Table 2.

<table>
<thead>
<tr>
<th>Disease-modifying drug</th>
<th>&lt;70 years old</th>
<th>≥70 years old</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methotrexate</td>
<td>72 (53.73%)</td>
<td>9 (40.91%)</td>
<td>0.667</td>
</tr>
<tr>
<td>Leflunomide</td>
<td>22 (16.42%)</td>
<td>5 (22.73%)</td>
<td></td>
</tr>
<tr>
<td>Sulfasalazine</td>
<td>2 (1.49%)</td>
<td>1 (4.55%)</td>
<td></td>
</tr>
<tr>
<td>Hydroxychloroquine</td>
<td>6 (4.48%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>At least two of the above</td>
<td>7 (5.22%)</td>
<td>1 (4.55%)</td>
<td></td>
</tr>
</tbody>
</table>

Conclusion: DMARD concomitant treatment has been related to a higher second biological treatment survival. This beneficial effect was not observed in RA patients ≥70 years of age whose second biological agent withdrawal cause was failure. In this age group, withdrawal related to adverse events was more frequent.

References:

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.4979

AB0280

SURVIVAL ANALYSIS ON SECOND BIOLOGIC THERAPY IN PATIENTS WITH RHEUMATOID ARTHRITIS OLDER THAN 65 YEARS

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Background: Patients with Rheumatoid Arthritis (RA) ≥65 years old constitute an important and not very well studied group. Even though the course of the disease may be similar to that of younger patients, treatment is usually less aggressive given the limited information on efficacy, especially of biological treatments, in this age group.

Objectives: To describe the characteristics of patients with RA ≥65 years old who started a second biological agent. To compare the survival of this second-line treatment between patients ≥65 and <65 years old.

Methods: Retrospective, observational and longitudinal study. Patients diagnosed of RA, who started a second biological agent between 2000 and 2019, who discontinued a first-line TNF inhibitor, were included. Demographic, clinical and analytical data were obtained. The sample was divided in 2 groups: <65 and ≥65 years old. Kaplan Meier and Log-rank survival analysis were performed, as well as Cox regression to identify related factors.

Results: 157 patients were identified, 42 (26.8%) were ≥65 years old. In this group, 73.8% were women, with a mean age at the beginning of second biological treatment of 71.43±4.76 years. Demographic and clinical data of ≥65 years old patients are shown in the table. The most frequent second biological agent was Rituximab (23.8%), followed by Adalimumab (21.4%) and Tocilizumab (19%). 76.2% of patients had a disease-modifying drug associated, being Methotrexate the most frequent (45.2%). Discontinuation of second biological agent occurred in 30 patients (71.42%) ≥65 years old, which is similar to the percentage found in patients <65 to the old (66.96%; p=0.70). The main causes of withdrawal of second-line agent in patients ≥65 years old were adverse effects (23.8%) and secondary failure (23.8%), whereas in <65 years were primary and secondary failure (18.3%) in both. Infections were more frequent in patients ≥65 years (14.3%) in comparison with patients <65 years (6.1%). In the survival analysis of the second biological agent, patients ≥65 years presented a median survival of 45 months (IC-95%=14.10-75.99); while patients <65 years had a median survival of 47 months (IC-95%=29.55-64.46), without statistically significant differences (p=0.803) (See Figure).

Among elderly patients no statistically significant differences were found after comparison of survival curves in the subgroups: 65-69, 70-74 and ≥75 years. Rituximab presented a higher survival rate in patients ≥65 years (84.3 months; p<0.001), followed by Abatacept (58.6 months). Smoking (HR=13.96; IC-95%=12.91-93.93), erosions (HR=7.04; IC-95%=1.05-47.31) and diabetes mellitus (HR=13.37; IC-95%=1.25-143.46) were identified as risk factors for discontinuation of second biological agent.

Conclusion: The survival of second biological agent after the failure of a first TNF inhibitor in patients ≥65 years is similar to the survival in younger patients, although there was a higher percentage of adverse effects in the first group. Rituximab and Abatacept showed a higher survival in patients ≥65 years. Smoking, erosions and diabetes mellitus were associated with an increased risk for the withdrawal of the second-line biological therapy.

References:

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.4911

AB0281

SAFETY AND RETENTION RATE AFTER SWITCHING FROM ETANERCEPT ORIGINATOR (ETN) TO ETANERCEPT BIOSIMILAR (SB4) IN INFLAMMATORY JOINT DISEASES: DATA FROM REAL LIFE.

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Background: SB4 in now commonly used in the treatment of inflammatory joint diseases, with evidence of efficacy and persistence up to 12 months from switching in both randomized controlled trials in Rheumatoid Arthritis (RA), Psoriatic Arthritis (PsA) and Ankylosing Spondylitis (AS).

Objectives: we investigated the safety and retention rate of SB4 at 6, 12 and 18 months after switching from ETN in two rheumatology departments in our region.

Methods: adult patients with RA, PsA, AS, Juvenile Idiopathic Arthritis (JIA) and other rheumatic diseases treated with ETN for at least 6 months, switched to SB4 in stable clinical conditions, were eligible for this retrospective evaluation. Data on adverse events (in particular infectious events), loss of efficacy (articular, cutaneous, ocular or intestinal disease re-activation) and persistence on treatment were collected since latest available follow-up. Retention rate, reason for discontinuation and subsequent management data were collected at 6, 12, 18 months.

Results: 220 patients (142 females, mean age 56±7 years, disease duration 12±4 years, ETN duration 7±4 years) were enrolled, with median follow up of 12.1 (9.7-15.8) months duration; ETN was used in different biologic DMARDs treatment lines (first 78.8%, second 177%, third 3.2 %, fourth 2.3%). Study
population was composed of 85 RA, 81 PsA, 33 AS, 14 JIA and 7 other conditions (mostly sclerodermia). In the follow-up, 50 patients (22.7%) presented with at least one non-serious adverse event, with 36 (16.4%) disease re-activation (mostly seropositive) and 30 (13.5%) died and 11 for safety and 19 loss of efficacy SB4 interruptions. Retention rates were 99.1 (210/212) at 6, 90.9% (150/165) at 12 and 81.5% (53/65) at 18 months respectively. Back-switch to ETN was performed in 17/30 cases, the remaining cases were managed with change of bDMARD or csDMARD). Age was the only significant predictor of SB4 interruption at 6 months (OR 1.058, 95%CI 1.007-1.112, p=0.026), while disease, bDMARD line, csDMARD combination, gender, disease duration or ETN duration did not influence retention rates at 6, 12 or 18 months.

Conclusion: our real-life data confirm the safety profile of switching from ETN to SB4. In our patients, the data show a higher retention rate, when compared to other real-life registries data (1,2)

References:

Disclosure of Interests: Cosimo Bruni Speakers bureau: Actelion, Eli Lilly, Stefano Gentilescu: None declared, Marco Capassoni: None declared, Giovanni Pacini: None declared, Marco Bardelli: None declared, Caterina Baldi: None declared, Lorenzo Tofani: None declared, Laura Comiti: None declared, Francesca Nacci: None declared, Francesca Bartoli: None declared, Ginevra Fiori: None declared, Luca Cantarini: None declared, Serena Guiducci: None declared, Bruno Frediani: None declared, Marco Matucci-Cerinic Grant/research support from: Actelion, MSD, Bristol-Myers Squibb, Speakers bureau: Actelion, Lilly, Boehringer Ingelheim DOI: 10.1136/annrheumdis-2020-eular.1948

AB0283

CLINICAL EFFECTIVENESS OF ABATACEPT MONOTHERAPY OR ABATACEPT CONCOMITANT METHOTREXATE THERAPY IN RHEUMATOID ARTHRITIS PATIENTS PREVIOUSLY TREATED WITH BIOLOGICAL DISEASE-MODIFYING ANTIRHEUMATIC DRUGS (BDMARDS)

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Background: Concomitant use of methotrexate (MTX) in abatacept (ABA) therapy is associated with good clinical response in patients with rheumatoid arthritis (RA) who are naïve to biological disease-modifying antirheumatic drugs (bDMARDs). However, it is unclear when abatacept is used in patients with prior bDMARDs use.

Objectives: We compared the effectiveness of abatacept monotherapy versus abatacept combined with methotrexate therapy in rheumatoid arthritis patients with prior bDMARDs use.

Methods: Retrospective cohorts study. Rheumatoid arthritis patients treated with abatacept from 2009 and 2019 (n=86). Socio-demographic, clinical and pharmacological characteristics of patients were collected. We compared clinical effectiveness between ABA monotherapy patients (n=49) and abatacept concomitant methotrexate therapy patients (n=37), prior treated with bDMARDs. The effectiveness was measured according to The European League Against Rheumatism (EULAR) response with Disease Activity Score (DAS28) like satisfactory (DAS28<3.2) or unsatisfactory (DAS28>3.2), after 12 months of ABA therapy in RA patients.

Results: 49 RA patients have been evaluated in ABA monotherapy group; 83.67% (41/49) were women, disease duration was 16 (10-22) years and age of RA diagnosis was 48 (38.25-57.00). Concomitants glucocorticoids were administrated in 81.63% (40/49). Rheumatoid factor (RF) was positive in 75.11% (37/49) patients and cyclic citrullinated peptide antibodies (ACPA) in 71.43% (35/49). At 12 months, 40.82% (20/49) of patients had satisfactory EULAR response.

In the combination therapy group, the age of RA diagnosis was 42.5 (35.75-53.50), 75.68% (28/37) were women and the disease duration was 12 (7-21) years. 89.19% (33/37) had concomitants glucocorticoids and the RF was positive in 72.97% (27/37) of patients. EULAR response was satisfactory at 12 months in 43.24% (16/37) of patients. No difference in treatment effectiveness was found in patients receiving abatacept in combination therapy with MTX compared with ABA monotherapy (p=0.829; ICCp=0.35-2.35).

Conclusion: Abatacept plus methotrexate therapy did not improve the effectiveness in rheumatoid arthritis patients with prior bDMARDs use, compared with abatacept monotherapy.

References:

Table 1. Baseline demographic and clinical characteristics of the patients in remission or low disease activity.

<table>
<thead>
<tr>
<th>NO TAPERING (n=41)</th>
<th>TAPERING (n=40)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (yrs)</td>
<td>57±11</td>
<td>58±13</td>
</tr>
<tr>
<td>Mean disease duration (yrs)</td>
<td>12±9</td>
<td>12±7</td>
</tr>
<tr>
<td>Starting bDMARD to tapering/monitoring (months)</td>
<td>52±45</td>
<td>67±41</td>
</tr>
<tr>
<td>Mean monitoring period (months)</td>
<td>22±24</td>
<td>19±23</td>
</tr>
<tr>
<td>Taking bDMARD at any time (n (%))</td>
<td>40 (98%)</td>
<td>37 (92%)</td>
</tr>
<tr>
<td>Taking glucocorticoids</td>
<td>29 (71%)</td>
<td>28 (70%)</td>
</tr>
<tr>
<td>Mean prednisone dose (mg/day)</td>
<td>2.5±2.9</td>
<td>2.1±2.7</td>
</tr>
<tr>
<td>DAS28 at the time of tapering or first LDA/REM</td>
<td>2.3±0.8</td>
<td>2.3±0.9</td>
</tr>
<tr>
<td>Previous bDMARDs x1 (n (%))</td>
<td>10 (24.4%)</td>
<td>4 (10%)</td>
</tr>
</tbody>
</table>