Conclusions: The IR of ADR was 16.2%, being similar in all age categories. Gastrointestinal was the main cause of ADR followed by infections. We have found differences in discontinuation rates among DMARD due to ADR, being Abatacept, Gold and Leflunomide the drugs with the highest risk. Methotrexate had a lower risk of ADR compared to other DMARD. Caution should be taken in patients receiving combined therapy and with certain comorbidities

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Rheumatoid arthritis - biological DMARDs

SAT0165

REASONS FOR BDMARD CESSATION AND SUBSEQUENT PERSISTENCE OF SECOND LINE TREATMENT IN A LARGE REAL WORLD RHEUMATOID ARTHRITIS REGISTRY

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Background: The current recommendations for treating Rheumatoid Arthritis (RA) patients (pts) who fail on conventional disease modifying anti-rheumatic drugs (DMARDs) is to use biologic (b) or targeted synthetic (ts) DMARDs. Pts who fail first (1st) line b/tsDMARDs are recommended to go on other b/tsDMARDs; however, reasons for stopping or switching between bDMARDs according to mode of action and the persistence on treatment are not well characterized in real world patient populations.

Objectives: The primary objective was to identify the reasons for stopping 1st line b/tsDMARDs in RA pts treated in the clinical practice setting. The secondary objectives were to identify second (2nd) line b/tsDMARDs choices in pts who stop TNF inhibitors (TNFis) within 6 months (mo) due to lack of efficacy and the persistence on these treatments.

Methods: Pts ≥ 18 years with confirmed RA who were treated with 1st line b/tsDMARDs, from 1 August 2010 to 30 June 2017, by physicians participating in the OPAL-QUMI database, were included in the analyses. Reasons for stopping b/tsDMARDs were recorded by the treating physician during routine visits. The following b/tsDMARDs were included abatacept (ABA), adalimumab, certolizumab pegol, etanercept, golimumab, infliximab and tocilizumab (TCZ), rituximab (RTX) and tofacitinib (TFB). Data were analysed using descriptive statistics for continuous variables and frequency counts for categorical variables. Persistence on treatment was summarised using Kaplan-Meier (K-M) methodology. Individual TNFis were combined for simplicity.

Abstract Sat0165 – Table 1. Patients receiving 1st line treatment by mechanism of action.

First-line Treatment	RTX	TCZ	TFB	ABA	TNFis
Started, n	230	555	518	609	5002
Stopped, n(%)	51(22)	238(43)	105(20)	233(38)	2029(41)
Stopped within 6 months; n(%) ^a	11(22) ^a	41(17) ^{a*}	57(54)	72(31) ^a	733(36) ^{a*}

^apercentage relative to subset stopped treatment
^ap<0.001: RTX vs TFB; TCZ vs ABA; TNFis vs TFB
^ap<0.0001: TCZ vs TFB; TNFis/ABA vs TFB

Abstract Sat0165 – Table 2 K-M. estimates of persistence on 2nd line b/tsDMARDs after discontinuation of 1st line TNFis due to lack of efficacy.

Table 2: K-M estimates of persistence on 2 nd line b/tsDMARDs after discontinuation of 1 st line TNFis due to lack of efficacy.	RTX	TCZ	TFB	ABA	TNFis
N	13	49	25	92	130
6 months, %	75	78	71	61	60
12 months, %	75	57	ND	49	40

ND=not determined

Results: A total of 6914 pts received 1st line b/tsDMARDs. Median age was 61 years, median disease duration (RA onset to last visit) was 10 years. The majority

(75%) were females. Treatment was stopped in 2656 pts (38%); 914 (34%) of these stopped within 6 mo of treatment initiation. The highest and lowest percentage of pts stopping treatment within 6 mo was in pts receiving TFB (54%) and TCZ (17%), respectively (table 1). The most common reasons for stopping therapy within 6 mo were lack of efficacy (45%>ABA, 44%>TNFis, 33%>TFB and 27%>TCZ) and adverse reactions (21%>TFB, 20%>TCZ, 15%>TNFis, 13%>ABA). Stopping due to lack of efficacy-primary failure was highest for TFB (23%). The percentage of pts remaining on 2nd line b/tsDMARD treatment after stopping 1st line TNFis due to lack of efficacy was the highest for TCZ (78%) at 6 mo and RTX (75%) at 12 mo (table 2). Median time to stopping 2nd line treatment was 48 mo (95% CI:17–74) for RTX, 21 mo (95% CI:11–62) for TCZ, 21 mo (95% CI:6–21) for TFB; 11 mo (95% CI:8–22) for ABA and 9 mo (95% CI:7–12) TNFis.

Conclusions: The primary failure rate is lower than previously reported. In pts who failed 1st line TNFis within 6 mo of commencement due to lack of efficacy, 2nd line TNFis resulted in the lowest treatment persistence. These real world data will assist clinicians with treatment choices post primary TNFis failure.

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SAT0166

WHICH BIOLOGIC AGENT IS MOST SUITABLE FOR AN EXTENDED-INTERVAL TREATMENT FOR RHEUMATOID ARTHRITIS ? RESULTS FROM A MULTICENTER STUDY

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Background: Biological disease-modifying antirheumatic drugs (bDMARDs) have made apparent development of treating rheumatoid arthritis (RA). However, prescription of them appeared to be relatively difficult due to high cost. The newest EULAR recommendation advocates tapering of bDMARDs when RA activity is controlled.

Objectives: A multicenter clinical study on a longer interval treatment with three bDMARDs, Golimumab (GOL), which is one of TNF inhibitors, and two of non-TNF inhibitor, Tocilizumab (TCZ) and Abatacept (ABT) was investigated.

Methods: Patients, who were maintained at low disease activity by DAS28 score for more than 3 months treated with GLM, TCZ, ABT, were enrolled. These selected patients were treated with these drugs with 1.5 fold longer interval of standard schedule for 60 weeks, and the rate of patients, who preserved low disease activity were determined. The patients who were not tolerated these drugs because of the side effects or adverse events, were withdrawn from this study.

Results: One hundred thirty-one patients treated with GLM, 149 with ABT (S.C. 61, I.V. 88) and 299 with TCZ (S.C. 87, I.V. 212) were enrolled. Among these, 57 patients treated with GLM (43%), 40 with ABT(26%, S.C 18, I.V 22), 93 with TCZ (31%, S.C 21, I.V 72) were successfully maintained at low disease activity with