OP0115

EFFECT OF NINTEDANIB ON PROGRESSION OF INTERSTITIAL LUNG DISEASE (ILD) IN PATIENTS WITH AUTOIMMUNE DISEASE-RELATED ILDS: FURTHER DATA FROM THE INBUILD TRIAL

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Background: In the INBUILD trial in patients with progressive fibrosing ILDs, nintedanib reduced the rate of decline in forced vital capacity (FVC) versus placebo over 52 weeks both in the overall population and in the subgroup with autoimmune disease-related ILDs. Patients continued blinded randomised treatment until the end of the trial.

Objectives: Assess the effects of nintedanib on the risks of death, acute exacerbation of ILD or death, and disease progression or death over the whole INBUILD trial in patients with autoimmune disease-related ILDs and a progressive phenotype.

Methods: Patients with progressive fibrosing ILDs other than idiopathic pulmonary fibrosis (IPF) were randomised to receive nintedanib 150 mg bid or placebo. Time to i) death, ii) first acute exacerbation of ILD or death, and iii) disease progression (absolute decline in FVC ≥10% predicted) or death, over the whole trial were analysed in patients with autoimmune disease-related ILDs. Incidence rates of adverse events per 100 patient–years were calculated based on events with onset between the first trial drug intake and the last intake plus 28 days. Analyses were descriptive.

Results: Of 663 patients, 170 (82 nintedanib, 88 placebo) had autoimmune disease-related ILDs (89 RA-ILD, 39 SSc-ILD, 19 MCTD-ILD, 23 other autoimmune ILDs including Sjogren's disease-related ILD [n=7], interstitial pneumonia with autoimmune features [n=5] and undifferentiated CTD-ILD [n=3]). Over the whole trial, in the nintedanib and placebo groups, respectively, mean (SD) exposure to drug was 15.4 (7.4) and 16.9 (6.1) months and maximum exposure was 26.0 and 25.2 months; 62 (75.6%) and 68 (77.3%) patients in these groups, respectively, completed the planned observation time. Over the whole trial, in the nintedanib and placebo groups, respectively, 9.8% and 12.5% of patients died, 12.2% and 20.5% of patients had ≥1 acute exacerbation of ILD or died, and 40.2% and 53.4% of patients had disease progression or died (Table). Diarrhoea was the most common adverse event, with incidence rates of 139.2 and 26.3 events per 100 patient–years in the nintedanib and placebo groups, respectively. Adverse events led to treatment discontinuation in 20.7% of patients in the nintedanib group and 13.6% of patients in the placebo group.

Conclusion: Data from the INBUILD trial suggest that nintedanib has a clinically meaningful effect on slowing the progression of ILD in patients with progressive fibrosing autoimmune disease-related ILDs, with adverse events that can be tolerated by most patients.

Table.

	Nintedanib (n=82)	Placebo (n=88)	HR (95% CI)*
Death	8 (9.8)	11 (12.5)	0.80 (0.32, 1.98)
≥1 acute exacerbation of ILD or death	10 (12.2)	18 (20.5)	0.58 (0.27, 1.27)
Disease progression (absolute decline in FVC ≥10% predicted) or death	33 (40.2)	47 (53.4)	0.72 (0.46, 1.13)

n (%) with event over the whole trial (mean [SD] exposure: 15.4 [7.4] and 16.9 [6.1] months in nintedanib and placebo groups, respectively). *Based on time to first event.

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OP0116

TEN-YEAR ANALYSIS OF VERY LOW-DOSE GLUCOCORTICOIDS IN EARLY RA (ESPOIR COHORT) SUPPORTS A TIME-DEPENDENT RISK OF SEVERE OUTCOMES

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Background: We previously failed to find any significant difference with regard to severe outcomes (death, severe infections, fractures, cardiovascular diseases [CVD]) between recent-onset RA patients taking or not low-dose GC treatment in a 7-year analysis of the ESPOIR cohort (1).

Objectives: To explore the 10-year tolerability profile of GC use in patients with early RA.

Methods: We analysed data from the early arthritis (less than 6 months disease duration) ESPOIR cohort. Patients were stratified in two groups, with or without GC treatment at least once during their follow-up (median 10 years IQR [9-10]). The primary outcome was a composite of death, CVD (including myocardial ischemia, cerebrovascular accident and heart failure), severe infection and fracture. In order to reduce the impact of treatment selection bias and potential confounding factors, the weighted Cox time-dependent analysis model was used with inverse probability of treatment weighting (IPTW) propensity score method.

Results: Among the 608 RA patients (480 women, mean age of 47.5 ± 12.1 years), 397 patients (65%) received low-dose prednisone (median 1.9 mg/day [IQR 0.6-4.2], mainly during the first 6 months (70%). The mean duration of GC treatment was 44.6 months ± 40.1. Overall, 95 events were identified during follow-up: 10 deaths, 18 CVD, 32 fractures and 35 severe infections. Based on univariate analysis at 10 years, patients taking GC experienced significantly more events (n=71) than those without GC (n=24) (p=0.035), especially severe infections (n=30 with GC versus 5 without GC, p=0.009) (table 1), with a cumulative dose effect (p=0.007). *On weighted Cox time-dependent analysis, using the IPTW propensity score method, the risk of events over time was significantly associated with GC treatment (p <0.001), age, history of hypertension and erythrocyte sedimentation rate. The risk associated with GC treatment, estimated by the hazard ratio (HR), increased between the first follow-up visit (HR at 6 months = 0.39, 95% CI 0.19-0.82) and 10 years (HR=6.83, 95% CI 2.29-20.35)* (figure 1 and table 2).