Conclusion: Adherence to MTX can affect disease activity during follow-up in Korean patients with RA. Our results provide a rationale for patient education to maintain good drug adherence in RA patients, to control disease activity.

Disclosure of Interests: None declared

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FR10127

SUPPRESSION OF RADIOGRAPHIC PROGRESSION AFTER GRADUAL METHOTREXATE TAPERING IN PATIENTS WITH RHEUMATOID ARTHRITIS: PATIENTS MAINTAINING LOW DISEASE ACTIVITY - PROSPECTIVE MULTICENTER STUDY-

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Background: Many studies have been reported to reduce/discontinue Biologics in the treatment of rheumatoid arthritis (RA). In contrast, study for tapering methotrexate (MTX) has been limited (1,2).

Objectives: We prospectively examined whether bone destruction will progress at 48 weeks after tapering or discontinuing MTX (UM0000029875). Methods: The subjects were RA patients who have maintained low disease activity or lower for 24 weeks or more in DAS28-CRP after MTX administration. Patients having PDUS Grade 2 or 3 per site by bilateral hand ultrasonography (26 area) were excluded in this study owing to risk for joint destruction. The joint destruction was evaluated by the joint X-ray evaluation by modified total Sharp scoring (mTSS) at 1 year after the start of tapering MTX. Evaluation of clinical disease activities, severe adverse events, the continuation rate during MTX tapering were also evaluated. According to tapering response, prognostic factor for good response for tapering, joint destruction was determined. Predictors for successful tapering MTX and progression of bone destruction were determined. Statistical analysis was performed by t-test or Wilcoxon rank sum test using SAS .13.2 software.

Results: The subjects were 79 (16 males, 63 females). Age average 60.9 yrs., disease duration 4 years 4 months, MTX dose 8.43 mg / w. DAS28- CRP 1.52, DMARDs (24.3%), ACPA 192.7 U/ml (70.5%), RF 55.6 IU/ml (65.4%), MTX was tapered from an average of 8.43 mg / w before study to 5.46 mg / w one year later. In the treatment evaluation, DAS28-CRP increased from 1.52 to 1.84, 89.7% of subjects did not progress joint damage. Other disease activities significantly increased (Table 1). The one-year continuation rate was 78.2%. Since tapering effects were varied widely, we divided patients into three groups; Flared group (N=14, initial MTX dose 8.11mg/w, final MTX dose 3.12mg/w), Low response group (N=34, final MTX reduction rate less than 50%, initial MTX dose 8.93mg/w, final MTX dose 6.22mg/w), High response group (N=34, final MTX reducing rate less than 50%, initial MTX dose 8.15mg/w, final MTX dose 3.15mg/w). Table 2. Predictors for successful tapering MTX and progression of bone destruction

Table 2. Predictors for successful tapering MTX and progression of bone destruction

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<th>Group</th>
<th>mTSS 1Y</th>
<th>CRP 1Y</th>
<th>ESR 1Y</th>
<th>DAS28-5</th>
<th>CDAI</th>
<th>SDAI</th>
<th>SJC</th>
<th>TJC</th>
<th>MMP3</th>
<th>HAQ-DI</th>
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* significant: Pairs test, Average(SD)

Conclusion: Patients with MTX-administered low disease activity and finger joint echo PDUS grade 1 satisfy almost no joint destruction even after MTX reduction. For tapering, predictors may be helpful for maintaining patient’s satisfaction.

References:

Disclosure of Interests: None declared

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FR10128

FILGOTINIB PROVIDED RAPID AND SUSTAINED IMPROVEMENTS IN FUNCTIONAL STATUS, PAIN, HEALTH-RELATED QUALITY OF LIFE, AND FATIGUE IN PATIENTS WITH RHEUMATOID ARTHRITIS AND INADEQUATE RESPONSE TO METHOTREXATE: RESULTS FROM THE FINCH 1 STUDY

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Background: In the FINCH 1 study, filgotinib (FIL)—an oral, potent, selective Janus kinase 1 inhibitor—in combination with methotrexate (MTX) provided significant improvements in the signs and symptoms of rheumatoid arthritis (RA) in patients (pts) with inadequate response to MTX. While EULAR guidelines recommend a treat-to-target approach focusing on reducing inflammation to prevent joint damage, physical disability, and mortality, pts consider control of pain and fatigue, along with maintenance of physical function and health-related quality of life (HRQoL), to be important aspects for their care.2,3

Objectives: To evaluate the rate and magnitude of change in patient-reported outcomes (PROs) from FINCH 1.

Methods: In the FINCH 1 study (NCT02889796), pts with active RA received oral FIL 200 mg + MTX, FIL 100 mg + MTX, PBO + MTX, or subcutaneous adalimumab (ADA) 40 mg + MTX for up to 52 weeks (W); pts receiving PBO at W24 were rerandomised 1:1 to FIL 100 or 200 mg. PROs included the HAQ-DI and VAS pain scale, SF-36, and FACIT-Fatigue questionnaire. The change from baseline (CBF) at each time point was assessed up to W52 for each FIL group with PBO for the CFB at each time point through W24. The logistic regression model was used to compare each FIL group with PBO for the CFB at each time point through W24.

Results: Of 1755 pts randomised and treated (475 FIL 200 mg + MTX, FIL 100 mg + MTX, PBO + MTX, or subcutaneous adalimumab), 970 (55.4%) pts received FIL 200 mg and 785 (44.6%) pts received FIL 100 mg. In the FINCH 1 study (NCT02889796), pts with active RA received oral FIL 200 mg + MTX, FIL 100 mg + MTX, PBO + MTX, or subcutaneous adalimumab (ADA) 40 mg + MTX for up to 52 weeks (W); pts receiving PBO at W24 were rerandomised 1:1 to FIL 100 or 200 mg. PROs included the HAQ-DI and VAS pain scale, SF-36, and FACIT-Fatigue questionnaire. The change from baseline (CBF) at each time point was assessed up to W52 for each FIL group with PBO for the CFB at each time point through W24. The logistic regression model was used to compare each FIL group with PBO for the proportion of pts achieving the minimum clinically important difference (MCID) of ≥0.22 reduction in CBF in HAQ-DI at each time point through W24.

Disclosure of Interests: None declared

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