line matched pairs of TNFi and ABA pts, respectively, in ACPA- cohort; Table 1). In the biologic-experienced pts, ABA (vs TNFi) had a higher reduction in CDAI score (10.2 vs 5.2, $p=0.035$; Table 2). In the biologic-experienced ACPA+ pts, ABA (vs TNFi) had higher reduction in disease activity (CDAI: 13.3 vs 6.2, $p=0.023$; Table 2; SDAI: 13.9 vs 7.0, $p=0.046$). No difference in disease activity was observed between the two groups among the ACPA- pts.

Conclusion: Real-world RA registry data further confirm findings from the AMPLE study that the overall efficacy of ABA is similar to TNFi agents in biologic-naïve pts with RA. Efficacy of ABA (vs TNFi) in biologic-experienced pts is greater, and greater reductions in joint disease activity in ACPA+ ABA (vs TNFi) pts were observed.

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AB0374

ADALIMUMAB DISCONTINUATION IN PATIENTS WITH RHEUMATOID ARTHRITIS AFTER ACHIEVING SUSTAINED REMISSION

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Background: the most important factor in the progress of pharmacotherapy of RA was the widespread implementation of therapy with biological disease-modifying antirheumatic drugs (bDMARD). Recently, the issues of optimizing the management of patients have attracted more and more attention. First of all, we are talking about the possibility of reducing the dose and the abolition of bDMARD with the maintenance of remission ("biological-free remission").

Objectives: to assess whether adalimumab (AD) can be gradually discontinued during continuous methotrexate (MTX) use in patients with early rheumatoid arthritis (ERA).

Methods: Within the REMARCA (the Russian study of methotrexate and biological agents in early active arthritis) study, the investigators examined 20 patients (17 women and 3 men; median age, 51 [41.5; 56] years) with ERA (disease duration, 10 [5.5; 20] months; DAS28, 5.17 [4.37; 6.51]; 85% of the patients were seropositive for rheumatoid factor and 85% for anti-cyclic citrullinated peptide antibodies).

All the patients received subcutaneous MTX 25 mg/week. Twelve weeks after beginning therapy with MTX, due to its inefficiency, ADA was added according to the standard scheme. Clinical and laboratory data was analyzed just before the therapy (point-3 months), then at the term of 6 (n=20), 12 (n=17), 24 (n=17) and 36 (n=17) months. To assess the effectiveness of therapy, indices of activity DAS28, CDAI and SDAI were used. The everyday life functioning of the patient was assessed quantitatively using the Russian version of the HAQ questionnaire.

Results: At week 24, with the combined therapy of methotrexate and adalimumab, about 75% of patients have reached remission/low disease activity: the median DAS28 was 3.0 [1.65; 3.73]; 85% of the patients achieved remission or low disease activity. After 3 months of ADA therapy, high or moderate disease activity remained in 3 (15%) patients; median DAS28 was 4.4 [4.3; 6.1]; the drug was discontinued in them due to ineffective

therapy. After 12-month follow-up, low DAS28 scores were observed in 5 (29.4%), DAS28 remission was in 12 (70.6%) of the 17 patients who continued ADA treatment; after 24 months, all the 17 patients were noted to have remission. After achieving sustained remission (≥ 6 -month duration during ADA therapy), there was a carefully controlled reduction (titration) in the dose of ADA with its complete discontinuation, by maintaining remission at 36-month follow-up; the median DAS28 was 1.6 [1.4; 2.2].

The disease duration up to 1 year and functional class reduction to I in the first year of observation (or=46.2; 95% CI 1.870-1141,178; $P=0.019$ and or=44.2; 95% CI 1,795-1088,143; $P=0.02$) were identified as predictors of maintaining long-term remission after the discontinuation of ADA. RF positivity and the presence of erosion initially determined the impossibility of ADA withdrawal. (fig.1)

Figure 1. Influence of different factors on the possibility of withdrawal of ADA in patients with RA in remission.

Remission maintenance

Conclusion: In most patients with early rheumatoid arthritis, early induction of remission can be maintained after stopping the biologic therapy, under condition that the therapy was carried out by a combination of bDMARD and methotrexate. The maintenance of remission after discontinuation of ADA therapy was influenced by the duration of the disease and the depth of remission.

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AB0375

HYPOGAMMAGLOBULINEMIA AFTER RITUXIMAB TREATMENT IN PATIENTS WITH RHEUMATOID ARTHRITIS IS NOT RARE AND IS ASSOCIATED WITH BETTER RESPONSE

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Background: Rituximab (RTX) is used as a second line treatment in rheumatoid arthritis (RA), with well-established efficacy. One of the most common adverse events of RTX use is hypogammaglobulinemia (HGG).

Objectives: To define, in RA patients treated with Rituximab, the frequency of HGG (IgG<700mg/dL or IgM<40mg/dL or IgA<70mg/dL) and to identify associations between its occurrence and clinical, epidemiological and other disease related features at baseline, RA outcomes and adverse events.

Methods: The patients received RTX for RA in two rheumatology centers from 1/2007 to 12/2018 were included. Demographical, clinical and laboratory parameters were recorded at baseline and at the last visit of the follow-up. Time of follow-up was defined as the time interval between the first RTX infusion and the last visit. Patients with monoclonal gammopathy and patients that received only one cycle of treatment were excluded. Severe infections were recorded defined as those which required hospitalization or antibiotics intravenously. Binomial regression analysis using stepwise backwards model having as dependent variables the "low IgG" or "low IgM" and independent variables: gender, age,