Objectives:

Randomized controlled trials have demonstrated both the efficacy and previous and concurrent treatments, and disease activity by DSAS28 with C reactive protein (DSAS28-CRP). All the patients were assessed at baseline, and after 4 and 12 months (T4 and T12, respectively). The reasons for withdrawal of treatment were registered and classified as primary or secondary inefficacy or adverse events (AEs). Kaplan-Meier statistical analysis has been done to evaluate the survival of the treatment in patients with at least 12 months follow-up.

Results:

We evaluated 161 patients [M/F 21:140; median age 67 years (IQR 21.7), median disease duration 180 months (IQR 161)]. RF was positive in 70.3% of patients, ACPA in 66.4%. ABA was the first biological DMARD in 68 patients (41%). At baseline, the median DSAS28-CRP was 4.3 (IQR 1.6) and ABA was administered in association with MTX in 96 patients (59.6%). One hundred and eleven patients (68.9%) started SC ABA [M/F 16/95; median age 64.5 years (IQR 21.5)], median disease duration 156 months (IQR 132), the remaining 50 IV ABA [M/F 5/45, median age 71 years (IQR 60.2), median disease duration 187 months (IQR 157)]. Median age and disease duration were significantly higher in patients receiving IV in comparison with SC ABA (p=0.006 and p=0.03, respectively).

We found a significant reduction of DSAS28-CRP values during the follow-up in comparison with baseline [4 months: median 3.5 (IQR 1.9), p<0.0001; 12 months: median 3.2 (IQR 1.4), p<0.0001]. Seven patients were lost to follow-up, in the remaining 154 patients a median treatment duration of 33 months (IQR 49) was registered. Data on drug survival are reported in Figure 1A: at 12 months, 92% of patients persisted on treatment; this percentage decreased to 72.4% at 24 months and to 67.9% at 36 months. Furthermore, we did not find any differences in drug survival either with respect to SC vs IV administration (12 months: 93.7% versus 88.6%; 24 months 78.9% versus 72.6%; 36 months 63.7% versus 72.6%; Figure 1B) or according to the association with MTX. Concerning the withdrawal reasons, 46 patients (29.9%) stopped ABA due to inefficacy (primary in 28, secondary in 18), 11 patients (7.1%) due to AEs, and 7 for inadequate adherence (4.5%). Finally, 10 patients switched from IV to SC administration, due to patient's preference.

Conclusion: In our monocentric RA cohort, we have observed a high retention rate of ABA at both 12 and 24 months, confirming the good profile of this drug in terms of effectiveness and safety, irrespective of the route of administration and association with MTX.

REFERENCES:


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Methods: We enrolled consecutive RA patients starting treatment with intra- venous (IV) or subcutaneous (SC) ABA according to the standard of care. All the patients fulfilled the 2010 ACR/EULAR classification criteria for RA. For each patient, we collected demographic parameters, serological status, previous and concomitant treatments, and disease activity by DSAS28 with C reactive protein (DSAS28-CRP). All the patients were assessed at baseline, and after 4 and 12 months (T4 and T12, respectively). The reasons for withdrawal of treatment were registered and classified as primary or secondary inefficacy or adverse events (AEs). Kaplan-Meier statistical analysis has been done to evaluate the survival of the treatment in patients with at least 12 months follow-up.

Results: We evaluated 161 patients [M/F 21:140; median age 67 years (IQR 21.7), median disease duration 180 months (IQR 161)]. RF was positive in 70.3% of patients, ACPA in 66.4%. ABA was the first biological DMARD in 68 patients (41%). At baseline, the median DSAS28-CRP was 4.3 (IQR 1.6) and ABA was administered in association with MTX in 96 patients (59.6%). One hundred and eleven patients (68.9%) started SC ABA [M/F 16/95; median age 64.5 years (IQR 21.5)], median disease duration 156 months (IQR 132), the remaining 50 IV ABA [M/F 5/45, median age 71 years (IQR 60.2), median disease duration 187 months (IQR 157)]. Median age and disease duration were significantly higher in patients receiving IV in comparison with SC ABA (p=0.006 and p=0.03, respectively).

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