this 1.5 folders longer interval treatment, respectively. The age of patients in ABT group was 73.5±10.6, and significantly higher than those in TCZ (58.6±11.9) and GOL (58.1±14.7) groups. At 60 weeks, DAS28 in ABT group was 3.1±0.5, and significantly higher than those in TCZ (2.6±0.7) and GLLM (2.6±0.7) groups. On the other hand, CDAI in GOL was 6.6±3.4, and was significantly higher than those in TCZ (4.4±2.6) or ABT (4.6±2.3) groups. Accordingly, successive rate at 60th week in ABT group was 52% and significantly lower than those in TCZ (69%) or in GOL (73%) groups as shown in figure. Finally, no significant difference in successive rate was observed between s.c. and i.v.

Conclusions: This study clarified that TCZ and GLM had higher successive rates than ABT for maintaining low disease activity for 60 weeks by longer interval treatment. This effectiveness might relate to the high therapeutic efficacy of TCZ and low antigenicity of GOL.

Disclosure of Interest: None declared


COMPARISON OF THE EFFICACY AND TOLERABILITY OF TOCILIZUMAB, SARILUMAB, AND SIRUKUMAB IN PATIENTS WITH ACTIVE RHEUMATOID ARTHRITIS: A BAYESIAN NETWORK META-ANALYSIS OF RANDOMIZED CONTROLLED TRIALS

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Background: A humanized, anti-human IL-6 receptor monoclonal antibody, tocilizumab, was developed to block IL-6 signaling and has been used as an effective therapeutic agent for patients that do not respond to methotrexate (MTX) or tumor necrosis factor (TNF) inhibitor. The successful use of tocilizumab in RA stimulated the development of other biologics targeted to the IL-6 pathway, such as anti-IL-6R (sarilumab) or anti-IL-6 (sirukumab) antibodies.

Objectives: The relative efficacy and tolerability of tocilizumab, sarilumab, and sirukumab were assessed in patients with rheumatoid arthritis (RA) and an inadequate response to MTX or TNF inhibitors.

Methods: We performed a Bayesian network meta-analysis to combine direct and indirect evidence from randomized controlled trials (RCTs) to examine the efficacy and safety of tocilizumab, sarilumab, and sirukumab in RA patients and an inadequate MTX or TNF inhibitor response.

Results: Fourteen RCTs, comprising 9,753 patients, met the inclusion criteria. Tocilizumab 8 mg combined with MTX or as monotherapy was the most effective treatment for active RA with an inadequate MTX or TNF antagonist response, followed by sarilumab and sirukumab, regardless of MTX combination. The ranking probability based on the surface under the cumulative ranking curve (SUCRA) indicated that tocilizumab 8 mg+MTX had the highest probability of being the best treatment to achieve the ACR50 response rate, followed by tocilizumab 8 mg, sarilumab 200 mg, sarilumab 200 mg+MTX, sirukumab 100 mg+MTX, tocilizumab 4 mg+MTX, sarilumab 100 mg+MTX, sirukumab 50 mg+MTX, sarilumab 150 mg+MTX, adalimumab 40 mg, and sirukumab 50 mg, and placebo+MTX. No significant differences were observed in withdrawals owing to adverse events after treatment with tocilizumab 8 mg+MTX, sirukumab 100 mg+MTX, or sarilumab 200 mg+MTX.

Conclusions: In RA patients with an inadequate MTX or anti-TNF therapy response, tocilizumab 8 mg as monotherapy and combined with MTX showed acceptable tolerability and the highest performance based on the ACR50 response rate, followed by sarilumab and sirukumab.

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Disclosure of Interest: None declared