Abstract FRI0118 – Figure 1. ACR responses after 4 and after 8 weeks of Dekavil treatment in the phase 1 study population including all dose levels (6 – 600µg/kg)

Conclusions: The data obtained in the population studied to date suggest that Dekavil may be a safe and well tolerated novel therapeutic for the potential treatment of RA.

Disclosure of Interest: M. Galeazzi: None declared, G. Sebastiani: None declared, R. Voll: None declared, O. Viapiana: None declared, J. Dudler: None declared, P. Zufferey: None declared, E. Selvi: None declared, S. Finzel: None declared, F. Bootz Employee of: Philogen Group (Sponsor of the study), D. Neri Shareholder of: Philogen Group (Sponsor of the study)

DOI: 10.1136/annrheumdis-2018-eular.5550

FRI0119 EFFECT OF DISCONTINUING TNF INHIBITORS DURING PREGNANCY ON THE COURSE OF RHEUMATOID ARTHRITIS AND JUVENILE IDIOPATHIC ARTHRITIS

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Background: Treatment changes at early pregnancy can be followed by a disease worsening.¹

Objectives: To investigate whether the discontinuation of tumour necrosis factor inhibitors (TNFi) use during pregnancy is associated with any changes of disease activity at the third trimester in women with rheumatoid arthritis (RA) and juvenile idiopathic arthritis (JIA).

Methods: A prospective cohort study was conducted using the Organisation of Teratology Information Specialists (OTIS) Autoimmune Diseases in Pregnancy Project in the U.S. and Canada. Pregnant women with RA and JIA were enrolled between 2005 and 2017. Information about medication and disease activity were collected by telephone-based interviews prior to gestational week 20 and at gestational week 32. Disease activity was assessed by the Health Assessment Questionnaire Disability Index (HAQ-DI), the patient's pain scale and the patient's global scale. The composite tool Patient Activity Scale (PAS) was calculated in retrospect.

Results: In the OTIS cohort, data were available for 490 women of whom 397 had RA and 93 had JIA. Of all patients, 323 (65.9%) used TNFi during pregnancy of whom 122 (24.9%) patients discontinued TNFi before gestational week 20 (the mean time of discontinuation was gestational week 6 (SD ±5.03)) and 201 (41.0%) used TNFi beyond week 20. There were 167 (34.1%) patients not taking TNFi during pregnancy. At the time of enrollment, disease activity was low to minimal in 357 (72.9%) patients as defined by PAS scores below 3.7.

From the first to the third trimester, women using TNFi beyond week 20 showed a decrease of the PAS scores ($p=0.02$, figure 1) whereas women not using TNFi and those discontinuing TNFi before gestational week remained stable.

The univariate regression analysis, but not the adjusted model, revealed that TNFi use beyond week 20 was associated with improved HAQ scores at the third trimester (coefficient B -0.142, 95% CI -0.258 to -0.026) and with improved PAS scores (coefficient B -0.423, 95% CI -0.843 to -0.002). However, the various TNFi treatment modes during pregnancy were not associated with any minimum clinically important difference at the third trimester.

When selecting for 58 patients with active disease (PAS score ≥ 3.71) at the first trimester, the discontinuation of TNFi before gestational week 20 was not associated with any clinically important worsening of the disease at the third trimester.

Conclusions: In patients with RA and JIA who enter pregnancy with well controlled disease, the discontinuation of TNFi before gestational week 20 is possible without a risk of disease flares at the third trimester.

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.5138

FRI0120 EVALUATION OF RITUXIMAB, TOCILIZUMAB AND ABATACEPT IN A FRENCH MULTICENTER RHUPUS COHORT

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Background: Rhupus, a combination of Rheumatoid Arthritis (RA) and Systemic Lupus Erythematosus, is a rare entity. Existing epidemiological and therapeutic data are limited.

Objectives: The aim of this study was to describe the therapeutic impact and safety of three biologic therapies: Rituximab, Tocilizumab and Abatacept in a french Rhupus cohort.

Methods: We have set up a transverse observational retrospective and multicentric study. To be included in the cohort, patients had to present an overlap syndrome fulfilling criterias for rheumatoid arthritis and lupus, and to be treated at least by one of these three therapies. Enrollment has been made with a file available on the CRI website and the analysis of the French RA registers (AIR, REGATE and ORA). Primary endpoint was the median time in therapeutic maintenance for each biological agent.

Results: Forty patients from fifteen rheumatologic centres were included. The main demographic data for these patients are given in table 1. Thirty of them received a treatment with Rituximab, twelve with Tocilizumab and seven with Abatacept. Nine patients received 2 biologics at two different times of the disease. The medians of therapeutic maintenance were 82 months with Rituximab, 48 with Tocilizumab and 55 with Abatacept. The detailed analysis of clinical and biologic parameters revealed differences in effectiveness between therapies: corticosteroid doses decreased more in Rituximab group, VAS activity decreased more in Abatacept group, CRP decreased more in Tocilizumab group. Safety of biologics was similar to the data in literature for RA patients.

	RITUXIMAB (n=30)	TOCILIZUMAB (n=12)	ABATACEPT (n=7)
Disease duration (years)	4.8	8.3	11.9
Median of therapeutic maintenance (month)	82	48	55
Average duration of treatment (month)	44.8 [5.8;83.8]	27.0 [4.3;49.7]	26.0 [-0.79;52.93]
DAS 28 CRP evolution	-1.03 [-2.73;0.67]	-1.88 [-3.36;-0.38]	-1.97 [-3.55;-0.41]
Prednisone evolution (mg/d)	-8.45 [-23.15;9.25]	-5.15 [-10.95;0.65]	-2.71 [-5.00;-0.43]
VAS evolution (/100)	-5.40 [-32.70;21.90]	-18.50 [-35.33;5.04]	-30.43 [-65.27;4.41]
CRP evolution (mg/L)	-14.46 [-46.46;17.54]	-21.75 [-53.41;9.91]	-12.86 [-25.95;0.26]

Conclusions: This study provides original data on the effectiveness and safety of non-TNF biologics, mostly rituximab, in a large cohort of patients with rhupus. We have not enough patients treated with Tocilizumab and Abatacept to conclude but the therapeutic maintenance of Rituximab in Rhupus is similar to the one usually observed in RA.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.2537

FRI0121

CHARACTERISTICS OF PATIENTS WITH EARLY RHEUMATOID ARTHRITIS WHO HAVE A DELAYED RESPONSE TO TREATMENT WITH METHOTREXATE IN MONOTHERAPY OR IN COMBINATION WITH ADALIMUMAB

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Background: In patients (pts) with rheumatoid arthritis (RA), treat-to-target recommendations call for adjustment of treatment if a target is not met within 3–6 months of initiation. While some pts continue therapy beyond 3–6 months despite not achieving the target, it's unclear if they still can achieve the target, and how the timing of target attainment impacts long-term outcomes.

Objectives: To evaluate clinical, functional, and radiographic outcomes on the basis of initial time to low disease activity (LDA) attainment among early RA pts who are naïve to MTX, or are MTX-insufficient responders (MTX-IR).

Methods: This post hoc analysis included pts receiving MTX in monotherapy or in combination with adalimumab (ADA) in 2 randomised, controlled trials (RCTs) of MTX-naïve pts with early RA: PREMIER included a 104 week (wk) RCT¹; OPTIMA included a 26 wk RCT followed by treatment adjustments based on a target of LDA at wks 22 and 26². Pts not achieving stable LDA received open-label (OL) ADA +MTX for an additional 52 wks (MTX-inadequate responders, IR). Pts were subgrouped by treatment and time to first LDA event [SDAI ≤11: 0–<3 months (mths), 3–≤6 mths, >6–≤12 mths]. The following were summarised for each subgroup: mean values and change from baseline in SDAI, HAQ-DI and modified total Sharp score (mTSS). The proportions of pts achieving SDAI remission (REM) at 1 year (yr) were assessed.

Results: Roughly equal proportions of pts on MTX alone experienced their first LDA response between 0–<3 mths (21%), 3–≤6 mths (21%), and >6–≤12 mths (17%). More pts on ADA+MTX experienced LDA within 3 mths (0–<3: 45% and 56% for MTX-naïve and MTX-IR backgrounds, respectively), with smaller proportions in the 3–≤6 mths (19% for both MTX-naïve and -IR backgrounds), and >6–≤12 mths groups (14% and 4% for MTX-naïve and MTX-IR backgrounds). Approximately 50% of the 0–<3 mth group across treatments achieved SDAI REM at 1 year. Interestingly, 10%, 14%, and 8% of the MTX, ADA+MTX (MTX-naïve), and ADA+MTX (MTX-IR) pts who first experienced LDA after 6 mths were in SDAI REM at 1 year.

Among MTX-naïve pts, pts on ADA+MTX had greater ΔHAQ and smaller ΔmTSS than pts on MTX alone at Wks 26 and 52 (table 1). Regardless of their time to first SDAI LDA response, pts on MTX monotherapy or ADA+MTX experienced comparable improvements in SDAI, HAQ-DI and comparable ΔmTSS at Wks 26 and 52.

Table 1 Mean Values at Baseline and Change From Baseline in Clinical, Functional, and Structural Parameters in Patients with Early RA Receiving MTX or ADA+MTX, on the Basis of First Achievement of Low Disease Activity by SDAI.

	MTX N=256			ADA+MTX, naïve N=631			ADA+MTX ¹ MTX-IR N=347		
Achievement of low disease activity at months									
Months	0 to <3	3 to ≤6	6 to ≤12	0 to <3	3 to ≤6	6 to ≤12	0 to <3	3 to ≤6	6 to ≤12
Mean (SE) SDAI at BL									
	40.4 (1.5)	44.8 (1.6)	49.9 (1.9)	39.8 (0.8)	49.0 (1.1)	52.8 (1.8)	18.7 (0.8)	27.3 (1.6)	29.2 (3.3)
Mean Change (SE) from BL in SDAI									
Wk 26	-32.0 (2.2)	-36.3 (1.8)	-32.5 (1.8)	-32.4 (0.9)	-39.9 (1.3)	-30.4 (2.1)	-11.2 (0.9)	-17.2 (1.9)	-14.0 (3.9)
Wk 52	-33.1 (2.2)	-36.9 (2.2)	-35.9 (2.2)	-34.2 (0.9)	-41.7 (1.4)	-43.4 (2.1)	-12.6 (0.9)	-18.1 (2.2)	-19.3 (4.1)
Mean (SE) HAQ-DI at BL									
	1.1 (0.1)	1.5 (0.1)	1.5 (0.1)	1.4 (0.0)	1.6 (0.1)	1.8 (0.1)	0.9 (0.0)	1.3 (0.1)	1.2 (0.1)
Mean Change (SE) from BL in HAQ-DI									
Wk 26	-0.8 (0.1)	-1.0 (0.1)	-0.8 (0.1)	-1.0 (0.0)	-1.1 (0.1)	-0.7 (0.1)	-0.3 (0.0)	-0.4 (0.0)	-0.4 (0.0)
Wk 52	-0.8 (0.1)	-1.1 (0.1)	-0.8 (0.1)	-1.0 (0.0)	-1.2 (0.1)	-1.0 (0.1)	-0.4 (0.0)	-0.4 (0.1)	-0.4 (0.1)
Mean (SE) mTSS at BL									
	16.6 (3.1)	21.7 (2.2)	19.7 (3.0)	12.4 (1.0)	16.5 (2.0)	14.6 (2.4)	12.0 (1.3)	11.6 (1.8)	14.1 (4.3)
Mean Change (SE) from BL in mTSS									
Wk 26	1.9 (0.5)	1.5 (0.4)	2.5 (0.5)	0.3 (0.1)	0.4 (0.2)	0.3 (0.2)	0.0 (0.2)	0.1 (0.2)	0.0 (0.2)
Wk 52	3.0 (0.7)	2.8 (0.6)	3.4 (0.7)	0.5 (0.1)	0.6 (0.2)	0.5 (0.2)	0.0 (0.1)	0.0 (0.2)	-0.1 (0.1)
§ timing of LDA outcome from time of ADA addition									
BL, baseline, Wk, week; SDAI, simplified disease activity index; HAQ-DI, health assessment questionnaire-disability index; mTSS, modified total Sharp score									

¹ timing of LDA outcome from time of ADA addition.

BL, baseline; Wk, week; SDAI, simplified disease activity index; HAQ-DI, health assessment questionnaire-disability index; mTSS, modified total Sharp score

Conclusions: Pts on ADA+MTX achieved a first SDAI LDA response earlier than pts on MTX monotherapy, regardless of whether they were MTX-naïve or MTX-IR. More pts with a very early response went on to achieve SDAI REM at 1 year. However, pts with a longer time (>6 mths) to their first SDAI LDA response had comparable clinical, functional and radiographic outcomes compared to pts who responded earlier (within 3 or 6 mths). Therefore, achieving a clinical response in the direction of the treatment target, even if not yet achieving it, may be sufficient to continue therapy in appropriate pts.

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Acknowledgements: AbbVie: study sponsor, contributed to design, data collection, analysis, interpretation; and writing, reviewing, approval of final version. Medical writing: Naina Barretto of AbbVie.

Disclosure of Interest: J. Smolen Grant/research support from: AbbVie, Consultant for: AbbVie, X. Bu Shareholder of: AbbVie, Employee of: AbbVie, X. Wang Shareholder of: AbbVie, Employee of: AbbVie, J. Suboticki Shareholder of: AbbVie, Employee of: AbbVie, A. Kavanaugh Grant/research support from: AbbVie Inc., Amgen, Astra-Zeneca, BMS, Celgene, Centocor-Janssen, Pfizer, Roche, and UCB, Consultant for: expert advice to AbbVie Inc., Amgen, Astra-Zeneca, BMS, Celgene, Centocor-Janssen, Pfizer, Roche, and UCB

DOI: 10.1136/annrheumdis-2018-eular.2635

FRI0122

DRUG SURVIVAL OF ADALIMUMAB IN PATIENTS WITH RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS AND PSORIATIC ARTHRITIS OVER 10 YEARS IN REAL-WORLD SETTING OF CZECH REGISTRY ATTR

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Background: Drug survival in real clinical practice is reflecting both efficacy and safety of the drug. It is valuable outcome measure complementary to data from RCT.

Objectives: To evaluate 10 years efficacy and survival of adalimumab (ADA) in Czech registry ATTR. To analyse reasons for drug discontinuation and analyse baseline demographic and clinical characteristics predictive for drug discontinuation. We also aimed to compare survival of ADA between 3 different diagnosis (RA, AS, SpA). Finally we aimed to compare survival between different anti TNF drugs.

Methods: All patients fulfilled criteria of Czech Rheum. Soc. for indication of anti TNF therapy and were included in registry. They were followed each 3 month first