glucocorticoid induction regimen, or relapse severity) had a significant differential effect on the primary outcome. By 24 months after entry, 20 months after randomization, 11/85 (13%) patients in the RTX group had experienced a relapse compared to 32/85 (38%) patients in the AZA group. 19/85 (22%) patients in the RTX group and 31/85 (36%) patients in the AZA group experienced at least one severe adverse event (SAE), 25/85 (29%) and 42/85 (49%) patients in the RTX group developed hypogammaglobulinemia (IgG <5g/l) and non-severe infections respectively, compared to 21/85 (25%) and 41/85 (48%) in the AZA group.

Methods: At the end of part 1, patients entered open-label part 2, in which GCA therapy (including initiation/termination of open-label TCZ and/or GCs) was given at the investigator’s discretion according to disease status. Time to first GCA flare during the 3-year study period was assessed using Kaplan-Meier analysis for patients in the intention-to-treat population according to disease onset status at baseline (new-onset/relapsing) based on their originally assigned treatment groups: TCZ QW, TCZ Q2W, or pooled PBO (PBO+26-week and PBO+52-week prednisone taper).

Results: Among patients randomly assigned in part 1, 47 of 100 (47%) in the TCZ QW group, 26 of 49 (53%) in the TCZ Q2W group, and 46 of 101 (46%) in the pooled PBO group had new-onset GCA at baseline; the rest had relapsing GCA. Median time to first flare over 3 years was longer for patients assigned to TCZ treatment in part 1 than for patients assigned to PBO; Kaplan-Meier analysis showed a clear separation between the TCZ QW and the pooled PBO groups over 3 years for patients with new-onset and relapsing GCA (Figure 1A). Separation between the TCZ QW and TCZ Q2W groups was also observed over 3 years in patients with new-onset and relapsing GCA although this was more evident in patients with relapsing GCA (Figure 1B). Higher proportions of patients in the TCZ QW group (new-onset, 49%; relapsing, 47%) than the pooled PBO group (new-onset, 28%; relapsing, 31%) and the TCZ Q2W group (new-onset, 27%; relapsing, 35%) remained flare-free during their entire treatment period. Cumulative prednisone dose over 3 years was lower for patients originally assigned to TCZ QW versus those originally assigned to PBO for patients with new-onset GCA and those with relapsing GCA at baseline (Figure 2).

Conclusion: In this 3-year analysis of GiACTA parts 1 and 2, time to first flare favored TCZ QW over TCZ Q2W in patients with new-onset and relapsing GCA. TCZ QW delayed time to first flare and resulted in lower cumulative GC exposure compared with PBO in patients with new-onset and relapsing GCA, supporting TCZ QW dosing in patients with GCA regardless of disease onset.

References:

Figure 1. Relapse-free survival in RITAZAREM trial: rituximab versus azathioprine

Conclusion: In the RITAZAREM trial, following induction of remission with RTX, RTX was superior to AZA for preventing disease relapse in patients with AAV with a prior history of relapse. There were no new major safety signals for use of these medications in this population.

Disclosure of Interests: Rona Smith Grant/research support from: Roche, David Jayne Grant/research support from: ChemoCentryx, GSK, Roche/Genentech, Sanofi-Genzyme, Consultant of: Astra-Zeneca, ChemoCentryx, GSK, InflaRx, Takeda, Insmed, Chugai, Boehringer-Ingelheim, Peter A. Merkel Grant/research support from: AstraZeneca, Bristol-Myers Squibb, Boehringer-Ingelheim, Celgene, ChemoCentryx, Genentech/Roche, Genzyme/Sanofi, GlaxoSmithKline, InflaRx, Kypha, TerumoBCT., Consultant of: AbbVie, AstraZeneca, Biogen, Bristol-Myers Squibb, Boehringer-Ingelheim, Celgene, ChemoCentryx, Genentech/Roche, Genzyme/Sanofi, GlaxoSmithKline, InflaRx, Insmed, Janssen, Sparrow, Kiniksa. DOI: 10.1136/annrheumdis-2020-eular.2717

Figure 2. Cumulative Prednisone Dose Over 3 Years: TCZ QW Versus PBO groups

Disclosure of Interests: John H. Stone Grant/research support from: Roche, Consultant of: Roche, Helen Spotswood Shareholder of: Roche Products Ltd, Employee of: Roche Products Ltd, Sebastian Unzony Grant/research support from: Genentech, Inc., Martin Aringer Consultant of: Boehringer Ingeheim, Roche, Speakers bureau: Boehringer Ingeheim, Roche, Daniel Blockmans Consultant of: yes, Speakers bureau: yes, Elisabeth Brouwer Consultant of: Roche (consultancy fee 2017 and 2018 paid to the UMC), Speakers bureau: Roche (2017 and 2018 paid to the UMC), Maria C. Did Speakers bureau: Roche, Bhashkar Dasgupta Grant/research support from: Roche, Consultant of: Roche, Sanofi, GSK, BMS, AbbVie, Speakers bureau: Roche, Jürgen Rech Consultant of: BMS, Celgene, Novartis, Roche, Chugai, Speakers bureau: AbbVie, Biogen, BMS, Celgene, MSD, Novartis, Roche, Chugai, Pfizer, Lilly, Carlo Salvanari: None declared, Robert Spierta Grant/research support from: Roche-Genetech, GSK, Boehringer Ingeheim, ChemoCentryx, Corbus, Forbius, Sanofi, Inflaxx, Consultant of: Roche-Genetech, GSK, CSL Behring, Sanofi, Janssen, ChemoCentryx, Forbius, Mitsubushi Tanabe, Min Bao Shareholder of: Roche, Employee of: Genentech. DOI: 10.1136/annrheumdis-2020-eular.1538
Background: Oral ulcer (OU) associated with Behçet’s syndrome are often painful, may interfere with the ability to eat and can negatively affect quality of life.1,2 Apremilast (APR), an oral phosphodiesterase 4 inhibitor, demonstrated efficacy in the treatment of OU associated with Behçet’s syndrome in a phase III, multicenter, randomized, double-blind, placebo (PBO)-controlled study (RELIEF; BCT-002).3

Objectives: To describe the efficacy of APR treatment in improving OU pain associated with Behçet’s syndrome in RELIEF.

Methods: Patients were randomized (1:1) to APR 30 mg twice daily (APR 30 BID) or PBO twice daily for a 12-week PBO-controlled phase, followed by a 52-week active treatment extension. Eligible patients were ≥18 years of age and had active Behçet’s syndrome with ≥3 OU at randomization or ≥2 OU at screening and randomization and without active major organ involvement. Clinical improvement in OU was evaluated by the area under the curve for the number of OU through Week 12 (AUC12w, primary efficacy endpoint) and by assessments of OU number. Patient-reported OU pain was evaluated by the 100-mm visual analogue scale (VAS). The statistical tests were 2-sided (α=0.05). The proportions of patients achieving the minimal clinically important difference (MCID) and higher rates of improvement, defined as ≥10-mm, ≥30-mm (3-fold MCID), ≥50-mm (5-fold MCID) improvements in OU pain VAS scores, respectively, were analyzed through Week 12. An ANCOVA model was used to analyze the primary endpoint and assessments of OU number and OU pain (VAS). The proportion of patients achieving improvement in OU pain VAS scores at Week 12 were summarized descriptively.

Results: A total of 207 patients were randomized and received ≥1 dose of study medication (APR: n=104; PBO: n=103). At baseline, the mean (SD) number of OU was 4.2 (3.7) in the APR 30 BID group and 3.9 (2.7) in the PBO group, and the mean (SD) OU pain VAS scores were 61.2 (27.6) and 60.8 (26.9), respectively. At Week 12, significantly greater improvements were observed with APR 30 BID vs. PBO in AUC12w (least-squares [LS] mean [SE]: 129.5 [15.9] vs. 222.1 [15.9]; P<0.0001), number of OU (LS mean [SE]: 1.1 [0.2] vs. 2.0 [0.3]; P=0.0003) and OU pain VAS scores (LS mean [SE] change from baseline: −40.7 [3.3] vs. −15.9 [3.3]; P<0.0001). The proportion of patients who achieved the MCID of ≥10-mm improvement in OU pain VAS scores at Week 12 was greater with APR 30 BID vs. PBO; this pattern was also observed for the higher 3- and 5-fold improvements in MCID (Figure 1). Greater proportions of APR 30 BID vs. PBO patients achieved ≥10-mm and ≥30-mm improvements in OU pain VAS scores over 12 weeks. Notably, greater achievement of ≥50-mm improvement in OU pain VAS scores was observed with APR 30 BID vs. PBO as early as Week 1 and maintained up to Week 12 (Figure 2).

Conclusion: For patients with active Behçet’s syndrome, APR 30 BID provided significantly greater improvements vs. PBO in OU number and OU pain at Week 12, including the greater proportion of patients achieving MCID and 3- and 5-fold MCID of OU pain in the APR 30 BID group vs. the PBO group. These results indicate a clinically meaningful treatment effect of APR 30 BID vs. PBO in the OU associated with Behçet’s syndrome.

References:

Figure 1. Proportion of Patients Achieving Improvements in OU Pain VAS at Week 12

<table>
<thead>
<tr>
<th>Improvement From Baseline in OU Pain VAS (0-100 mm)</th>
<th>APR 30 BID (n=104)</th>
<th>PBO (n=103)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤10 mm</td>
<td>77.9%</td>
<td>48.5%</td>
</tr>
<tr>
<td>10-30 mm</td>
<td>74.0%</td>
<td>42.7%</td>
</tr>
<tr>
<td>30-50 mm</td>
<td>67.3%</td>
<td>36.9%</td>
</tr>
</tbody>
</table>

Figure 2. Proportion of Patients Achieving ≥50-mm Improvements in OU Pain VAS after 12 Weeks

<table>
<thead>
<tr>
<th>Week</th>
<th>APR 30 BID (%)</th>
<th>PBO (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>77.9</td>
<td>48.5</td>
</tr>
<tr>
<td>2</td>
<td>74.0</td>
<td>42.7</td>
</tr>
<tr>
<td>3</td>
<td>67.3</td>
<td>36.9</td>
</tr>
</tbody>
</table>

Disclosure of Interests: Gülern Hatemii Grant/research support from: BMS, Celgene Corporation, Silk Road Therapeutics – grant/research support, Consultant of: Bayer, Eli Lilly – consultant, Speakers bureau: AbbVie, Mustafa Nevzat, Novartis, UCB – speaker, Alfred Mahr Consultant of: Celgene, Speakers bureau: Roche, Chugai, Mitsubishi Tanabe speakers bureau: Eisi, Tanabe-Mitsubishi – speaker; Celgene Corporation – advisory board, Dongyoung Kim: None declared, Melike Melikoglu: None declared, Sue Chae Flynn Royers: speaker; Celgene Corporation – employment – consultation of study conduct, Shannon McCue Employee of: Amgen Inc. – employment; Celgene Corporation – employment at the time of the study conduct, Sven Richter Employee of: Amgen Inc. – employment; Celgene Corporation – employment at the time of study, Michelle Brunori Employee of: Amgen Inc. – employment; Celgene Corporation – employment at the time of study conduct, Maria Parisi Employee of: Amgen Inc. – employment; Celgene Corporation – employment at the time of study conduct, Yusuf Yaziçi Consultant of: BMS, Celgene Corporation, Genentech, Sanofi – consultant, Consultant of: BMS, Celgene Corporation, Genentech, Sanofi – consultant

DOI: 10.1136/annrheumdis-2020-eular.2908

Disclosure of Interests: P. Rutherford1, D. Götte1.1Vifor Pharma, Medical Affairs, Zurich, Switzerland

Background: After successful remission induction, ANCA associated vasculitis (AAV) is a relapsing remitting long term condition and patients are at risk of organ damage from both active AAV and therapy in particular glucocorticoids (GC). The remission maintenance phase of AAV is critical for preventing relapse and ensuring organ protection.

Objectives: This retrospective study aimed to examine the definition of maintenance start, therapy used and clinical outcomes in patients managed in routine clinical practice.

Methods: 1478 AAV patients (France, Germany, Italy, Spain and UK) managed by 493 physicians (37% Rheumatologists) who completed induction therapy for AAV and initiated maintenance treatment between 2014-2016 were studied. Data were collected at the time maintenance was determined to begin by the physician and then at 6, 12, 18 and 36 months.

Results: 49% had granulomatosis with polyangiitis; mean age 54.2 years with 56% male. 49% had incident AAV and 51% were studied from a relapse. 70% received cyclophosphamide and GC and 30% received rituximab and GC. Physicians defined time of the start of maintenance from induction treatment start with mean of 5.7 months on basis of fixed time point 40%, starting new drug for maintenance 26%, reaching full remission 26% and no specific criteria 8%. At this time 43% were in full remission 26% and no specific criteria 8%. At this time 43% were in full remission 26% and no specific criteria 8%. At this time 43% were in full remission.

Conclusion: Time, physician dependency and mainly clinical outcome was captured relatively well with 30% had received rituximab and GC. Physicians defined the start of maintenance from induction treatment start with mean of 4.4 months. 26% had full remission 26% and no specific criteria 8%. At this time 43% were in full remission 26% and no specific criteria 8%. At this time 43% were in full remission.