Continuance rate of TNFi (IFX and ADA) treatment was significantly lower in ADRa-positive patients than in those negative (p=0.0066 and p=0.0127, respectively). In IFX group, patients with ANA titers of >160 before treatment showed more good EULAR treatment response (p=0.037 and p=0.033, respectively). In ADA group, 7 of 9 ANA-negative patients before treatment showed moderate or good EULAR response, but positive ANA both before and after treatment was not connected with the clinical response.

Conclusion: The presence of ANA before IFX or ADA is a risk factor for the appearance of ADRa, while ADRa did not appear in any patient negative for ANA before treatment. ANA of high titers before and after IFX treatment predicted existence of ADRa and possibly leading to the treatment failure.

REFERENCES

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SA10156 METHOTREXATE DISCONTINUATION AND DOSE DECREASES AFTER THERAPY WITH TOCLIZUMAB: RESULTS FROM THE CORRONA RHEUMATOID ARTHRITIS REGISTRY

Methods: Patients (N=444) with newly-diagnosed RA (≤6 months disease duration) treated with methotrexate (MTX) as monotherapy or combined with antimetabolites were included. MTX dose was assessed at baseline, 6, 12, and 24 months of therapy. Dose decreases were ≥20% of initial dose. In case of patients who had multiple dose decreases, the most recent one was considered. All analyses were reviewed and approved by the Corrona Data Safety Monitoring Board.

Results: Of 444 eligible patients, 82.7% were female, and 83.7% were white, with a mean (SD) disease duration of 11.6 (9.3) years and a baseline CDAI score of 24.0 (15.4). The mean (SD) MTX dose at baseline was 17.7 (5.8) mg. Overall, a total of 139 patients (31.3%) discontinued or decreased MTX at 6 months ranging from 28.2% to 38.2%. Improvements in CDAI scores and PROs were observed at 6 months in all baseline MTX dose groups and in patients who discontinued, decreased, or increased MTX doses at 6 months (Table 1). Similar patterns and results were observed at 12 months (not shown).

Conclusion: A considerable proportion of patients initiating MTX were able to discontinue or decrease the dose of MTX after TCZ initiation. Patients who were able to discontinue or decrease MTX experienced similar improvements in disease activity and functionality. Discontinuing or decreasing MTX may be an effective treatment strategy for patients initiating TCZ combination therapy.

REFERENCES

SA10157 REAL-WORLD EVALUATION OF PERSISTENCE WITH EARLY-LINE ABATACEPT VERSUS TUMOR NECROSIS FACTOR-INHIBITORS FOR RHEUMATOID ARTHRITIS COMPLICATED BY POOR PROGNOSTIC FACTORS

Methods: We performed a multicenter retrospective medical record review of adult RA patients with poor prognostic factors treated at 5 United States clinics located in the West, Midwest, and Southeast. Patients were treated with abatacept or TNFi as the first biologic treatment at the clinic complicated by poor prognostic factors. The presence of ANA before IFX or ADA is a risk factor for the appearance of ADRa, while ADRa did not appear in any patient negative for ANA before treatment. ANA of high titers before and after IFX treatment predicted existence of ADRa and possibly leading to the treatment failure.

