Objectives: This post hoc analysis aimed to provide information on the effect of tofacitinib 5 mg BID on laboratory values in PsA and RA patients.

Methods: For analysis of pts with active PsA treated with tofacitinib 5 mg BID, data were pooled from 2 Phase 3 studies and an ongoing long-term extension (LTE) study (data cut-off, 25 January 2017; database not locked; data may change). For analysis of pts with moderate or severe RA treated with tofacitinib 5 mg BID, data were pooled from 8 Phase 2, 7 Phase 3, and 1 LTE studies (data cut-off, 2 March 2017; for LTE, database not locked; data may change). All PsA and most RA pts received a background conventional synthetic disease-modifying antirheumatic drug. Data (to Month 12) for pts receiving constant tofacitinib 5 mg BID were evaluated, comprising pts who received tofacitinib 5 mg BID across studies, either at randomisation or following switch from placebo. Pts in the placebo groups who switched to tofacitinib 5 mg BID at Month 3 were included from the time they first received tofacitinib. Pts who switched tofacitinib dose were excluded. Change from baseline in haematologic (haemoglobin, neutrophils, lymphocytes) and lipid (low-density lipoprotein cholesterol, high-density lipoprotein cholesterol, total cholesterol, triglyceride) levels and key liver tests (bilirubin, alanine aminotransferase, aspartate aminotransferase, alkaline phosphatase, creatinine kinase, creatinine and C-reactive protein levels were also assessed. Pts meeting protocol-defined discontinuation criteria for laboratory values were evaluated.

Results: The constant tofacitinib 5 mg BID group comprised 348 PsA pts and 3040 RA pts. Mean (standard error) changes/percentage changes from baseline for laboratory values are presented in the table. Laboratory values generally stabilised after 1 to 3 months, and lymphocyte levels stabilised by 24 months (data not shown). In both PsA and RA, ≤30% of patients met discontinuation criteria for any laboratory value.

Conclusion: In this post hoc analysis of laboratory data with tofacitinib 5 mg BID, changes in key laboratory values were similar for PsA and RA, and discontinuations due to protocol criteria being met for laboratory values were infrequent. These results provide further information on the effect of tofacitinib on laboratory values in PsA and RA.

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Table 1: Changes in selected haematologic and lipid values. For key liver tests and creatinine, creatinine kinase values and creatinine levels stabilised by 24 months and were not shown. In both PsA and RA, ≤30% of patients met discontinuation criteria for any laboratory value.


AB0441 THERAPY WITH TOFACITINIB IN A COLOMBIAN POPULATION WITH RHEUMATOID ARTHRITIS: RESULTS OF THE DAILY CLINICAL PRACTICE

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Background: Rheumatoid arthritis (RA) is a chronic inflammatory disease that affects the quality of life and reduces life expectancy. It is characterized by the presence of autoantibodies and erosive synovitis that mainly involves small joints (1). Tofacitinib is the first oral Janus Kinase (JAK) inhibitor approved in 2012 for the treatment of patients with active, moderate to severe RA that does not respond to other therapies (2).

Objectives: The objective was to describe demographic and clinical results of a cohort of Colombian patients with RA treated with tofacitinib.

Methods: Descriptive observational study of a historical cohort of RA patients in a specialized center for the management of inflammatory arthropathies, from April 2014 to February 2018. The following variables were described: age, sex, time evolution of the disease, type of AR, comorbidities, disease activity (DAS-28), schedule and treatment time. For the descriptive analysis, categorical variables are presented as absolute and relative frequencies; while continuous variables are presented as mean and standard deviation (SD) or median and interquartile range (IQR) according to distribution. The outcome of DAS 28 ≤ 3 was estimated by incidence rate, defined as the number of patients who presented the outcome divided by the summation of total exposure time of the patients.

Results: Of 59 patients included, 88.1% (52) were women, with a median age of 58.8 years (IQR 49-68 years), 74.6% were seropositive, the median time from diagnosis was 18.2 years (IQR 12-28.3 years). High blood pressure was the most common comorbidity (40.7%) and 7% had tuberculosis history. The median number of bDMARD prior to tofacitinib was 2 (IQR 1-3). Sixty percent patients (39) were on monotherapy while 34% (20) were on combination with leflunomide (19) and methotrexate (1). The median time of treatment was 1.2 years (IQR 0.6-2 years). At the beginning, 84.7% patients (50) were in moderate or high disease activity and 15.3% (9) in remission or low activity; at the end of follow-up, 47.5% (28) were in remission or low activity and 52.5% (31) in moderate or high activity (p = 0.000). The mean DAS28 at the beginning of tofacitinib was 4.6 ± 1.55 and at the end of the follow-up was 3.5 ± 1.92, with a difference of means of 1.10 (IC95% 0.62-1.57), (p = 0.000). During the follow-up period, the rate of development of remission or low activity was 11.92 (95% CI 8.35-16.51) cases per 100 people-month observed (p = 0.000). Only 2 patients developed therapeutic failure.

Conclusion: Tofacitinib shows a good profile of effectiveness in patients with failure to prior bDMARD. Almost 50% patient reaches low disease activity or remission during follow up and low number of therapeutic failure was found.

REFERENCES
