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SAT0247

FEMALE SEX AND AGE AT DIAGNOSIS ARE ASSOCIATED WITH A DECREASED POSSIBILITY OF DRUG DISCONTINUATION IN GIANT CELL ARTERITIS: DATA FROM A MULTICENTER PROSPECTIVE COHORT OF 177 PATIENTS

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Background: Giant cell arteritis (GCA) usually requires long-term therapy with corticosteroids and/or Disease Modifying Anti-rheumatic Drugs (DMARDs) but the exact factors that are associated with drug discontinuation in these patients have not been well defined.

Objectives: To evaluate the baseline or on-treatment factors that influence drug survival in GCA.

Methods: Data were derived from an ongoing, multicenter, prospective cohort study of patients with GCA. During the 1st phase of the study, data regarding demographic and clinical characteristics at baseline, type of treatment, adverse events of therapy and co-morbidities were retrospectively collected and analyzed. Predictors of drug discontinuation were examined by univariate and multivariate logistic regression analyses.

Results: One hundred and seventy seven patients were included in the study; 70% (n=120) were women with a mean age at diagnosis of 74 ± 8.4 years. Diagnosis was established by temporal artery biopsy in 127 patients (72%), ultrasound of temporal arteries in 37 patients (21%) and large vessel imaging in 10 patients (6%). At diagnosis, the median ESR and CPR were 103 mm/h and 63 mg/L, respectively. All patients were treated initially with pos corticosteroids (median daily starting dose: 41 mg), while 12 (7%) of patients received pulse steroids. At the 1st patient evaluation (median follow-up from diagnosis: 3 years), the median daily steroid dose was 5 mg, while in 34% (n= 62) and 8% (n= 14) of patients a synthetic or biologic DMARD had been added, respectively. During that period, 24% (n=43) of patients had discontinued corticosteroids and 18% (n=32) all treatments. By univariate analysis, DMARD use was associated with a higher possibility for corticosteroid discontinuation (OR=2.3, p=0.017) but by multivariate logistic regression analysis only female sex (OR=0.49, p=0.07) and age at diagnosis (OR=0.94, p=0.01) were associated with a decreased risk for corticosteroid discontinuation. Similar results were found for discontinuation of all drugs [female sex (OR=0.4, p=0.05) and age at diagnosis (OR=0.9, p=0.046)].

Conclusion: In this large GCA cohort, only one out of four patients managed to discontinue corticosteroids and 20% all treatments ~3 years after diagnosis. Multivariate analysis revealed only female sex and age at diagnosis as independent factors for treatment discontinuation.

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SAT0248

CLINICAL OUTCOMES OF PATIENTS WITH GIANT CELL ARTERITIS TREATED WITH TOCILIZUMAB IN REAL-WORLD CLINICAL PRACTICE

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Background: Previously, the GACTA study demonstrated the superiority of subcutaneous (SC) tocilizumab (TCZ) plus prednisone vs prednisone alone in achieving sustained glucocorticoid (GC)-free remission in patients with giant cell arteritis (GCA).¹

Objectives: To evaluate the effectiveness and safety of SC and intravenous TCZ in real-world clinical practice.

Methods: We performed a retrospective analysis of GCA patients treated with TCZ at a single center (MGH) between 2010-2018. Annual relapse rate, time to disease relapse, number of relapses, prednisone use, and adverse events (AE) before and after TCZ initiation were assessed. Disease relapse was defined as the re-appearance of clinical manifestations of GCA (e.g., cranial symptoms) that required treatment modification.

Results: A total of 60 GCA patients were included in the analysis. **Table 1** depicts the baseline characteristics and the treatments received by this cohort. The median (IQR) disease duration before TCZ use was 0.6 (0.2-1.6) years. Fifty-eight patients (96.7%) received concomitant prednisone (mean [SD] dose: 30 [18.3] mg daily) at the time of TCZ initiation. Patients received TCZ for a median (IQR) period of 0.5 (0.3-1.4) years. Before TCZ treatment, 43 patients (71.7%) had ≥1 relapse (median [IQR] time to relapse 0.5 [0.3-0.7] years). After TCZ initiation, 18 patients (30.0%) had ≥1 relapse (estimated median [IQR] time to relapse 2.1 [0.6-2.3] years). The annual rate of relapse was lower on TCZ than while off TCZ (RR=0.40 [95% CI, 0.25-0.63]; P=0.0001) (**Table 2**). Twenty-seven patients (46.6%) successfully tapered off prednisone during TCZ treatment. The incidence of AEs and serious AEs (SAE) was similar before and after TCZ initiation (**Table 2**). During TCZ treatment, however, 38 of 81 AEs were considered related or possibly related to prednisone. An AE led to TCZ discontinuation in 5 patients. No deaths occurred during the study period.

Conclusion: In this retrospective analysis, TCZ improved clinical outcomes in patients with GCA as indicated by a reduced incidence of relapses and by the ability to discontinue prednisone. The occurrence of AEs and SAEs (many due to GC) did not differ substantially while patients were on or off TCZ. These real-world findings support the previously reported efficacy and safety profile of TCZ in patients with GCA.

REFERENCE

[1] Stone JH, et al. N Engl J Med. 2017;377(4):317-328.

Table 1.. Patient baseline characteristics and treatments

	Total Patients (N = 60)
Age, mean (SD)	69.4 (9.4)
Female sex, n (%)	43 (71.7)
Caucasian ethnicity, n (%)	53 (88.3)
Clinical manifestations at disease onset	
Headache, n (%)	47 (78.3)
Scalp tenderness, n (%)	26 (43.3)
Jaw claudication, n (%)	31 (51.7)
Amaurosis fugax, n (%)	11 (18.3)
Transient blurry vision, n (%)	18 (30.0)
Diplopia, n (%)	2 (3.3)
PMR symptoms, n (%)	32 (53.3)
ESR (mm/hr), mean (SD)	72.6 (33.6)
CRP (mg/L), mean (SD)	76.1 (72.6)
Positive TA biopsy, n (%)	26 (43.3)
Prednisone dose (mg/day) at disease onset, mean (SD)	54 (19.0)
Use of other immunosuppressants before TCZ initiation, n (%)	15 (25)
Duration of disease before TCZ initiation (years), median (IQR)	0.6 (0.2-1.6)
Prednisone dose (mg/day) at TCZ initiation, mean (SD)	30 (18.3)
Received TCZ IV, n (%) [†]	22 (37.3)
Received TCZ SC, n (%) [†]	43 (72.9)
Duration of TCZ treatment (years), mean (SD)	0.9 (1.0)
Duration of TCZ treatment (years), median (IQR)	0.5 (0.3-1.4)

CRP, C-reactive protein; ESR, erythrocyte sedimentation rate; IV, intravenous; PMR, polymyalgia rheumatica; SC, subcutaneous; TA, temporal artery; TCZ, tocilizumab.