High Disease Activity (HDA; SLEDAI-2K≥10) at Screening, with an acceptable safety profile.

Objectives: Post-hoc analysis of ADDRESS II and its long-term extension to describe 48-wk rates of LDA and remission in patients with HDA at Screening.

Methods: Pts were randomised 1:1:1 to weekly subcutaneous PBO or atacicept 75 or 150 mg for 24 wks in ADDRESS II. Completers entered the extension study at the same dose, except PBO patients who switched to atacicept 150 mg (PBO/atacicept 150 mg). This analysis includes: LDA (SLEDAI-2K≤2); LLDAS (SLEDAI–2K≤4 without major organ activity, no new disease activity vs previous visit, Physician's Global Assessment [PGA]≤1, prednisone-equivalent ≤7.5 mg/day, and stable immunosuppressants); and remission (clinical SLEDAI-2K=0, PGA <0.5, prednisone ≤5 mg/day) per definitions proposed by DORIS.[1]

Results: Of 306 ADDRESS II pts, 158 (52%) had HDA at entry; 42.4% achieved SRI-6, 23.4% LDA, 15.8% LLDAS and 10.8% remission at Wk 24. At Wk 48, 52.5% achieved SRI-6, 26.6% LDA, 19.0% LLDAS and 10.8% remission. Among the 83 HDA patients with an SRI-6 response at Wk 48, LDA, LLDAS, and remission represented increasingly stringent subsets (49.4% [n=41] attaining LDA, 34.9% [n=29] LLDAS, and 20.5% [n=17] remission). LDA, LLDAS and remission rates were higher in patients treated with atacicept 150 mg vs 75 mg and PBO/atacicept 150 mg (table 1; figure 1).