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 hypogammaglobulinaemia (IgG <5g/l) and non-severe infections respectively, compared to 21/85 (25%) and 41/85 (48%) in the AZA group.

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.

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OP0027

TIME TO FLARE AND GLUCOCORTICOID EXPOSURE IN PATIENTS WITH NEW-ONSET VERSUS RELAPSING GIANT CELL ARTERITIS TREATED WITH TOCILIZUMAB OR PLACEBO PLUS PREDNISONE TAPERING: 3-YEAR RESULTS FROM A RANDOMIZED CONTROLLED PHASE 3 TRIAL

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Background: In part 1 of the 52-week, double-blind GiACTA trial, tocilizumab (TCZ) every week (QW) or every other week (Q2W) + prednisone tapering reduced the risk for flare versus placebo (PBO) + 26-week prednisone tapering among patients with new-onset giant cell arteritis (GCA) at baseline. Among patients with relapsing GCA, TCZ QW but not Q2W + prednisone reduced the risk for flare versus both PBO groups, and there was separation in the time to flare between the TCZ QW and Q2W groups.¹

Objectives: To report time to first flare and potential cumulative glucocorticoid (GC) sparing over 3 years of the GiACTA trial (part 1 + 2-year open-label part 2) among patients with new-onset or relapsing GCA.

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.

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

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OP0028

EFFICACY OF APREMILAST FOR THE PAIN OF ORAL ULCERS ASSOCIATED WITH ACTIVE BEHÇET'S SYNDROME: 12-WEEK RESULTS FROM THE RANDOMIZED, PHASE III RELIEF STUDY

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Background: Oral ulcers (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 (AUC_{Wk0-12}; 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,⁴ ≥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 AUC_{Wk0-12} (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 on the OU associated with Behçet's syndrome.

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

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

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OP0029

MAINTENANCE TREATMENT FOR ANCA-ASSOCIATED VASCULITIS IN REAL WORLD PRACTICE IN EUROPE – REALITY OF VASCULITIS REMISSION AND RELAPSE AND SIGNIFICANT BURDEN OF DISEASE

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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 organ or life threatening AAV and initiated maintenance therapy between 2014-16 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 vs 50% in partial and 7% refractory. Various maintenance regimes were used, 21% received rituximab (88% 6 monthly and 8% 12 monthly, 4% other) at varying planned doses 34% 1g, 40% 500mg and 23% 375mg/m², 4% other regime. Remission rates varied, relapse of different severity still occurs and many patients experienced adverse events (AE) and infections with prolonged GC use being common.

At the most recent clinic review patients had been followed for a mean of 50.7 months – 6% had died, 38% had relapsed at least once, and 11% required renal replacement therapy. 54% had no vasculitis activity, 26% were ANCA positive

	Maintenance start	6 months	12 months	18 months	36 months
Remission full/partial %	43 / 50	59 / 38	67 / 30	72 / 25	74 / 22
Total relapse / major %		12/49	9 / 45	6/ 44	7 / 32
Receiving GC %	65	61	53	46	39
At least one AE %	66	52	48	43	42
At least one infection %	54	42	32	27	26