Adalimumab, Certolizumab, Golimumab, and Infliximab; and non-TNFi included Abatacept, Rituximab, Tocilizumab, and Tofacitinib.

Over a mean (SD) follow-up of 2.4 (1.4) years, bDMARD discontinuation/switching was reported for 37.6% of patients, with significant difference in time to discontinuation between TNFi and non-TNFi users (Logrank p=0.01). However, there was no significant difference due to non-response or loss of response (Logrank p=0.67) between the two groups. At 2 years, more patients remained on TNFi (71.0%) compared to non-TNFi (57.0%). At 5 years, 51.0% and 44.0% of patients still remained on TNFi and non-TNFi, respectively.

Conclusions: The overall retention rate for biologics was comparable to finding in European registries. We found that patients stay on TNFi longer compared to non-TNFi. However, no significant difference was found between the two groups, for discontinuation or switching of bDMARDs due to non-response or loss of response. Further analyses are required to adjust for the effect of potential confounders (e.g. age, sex, disease activity, and other treatment regimens) on biologic discontinuation.

REFERENCE:

Disclosure of Interest: M. Movahedi Employee of: OBRI, S. Couta Employee of: OBRI, A. Cesta Employee of: OBRI, C. Bombardier Grant/research support from: OBRI was funded by peer reviewed grants from CIHR (Canadian Institute for Health Research), Ontario Ministry of Health and Long-Term Care (MOHLTC), Canadian Arthritis Network (CAN) and unrestricted grants from: Abbvie, Amgen, Celgene, Hospira, Janssen, Lilly, Merck, Novartis, Pfizer, Roche, Sanofi, & UCB, Consultant for: Dr. Bombardier holds a Canada Research Chair in Knowledge Transfer for Musculoskeletal Care and a Pfizer Research Chair in Rheumatology DOI: 10.1136/annrheumdis-2018-eular.2131

SA10197 ADHERENCE TO BIOLOGIC THERAPY OF RHEUMATOID ARTHRITIS PATIENTS – IS THERE ANY RELATION WITH DISEASE ACTIVITY?

N. Madeira1, A. Cardoso2, R. Trinca3, C. Silva1, H. Santos1, C. Miguel1, F. Barcelos1, D. Medeiros1, R. Campanilho Marques1, L. Cunha Miranda1

1Rheumatology, 2Nutrition, 3Nursing, Instituto Português de Reumatologia, Lisbon, Portugal

Background: In the last years, there has been an increase interest in using Patient Reported Outcomes (PROs) in clinical trials and daily clinical practice in Rheumatology to provide patient-centered care. The most frequently reported PROs are patient’s pain, patient’s global assessment (PGA) of disease activity and reports of functional capacity, fatigue, anxiety and depression. To date, studies that explore patient adherence to rheumatic medicines are scarce.

Objectives: To study the level of adherence to biologic therapy of Rheumatoid Arthritis (RA) patients, followed at a day care hospital of Rheumatology.

Methods: Observational and cross-sectional study which took place in two months of consultation of day care hospital (5 periods per week). Patients with a diagnosis of RA according to 1987 American College of Rheumatology (ACR) and/or 2010 ACR/European League Against Rheumatism criteria, on biologic diagnosis of RA according to 1987 American College of Rheumatology criteria, on biologic continuation were included in the analysis. Data collected from biologics database and medical records. Effectiveness was assessed by change in Disease activity scores (DAS 28) and European League Against Rheumatism response criteria (EULAR) after 6 months of therapy.

Results: 220 patients had received abatacept with at least 6 months follow up during the study period. 176 were females and 44 males with mean age of 67.83 years (SD ±10.32). Mean disease duration in these patients was 14.42 years (SD ±6.11). 152 (69%) were seropositive (Rheumatoid factor and/or anti-CCP antibody). 207 (94%) patients had received a prior biologic and only 13 (6%) patients were biologic naïve. 193 (87.7%) patients were initiated on intravenous (iv) abatacept and 27 (12.2%) patients on subcutaneous (s/c) abatacept. 90 (40.9%) patients were successfully switched from iv to s/c abatacept.

The mean number of prior biologic drugs use per patient was 1.70 (SD = 1.03). 83.8 % patients were co-prescribed DMARDs at the initiation of abatacept therapy. Mean baseline DAS 28 score was 6.02 (SD = 3.11). Average DAS 28 change at 6 months was -1.5 (95 % CI -1.27, -1.33). 75 % patients had a positive EULAR response (38% good, 37% moderate) and 25% had no response at 6 months.

Overall 57 (25.9 %) patients discontinued treatment. 43 (19.5%) patients discontinued abatacept early (<9 months) due to primary inefficacy (10.9 %) and adverse reactions (8.6%). 24 (10.9%) patients discontinued abatacept later, after a mean 27.46 (SD = 12.9) months of use, due to secondary loss of efficacy (6.3%) and adverse reactions (4.5%).

82 % (180/220) of RA patients continued taking abatacept beyond 6 months. 61.5 % (91/148) patients were still adherent at 2 years, 51.3% (39/76) retained the drug beyond 48 months.

SA10198 DRUG SURVIVAL AND EFFICACY OF ABATACEPT IN RHEUMATOID ARTHRITIS PATIENTS IN ROUTINE CARE – 7 YEAR EXPERIENCE FROM A SINGLE CENTRE IN THE UNITED KINGDOM

N. Nolka1, T. Sheeran1, S. Venkatachalam1, 2The Rheumatology Centre – Cannock, Wolverhampton, The Royal Wolverhampton NHS Trust, Cannock, United Kingdom

Background: Even after the advent of multiple biologic drugs, optimum treatment of rheumatoid arthritis (RA) in a real-world situation continues to be challenging. The data on long-term drug survival of biologic drugs in routine clinical practice is lacking. We extended our earlier analysis of abatacept use in RA patients 1,2 from a single centre in the United Kingdom over 7 years.

Objectives: To assess the efficacy, tolerability and drug survival of abatacept use in RA patients in a routine clinical setting like ours.

Methods: From November 2010 to December 2017, all RA patients with at least 6 months of follow up after abatacept initiation were included in the analysis. Data on demographics, disease duration, previous biologics, mode of administration, reasons for discontinuation and length of abatacept therapy were retrospectively collected from biologics database and medical records. Effectiveness was assessed by change in Disease activity scores (DAS 28) and European League Against Rheumatism response criteria (EULAR) after 6 months of therapy.

Results: 220 patients had received abatacept with at least 6 months follow up until December 2017. 176 were females and 44 males with mean age of 67.83 years (SD ±10.32). Mean disease duration in these patients was 14.42 years (SD ±6.11). 152 (69%) were seropositive (Rheumatoid factor and/or anti-CCP antibody). 207 (94%) patients had received a prior biologic and only 13 (6%) patients were biologic naïve. 193 (87.7%) patients were initiated on intravenous (iv) abatacept and 27 (12.2%) patients on subcutaneous (s/c) abatacept. 90 (40.9%) patients were successfully switched from iv to s/c abatacept.

The mean number of prior biologic drugs use per patient was 1.70 (SD = 1.03). 83.8 % patients were co-prescribed DMARDs at the initiation of abatacept therapy. Mean baseline DAS 28 score was 6.02 (SD = 3.11). Average DAS 28 change at 6 months was -1.5 (95 % CI -1.27, -1.33). 75 % patients had a positive EULAR response (38% good, 37% moderate) and 25% had no response at 6 months.

Overall 57 (25.9 %) patients discontinued treatment. 43 (19.5%) patients discontinued abatacept early (<9 months) due to primary inefficacy (10.9 %) and adverse reactions (8.6%). 24 (10.9%) patients discontinued abatacept later, after a mean 27.46 (SD = 12.9) months of use, due to secondary loss of efficacy (6.3%) and adverse reactions (4.5%).

82 % (180/220) of RA patients continued taking abatacept beyond 6 months. 61.5 % (91/148) patients were still adherent at 2 years, 51.3% (39/76) retained the drug beyond 48 months.
Conclusions: Abatacept continues to be a safe and effective treatment option for patients with RA who are biologic naïve or after discontinuation of prior biologic due to failure or intolerance. A significant number of patients continued on abatacept even after 4 years.

REFERENCES:

Acknowledgements: We would like to thank the whole team and patients at The Rheumatology Centre of The Royal Wolverhampton trust.

Disclosure of Interest: None declared.


SAT0199

SWITCH FROM INNOVATOR ETANERCEPT TO BIOSIMILAR ETANERCEPT IN INFLAMMATORY RHEUMATIC DISEASES: THE EXPERIENCE OF COCHIN UNIVERSITY HOSPITAL PARIS-FRANCE.

O. Al Tabaa1, A. Etcheto1, C. Miceli-Richard1, M. Anna1, M. Dougados1.
Rheumatology, Cochon University Hospital, Paris, France

Background: Etanercept biosimilar (bETN) is available for treatment of spondyloarthritis (SpA) and rheumatoid arthritis (RA) since 2016 in France. Data showing effectiveness and safety of bETN are still limited.

Objectives: 1/To evaluate the RA and SpA patients’ characteristics associated with the switch 2/To evaluate the safety and efficacy of bETN.

Methods: Patients: All the patients receiving innovator etanercept for at least 3 months on October 2016 and monitored in the department of rheumatology B of Cochon hospital. Physicians: All the 9 physicians in charge of at least one patient. Study design: After information (one hour session) on the biosimilars, all the physicians were invited to propose a switch from innovator etanercept to bETN. Data collected: physicians’ characteristics, patients’ characteristics (demographics, diagnosis of the rheumatic disease, disease activity parameters).

Results: Of the 435 outpatients who had received etanercept; 304 were receiving etanercept in 2016 and 183 were eligible for a potential switch (the remaining 121 patients did not attend any out-patient-clinic between October 2016 and April 1st 2017). The percentage of patients who switched to bETN was 51.6% (94 patients). This switch was more frequently performed in patients monitored by older physicians (mean age: 50.4±14.3 vs 44.8±11.3, p=0.005) and by physicians with a full-time academical position (56.4 % vs 13.5 %, p<0.001)

The patients’ characteristics were similar: % RA (51.1% vs 44.9%), age (52.1±15 vs 50.5±15), female gender (57.4% vs 51.6%), disease duration (16.8±11.9 vs 14.8±11.3) except for the NSAID intake (28.3 % vs 14.8±11.3, p=0.02) and the global evaluation (25.2±19.4 vs 19.1±21.8, p=0.02) in the switchers vs non-switchers.

However, no independent factors were associated with the switch in the multivariate analysis.

The bETN retention rate was 83 % (0.76 – 0.92) after a 6 month follow-up period.

The univariate analysis aimed at evaluating the baseline predisposing factors of the switch in the multivariate analysis.

There was no difference in the changes in the disease activity parameters in both the completer and ITT population.

Conclusions: This study suggests that:
1/The probability to switch from etanercept innovator to bETN was mainly related to physicians' behavior
2/Using an open design, the percentage of patients complaining of a lower efficiency and/or a worse safety profile of the biosimilar was high
3/There was no objective parameter permitting to conclude at a lower efficiency and/or a worse safety profile of the bETN in comparison to the innovator etanercept.

Disclosure of Interest: None declared.


Table 1 Key Safety Events and Lab Abnormalities per 100 PYE*

<table>
<thead>
<tr>
<th>Filgotinib</th>
<th>Filgotinib Monotherapy</th>
<th>Total a (N=379)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment-emergent AEs (TEAEs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious TEAEs</td>
<td>5.9</td>
<td>3.9</td>
</tr>
<tr>
<td>TEAEs for infections</td>
<td>44.5</td>
<td>39.3</td>
</tr>
<tr>
<td>Serious TEAEs for infections</td>
<td>1.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Malignancy (incl. MSHC)</td>
<td>0.8</td>
<td>0.4</td>
</tr>
<tr>
<td>Herpes Zoster</td>
<td>1.2</td>
<td>1.3</td>
</tr>
<tr>
<td>Deep Vein Thrombosis b</td>
<td>0.2</td>
<td>0</td>
</tr>
<tr>
<td>Pulmonary Embolism c</td>
<td>0.2</td>
<td>0</td>
</tr>
<tr>
<td>Acute Tubulointerstitial Nephritis</td>
<td>0.2</td>
<td>0</td>
</tr>
<tr>
<td>Grade 3 Laboratory Abnormalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemoglobin ↓</td>
<td>0.5</td>
<td>0.1</td>
</tr>
<tr>
<td>Lymphocytes ↓</td>
<td>1.2</td>
<td>1</td>
</tr>
<tr>
<td>Neutrophils ↓</td>
<td>0.3</td>
<td>0.1</td>
</tr>
<tr>
<td>Platelets ↓</td>
<td>0</td>
<td>0.3</td>
</tr>
<tr>
<td>ALT↑</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>Creatinine ↑</td>
<td>0.3</td>
<td>0</td>
</tr>
<tr>
<td>LDL &gt;190 mg/dl</td>
<td>17.0</td>
<td>3.5</td>
</tr>
<tr>
<td>HLD &lt;40 mg/dl</td>
<td>5.1</td>
<td>6.9</td>
</tr>
</tbody>
</table>

* Treatment groups with fewer than 10 subjects were omitted for clarity; † Non-melanoma skin cancer; ‡ Single patient DVT leading to PE

REFERENCES: