
**Background:** Intestinal Lung Disease (ILD) is a severe complication of Rheumatoid Arthritis (RA). Several conventional disease-modifying anti-rheumatic drugs (cDMARDs) and biologic (b) DMARDs may induce or impair ILD-RA. Abatacept (ABA) may be useful in ILD-RA (1).

**Objectives:** To assess the efficacy and safety of ABA in a large series of ILD-RA patients for a long-term follow-up.

**Methods:** Multicenter open-level study of ILD-RA treated with at least dose of ABA. ILD was diagnosed by high-resolution computed tomography (HRCT).

We study these outcomes: a) 1-point change Modified Medical Research Council (MMRC); b) forced vital capacity (FVC) and/or DLCO improvement or decline ≥10%; c) change in HRCT; d) change in DAS28. 

**Results:** We studied 263 patients (150 women/113 men) (mean age 64.6 ± 10 years), with ILD-RA. At ABA onset they were smokers or ex-smoker (53.8%), positive APCC (88.6%), median [IQR] duration of ILD of 12 [3-41.25] months, mean DAS28 (65.7 ± 18.3) and FVC (85.9 ± 21.8).

The ILD-pattern were usual interstitial pneumonia (UIP) (40.3%), non-specific interstitial pneumonia (NSIP) (31.9%) and others (27.8%). ABA was prescribed at standard subcutaneous (125 mg/w) in 196 (74.5%) or intravenously (10 mg/kg/w) in 67 (25.5%); in monotherapy (n=111) or combined with cDMARDs (n=152); especially leflunamide (n=55), MTX (n=46), or antimalarials (n=21).

After a mean follow-up of 22.7 ± 19.7 months most outcomes remain stable (Figure). Moreover, DAS28 improved from 4.5 ± 1.5 to 3.1 ± 1.3; prednisone dose reduced from a median 7.5 [5-10] to 5 mg [5-7.5] and retention rate was 76.4%.

The main adverse effects were serious infections (n=28), neoplasia (n=3), serious infusion reaction (n=1) and myocardial infarction (n=1).

**Conclusion:** ABA seems effective and relatively safe in ILD-RA.


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**Conclusion:** Glucocorticoid steroid (GC) use among patients with arthritis is common. The introduction of TNF inhibitors (TNFi) has been a breakthrough in the treatment of arthritis leading to remission for many patients. However, there is scarce information on the impact of TNFi on the use of GC among patients with inflammatory joint diseases.

**Objectives:** To explore oral GC use in patients with rheumatoid arthritis (RA), psoriatic arthritis (PsA), and axial spondyloarthritis (axSpA) before and after the initiation of TNFi therapy. Furthermore, to evaluate if patients on long term GC treatment were receiving active preventive osteoporosis treatment and how treatment with TNFi affected the use of topical steroids in patients with PsA.

**Methods:** Clinical data on patients with RA, PsA and axSpA who initiated TNFi therapy with etanercept, infliximab, adalimumab or golimumab for the first time between 2005-2015 was collected from the ICEBIO registry. ICEBIO is a nationwide registry on all patients treated with biologics for rheumatologic disorders in Iceland. The use of oral GC, topical steroids and bisphosphonates was collected from the Icelandic Prescription Medicines Registry (IPMR) for a period of four years, two years before and after the initiation of TNFi. Medication use was then evaluated by counting the number of individuals receiving a medication in a given year, the total number of prescriptions, and the defined daily dose (DDD). Five controls were randomly selected from IPMR and matched on age, sex and time frame.

**Results:** 621 patients with RA, PsA or axSpA received 2630 prescriptions (4.2 prescription per patient; 3105 controls received 1337 prescriptions or