Conclusions: This study provides original data on the effectiveness and safety of non-TNF biologics, mostly rituximab, in a large cohort of patients with rheumatoid arthritis. We have not enough patients treated with tocilizumab and abatacept to conclude but the therapeutic maintenance of Rituiximab in Rheusus is similar to the one usually observed in RA.

Disclosure of Interest: None declared


FRI0121

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

J. Smolen1, X. Bu2, X. Wang3, A. Suboticki4, A. Kavanaugh3. 1Medical University of Vienna, Vienna, Austria; 2AbbVie Inc., North Chicago, 3University of California, San Diego, USA

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 26. Pts not achieving stable LDA received open-label OPTIMA included a 26 wk RCT followed by treatment adjustments based on a target of LDA at wks 22 and 26. Pts not achieving stable LDA received open-label 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 mths (21%), 3–6 mths (6%), >6–12 mths (17%)]. More pts on ADA+MTX experienced LDA within 3 mths (0–<3: 43% vs 56% for MTX-naive and MTX-IR backgrounds, respectively), with smaller proportions in the 3–6 mths (19% for both MTX-naive and IR backgrounds), and >6–12 mths groups (14% and 4% for MTX-naive and MTX-IR backgrounds). Approximately 50% of the 0–3 mths group across treatments achieved SDAI REM at 1 year. Interestingly, 10%, 14%, and 8% of the MTX, ADA+MTX (MTX-naive), 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.

<table>
<thead>
<tr>
<th></th>
<th>MTX N=205</th>
<th>ADA+MTX, naïve N=621</th>
<th>ADA+MTX, MTX-IR N=347</th>
</tr>
</thead>
<tbody>
<tr>
<td>Months</td>
<td>0 to &lt;3</td>
<td>3 to 6</td>
<td>6 to 12</td>
</tr>
<tr>
<td>Mean (SD) SDAI at IL</td>
<td>44.8 (5.8)</td>
<td>46.4 (4.9)</td>
<td>40.1 (3.9)</td>
</tr>
<tr>
<td>Mean (SD) mTSS</td>
<td>27.0 (4.3)</td>
<td>30.8 (5.0)</td>
<td>26.0 (4.0)</td>
</tr>
<tr>
<td>Mean (SD) HAQ-DI</td>
<td>1.3 (0.7)</td>
<td>1.5 (0.8)</td>
<td>1.6 (0.9)</td>
</tr>
<tr>
<td>Mean (SD) DAS28</td>
<td>3.2 (0.9)</td>
<td>3.7 (1.0)</td>
<td>3.8 (0.9)</td>
</tr>
<tr>
<td>Mean (SD) CRP</td>
<td>2.3 (0.7)</td>
<td>2.8 (0.8)</td>
<td>3.0 (0.9)</td>
</tr>
</tbody>
</table>

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.

REFERENCES:

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


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 ATTRA

K. Pavelka1, J. Zavada2, Z. Kristkova1, L. Szzukova3. 1Institute of Rheumatology, Praha; 2Institute of Biostatistics and Analyses, Ltd., Spin-off company of the Masaryk University; 3Institute of Biostatistics and Analyses, Ltd., Masaryk University, Brno, Czech Republic

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 ATTRA. 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