Abstract THU0208 – Table 1. Baseline characteristics

	Bionaïve	Bioexperience (after antiTNF failure)	P
Gender, female %	78.3	73.9	NS
Age, years, mean (Q1-Q3)	52.8 (18-82)	54.8 (19-82)	NS
Disease duration, years, mean (Q1-Q3)	5.8 (0-37)	8.0 (1-33)	<0.001
> 2 yr	58.2	89.0	<0.001
Never smoker %	68.4	69.2	NS
Seropositivity, %	73.9	73.6	NS
Erosions, %	47.6	61.9	0.023
Comorbidities (yes), %	32.7	40.9	NS
Corticosteroids (yes), %	72.8	63.6	NS
Prior Biologic Treatment %	-	Etanercept 46.6 Adalimumab 39.8 Infliximab 11.4 Golimumab 2.3	
CZP monotherapy, %	14.3	19.3	NS
>1 concomitant csDMARD, %	8.5	2.3	0.047
TJC, mean (SD)	9.3 (±6.2)	9.6 (±6.4)	NS
SJC, mean (SD)	6.7 (±4.7)	7.2 (±5.8)	NS
CRP, mg/L, mean (SD)	6.6 (±15.8)	9.2 (±14.7)	NS
ESR, mean (SD)	29.6 (±22.8)	30.1 (±24.5)	NS
HAQ, mean (SD)	1.2 (±0.7)	1.2 (±0.7)	NS
DAS28, mean (SD)	4.7 (±1.1)	4.7 (±1.1)	NS

Disclosure of Interest: None declared

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THU0209 4 YEARS FOLLOW-UP OF A COHORT OF PATIENTS WITH RHEUMATOID ARTHRITIS IN SUSTAINED CLINICAL REMISSION AND OPTIMISATION OF BIOLOGICAL THERAPY

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Background: The objectives of Rheumatoid Arthritis (RA) treatment comprise achieving persistent Clinical Remission (CR) or sustained low clinical activity. Nowadays management follows a “treat to target” strategy based on adjustment of treatment in accordance with protocols. In patients with persistent disease activity after treatment with at least two of the classic disease-modifying antirheumatic drugs the use of biological therapy is recommended. Once sustained CR is achieved, the most efficient strategy is optimisation, by tapering the dose of the biological therapy or by increasing administration intervals. Searching for the lowest effective dose for each patient could minimise the risk of adverse effects and improve the cost-effectiveness of RA treatment.

Objectives: To prove that the performance of an optimisation strategy in patients with RA and sustained CR under biological treatment maintains the proportion of patients with DAS28 ≤2.6 after 4 years, to assess the maintenance of the effectiveness of the optimisation at 4 years in terms of clinical manifestations, and to analyse the time until relapse.

Methods: An open observational prospective study that included 70 patients with RA (CREATE registry) in CR at least for 6 months, under treatment with tapered dose of biological therapy (TNFi, abatacept or tocilizumab). Treatment effectiveness was assessed with the main variable DAS28 ≤2.6. Statistical analysis included a descriptive study of variables and a confidence interval of 95% (95% CI) was estimated. For bivariate analysis, we used Student t-test for independent samples, repeated measures analysis of variance and mixed analysis of variance, and as a post-hoc contrast, Sidak adjustment. The log-rank test was used to compare the time until relapse according to the biological therapy.

Results: The mean age of the patients was 56.9 (13.7) years, 78.6% were women, 68.8% were rheumatoid factor (RF) positive and 66.7% ACPA positive; the mean DAS28 at the beginning of the optimisation was 2.24 (0.73). After 4 years, 27.7% (95%CI:16.82%–38.58%) of patients maintained CR with the optimised dose, with a DAS28 2.15 (0.81). Through the first year, the percentage of relapses was 15.71%, in the second year, 7.35% and 4.61% relapsed during the third year. The median time of optimisation until relapse was 13.83^{3,18} months (95% CI:7.6–20.06). No significative differences were found at comparing the survival curves of the optimised patients until relapse for 4 years according to the biological therapy (TNFi vs no TNFi) (log-rank test:0.865, p:0.352) (graphic).

Conclusions: After 4 years, all of the patients maintained DAS28 levels of low disease activity, including those who had suffered a previous relapse and had turned back to the previous dose of biological treatment. In view of this outcomes, optimisation strategy in clinical practice is possible and effective in patients with persistently controlled RA.

Disclosure of Interest: None declared

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THU0210 SAFETY, TOLERABILITY AND EFFICACY OF SUBCUTANEOUS TOCILIZUMAB ADMINISTERED AS MONOTHERAPY OR IN COMBINATION WITH CSDMARDS IN RHEUMATOID ARTHRITIS: RESULTS FROM THE OSCAR STUDY

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Background: Efficacy and safety of intravenously (IV) administered tocilizumab (TCZ) in rheumatoid arthritis (RA) has been shown. Recently, efficacy and safety was confirmed for subcutaneous (SC) administration of TCZ.¹ The possible effects of SC TCZ upon tapering of GCs/NSAIDs has not been investigated.

Objectives: First, to establish the safety and efficacy of SC TCZ monotherapy or in combination with csDMARDs in DMARD-IR RA. Second, to assess GC/NSAID dose reduction and/or discontinuation under SC TCZ treatment.

Methods: The OSCAR study was a Dutch multicenter, open-label, single arm phase IV study within the phase 4 TOZURA program.¹ RA patients with an inadequate response (IR) to csDMARDs and 1 bDMARD were treated with weekly SC

Abstract THU0208 – Table 2. Effectiveness of CZP. Comparing at 12 months bionaïve and bioexperience groups

	Bionaïve	Baseline Bioexperience (after antiTNF failure)	Bionaïve	3 months Bioexperience (after antiTNF failure)	Bionaïve	12 months Bioexperience (after antiTNF failure)	P
HAQ, mean (SD)	1.2 (±0.7)	1.2 (±0.7)	1.1 (±0.7)	1.1 (±0.7)	0.9 (±0.6)	0.9 (±0.7)	0.925
DAS28, mean (SD)	4.7 (±1.1)	4.7 (±1.1)	3.5 (±1.3)	3.7 (±1.2)	3.0 (±1.3)	3.4 (±1.3)	0.011
Corticosteroids (yes), %	72.8	63.6	61.8	56.8	43.8	45.5	0.780
DAS28 remission,%	-	-	25.2	17.9	45.5	32.1	0.031
DAS28 LDA,%	-	-	43.6	31.0	61.7	45.2	0.008
EULAR Response,%	-	-	60.2	54.8	77.1	64.3	0.020