population was composed of 85 RA, 81 PsA, 33 AS, 14 JIA and 7 other conditions (mostly scleroderma). 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 articular) and 30 (13.6% - 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)

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Disclosure of Interests: Cosimo Bruni Speakers bureau: Actelion, Eli Lilly, Stefano Gentileschi: None declared, Marco Capassoni: None declared, Giovanni Pacini: None declared, Marco Bardelli: None declared, Caterina Baldi: None declared, Lorenzo Tofani: None declared, Laura Cometi: 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

AB0282

CLINICAL EFFECTIVENESS OF ABACEPT MONOTHERAPY OR ABACEPT 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)^{1,2}. However, it is unclear when abatacept is used in patients with prior bDMARDs use³.

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 between 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 administered in 81.63% (40/49). Rheumatoid factor (RF) was positive in 75.51% (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 ($p=0.829$; $IC_{95}=0.35-2.35$).

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

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.6047

AB0283

REDUCED HOSPITAL ADMISSION IN RA PATIENTS TAPERING BIOLOGIC DMARDs: PRELIMINARY ANALYSIS OF A RETROSPECTIVE STUDY

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Background: bDMARDs are among the most effective therapies in the management of inflammatory arthritides, but they are associated with potentially severe adverse events (AEs), particularly infection. Tapering strategies of bDMARDs for patients in remission/low disease activity (R/LDA) have demonstrated comparable efficacy to standard-dose treatments, but their safety profile has not been studied yet.

Objectives: To compare the number and the causes of hospital admissions in RA patients in R/LDA continuing or tapering bDMARDs.

Methods: Consecutive patients with rheumatoid arthritis (RA) evaluated between 2011 and 2017, were assigned, based on treating physician's discretion, to continue the standard dose (STD) of bDMARDs or to undergo a predetermined tapering strategy (TAP), after being in R/LDA for two consecutive visits at least 3 months apart. Down-titration of bDMARDs was obtained by a stepwise increase of the dosing interval to achieve a reduction of about 30% (e.g. administration of etanercept every 10 days instead of weekly). Demographic, clinical data and concomitant treatments were retrospectively retrieved from the electronic charts of the outpatient clinics. Information about hospital admissions, including main diagnosis, period and duration of hospitalization, and death were retrieved from the Regional Healthcare System Database.

For the STD group, the observation period started with the occurrence of remission and finished with one of these events: loss of remission, switch to another bDMARD, withdrawal of the bDMARD, severe AE, death, end of the study period in (December 2017). For the TAP group, the observation period started with tapering onset and finished with one of these events: reduction of the dosing interval due to either a relapse (according to a DAS28 increase) or to a subjective, symptomatic relapse (according to the patient's definition), switch to another bDMARD, withdrawal of the bDMARD, severe AE, death, end of the study period in (December 2017).

Results: 81 patients were included, of whom 40 underwent TAP. Demographic, clinical and treatment data are shown in table 1. Baseline characteristics were comparable between the two groups, except for the number of previous bDMARDs before observational period entry that was slightly higher in the STD group (STD 1.0±0.9 versus TAP 0.5±0.8, $P=0.11$).

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

	NO TAPERING (n=41)	TAPERING (n=40)	p value
Mean age (yrs)	57±11	58±13	0.563
Mean disease duration (yrs)	12±9	12±7	0.897
Starting bDMARD to tapering/monitoring (months)	52±45	67±41	0.128
Mean monitoring period (months)	22±24	19±23	0.632
Taking sDMARD at any time ((n (%))	40 (98%)	37 (92%)	0.359
Taking glucocorticoids	29 (71%)	28 (70%)	0.999
Mean prednisone dose (mg/day)	2.5±2.9	2.1±2.7	0.527
DAS28 at the time of tapering or first LDA/REM	2.3±0.8	2.3±0.9	0.863
Previous bDMARDs >1 (n (%))	10 (24.4%)	4 (10%)	0.140