(Figure 1). To identify the risks of discontinuation, we analyzed by multivariable Cox proportional hazard modeling in patients who discontinued treatment due to adverse events, the risk factors (hazard ratio: HR, confidence interval: CI) were over 3 of Steinblocker class (HR 1.85 [1.02-2.04]), age (HR:1.07 [1.04-1.10]) and Non-concomitant with methotrexate (HR 1.90 [1.08-3.33]) (Figure 2).

Table 1.

Age (years)	56.1 ± 13.4
Gender	
n (% male)	110 (19%)
n (% female)	460 (81%)
Disease duration (years)	11.1 ± 9.8
stage	
1,2	104 (19%)
3,4	455 (81%)
class	
1,2	336 (60%)
3,4	225 (40%)
Methotrexate use, no (%)	400 (70%)
Glucocorticoid use, no (%)	262 (47%)
Rheumatoid Factor, no (%)	287 (65%)
anti CCP antibody, no (%)	137 (87%)

Conclusion: The most common reason for discontinuation was adverse events in long term observation. The risk factors for discontinuation were class, age, and non-concomitant MTX. These results suggested that comorbidity has a significant impact on continuation rates because there are some reasons of non-concomitant MTX in addition to relate with age and the activities of daily living.

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AB0234 SURVIVAL OF ABATACEPT IN RHEUMATOID ARTHRITIS PATIENTS: A REAL-LIFE STUDY

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Background: Abatacept (ABA) is a biological drug approved for the treatment of rheumatoid arthritis (RA) patients that, by working on CTLA4, can inhibit T-cell activation. Randomized controlled trials have demonstrated both the efficacy and a good safety profile, characterized by a lower infectious risk in comparison with other biological DMARDs, in RA patients. In a real-life setting, the drug retention rate could be considered as a surrogate of drug effectiveness. Data from the literature reported a retention rate of ABA ranging from 55 to 76% at 12 months and from 54 to 64% at 24 months (1-3).

Objectives: In the present longitudinal analysis, we evaluated the retention rate of ABA in a large monocentric RA cohort.

Methods: We enrolled consecutive RA patients starting treatment with intravenous (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 DAS28 with C reactive protein (DAS28-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 66 patients (41%). At baseline, the median DAS28-CRP was 4.3 (IQR 1.6) and ABA was administered in association with MTX in 96 patients (59.6%). One hundred-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=0.008 and p=0.03, respectively). We found a significant reduction of DAS28-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 78.2% 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.

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AB0235 RITUXIMAB (BIOSIMILAR) IN RHEUMATOID ARTHRITIS: CLINICAL & IMMUNOLOGICAL RESPONSE TO VARYING DOSES- EXPERIENCES FROM A TERTIARY CARE CENTER IN SOUTH INDIA

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Background: Rituximab (RTX) is a chimeric monoclonal antibody against CD20. There is a paucity of studies done with RTX biosimilars. This is a Retrospective and Observational study from January 2018 to December 2019 done in the Department of Clinical Immunology & Rheumatology, Sri Ramachandra Institute of Higher Education and Research, Chennai, India.

Objectives: 1.To find the effects of varying doses of RTX in attaining clinical remission in RA.

2.To find if CD19, CD20 & IgG help in identifying impending flare & if these levels help in deciding the timing of the next dose of RTX.

Methods: Rheumatoid arthritis (RA) cases who were given Rituximab from January 2018 were selected. Clinical Response at 6 & 12 months & wherever feasible at 18 & 24 months was assessed by Simplified Disease Activity index (SDAI). RTX initial dose was given at 0 and 14 days followed by fixed dose at six months interval.CD19, CD20 B cell count, IgG levels were tested in patients in whom it was feasible at baseline & 6 months (select patients at 12,18 &24 months). Patients were divided in to 5 groups (DMARD naïve, DMARD resistant & Interstitial Lung disease (ILD) [Lung involvement>20% in Computed Tomography (CT)]) and (500mg & 1g). Patients were divided into three clinical groups, (DMARD naïve, DMARD resistant & Interstitial Lung disease (ILD) [Lung involvement>20% in Computed Tomography (CT)]) and two treatment groups (500mg & 1g) based on clinical indication for RTX and dose of RTX,