respectively. During the 3-year follow-up, 130 pts (42 with TNFi and 88 with SEC) discontinued treatment: 80 (22 with TNFi and 58 with SEC) for lack of effectiveness, 41 (16 with TNFi and 25 with SEC) for adverse events. No patient

treated with SEC presented a new-onset inflammatory bowel disease.

Figure 1. Persistence with SEC after 3 years of follow-up

Conclusion: In this real world cohort of AxSpA pts, SEC was mostly prescribed at second and third-line, contrary to axSpA pts treated with TNFi. Most reason of discontinuation were related to lack of effectiveness with both therapeutic classes.

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AB0465

INDIVIDUAL COMPONENTS CONTRIBUTING TO THE ACHIEVEMENT OF ASAS40 RESPONSE IN BIOLOGIC NAÏVE PATIENTS WITH RADIOGRAPHIC axSpA: RESULTS FROM THE COAST-V TRIAL

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Background: Ixekizumab (IXE), an IL-17A antagonist, is effective in patients with radiographic axial spondyloarthritis (rad-axSpA). Assessment in SpondyloArthritis International Society (ASAS) 40 response – the primary study endpoint – was achieved at week (wk) 16 by 48% of those treated with 80mg subcutaneous IXE every 4 wks (Q4W) in the phase 3 COAST V trial (NCT 02696785)¹. Until now, no information has been available on the efficacy of IXE on the components of ASAS40 composite endpoint.

Objectives: To describe which individual components of ASAS40 drive achievement of efficacy response.

Methods: This exploratory post-hoc analysis was based on COAST V data. Patients enrolled in COAST V met ASAS criteria for rad-axSpA and were biological disease-modifying antirheumatic drug (bDMARD)-naïve. Patients were assigned 1:1:1 to subcutaneous placebo (PBO), IXE Q4W, IXE Q2W or 40mg adalimumab (ADA). Only data for approved doses are shown.

To reach ASAS40 response, patients must have an improvement of at least 40% and at least 2 units for at least 3 of 4 individual components which define response (patient global assessment of disease activity, spinal pain, inflammation (defined as the mean of Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) questions 5 and 6), and function (Bath Ankylosing Spondylitis Functional Index - BASFI)), without worsening in the remaining component. We describe the percentage of patients who achieved this change, had an insufficient response, or deteriorated in each component out to wk 16 for IXE Q4W, ADA and PBO. The time course of the change from baseline in individual components of the ASAS response is depicted descriptively per treatment arm by use of the mean and standard deviation. Observed data have been utilised.

Results: IXE Q4W response at 16 wks was driven by all 4 individual components of the ASAS40 with the largest improvements for patients treated with IXE Q4W seen in inflammation and spinal pain (Figure 1).

At wk 16, at least 50% of all patients treated with IXE Q4W achieved response on spinal pain (60.3%), inflammation (60.3%) and patient global assessment (50%), with 43.6% of patients meeting the response criteria for function (Table 1). The corresponding results for ADA were 43.2%, 47.7% 39.8%, and 35.2%.

Conclusion: Our findings show that meeting ASAS40 response criterion for an individual component at 16 wks by patients treated with IXE Q4W was broadly similar between individual components. However, a clinically relevant improvement was more frequently observed for the spinal pain and inflammation components.

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Table 1. Observed changes from baseline (CFB), percentage improvements and response status of patients enrolled in COAST V trial at wk 16

Measure	Observed CFB (SD)	Observed % improvement (SD)	Improvement >=40% and >=2 units n (%)	Insufficient response n (%)	Deteriorated n (%)
IXE Q4W (N=78)					
Patient global assessment	-2.6 (2.9)	32.3 (51.1)	39 (50.0)	30 (38.5)	9 (11.5)
Spinal pain	-3.3 (2.7)	43.4 (34.4)	47 (60.3)	27 (34.6)	4 (5.1)
Inflammation*	-3.2 (2.5)	46.8 (32.8)	47 (60.3)	25 (32.0)	6 (7.7)
Function	-2.5 (2.3)	39.6 (31.0)	34 (43.6)	37 (47.4)	7 (9.0)
ADA (N=88)					
Patient global assessment	-2.6 (2.4)	35.2 (33.4)	35 (39.8)	48 (54.5)	5 (5.7)
Spinal pain	-2.6 (2.4)	36.8 (34.7)	38 (43.2)	44 (50.0)	6 (6.8)
Inflammation*	-2.6 (2.4)	38.4 (36.9)	42 (47.7)	37 (42.0)	9 (10.2)
Function	-2.1 (2.2)	35.2 (34.3)	31 (35.2)	48 (54.6)	9 (10.2)
PBO (N=86)					
Patient global assessment	-1.5 (2.0)	18.0 (37.9)	21 (24.4)	54 (62.8)	11 (12.8)
Spinal pain	-1.9 (1.9)	25.8 (26.7)	23 (26.8)	55 (64.0)	8 (9.3)
Inflammation*	-1.4 (1.9)	20.9 (33.9)	19 (22.1)	53 (61.6)	14 (16.3)
Function	-1.3 (1.8)	19.1 (31.6)	16 (18.6)	51 (59.3)	19 (22.1)

*Inflammation is the mean of BASDAI 5 (Morning stiffness severity) and BASDAI 6 (Morning stiffness duration)

Figure 1: Mean (SD) change from baseline (observed) on individual components of ASAS40 by treatment arm and wk

Mean baseline values for PBO, ADA and IXE Q4W respectively: Patient global assessment (7.1, 7.1, 6.9), spinal pain (7.4, 7.0, 7.2), inflammation (Q5/6) (6.7, 6.6, 6.5), function (6.3, 6.1, 6.1)

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AB0466

RETENTION RATE AND EFFECTIVENESS OF SECUKINUMAB VERSUS TNF INHIBITOR SWITCHING IN ANKYLOSING SPONDYLITIS PATIENTS WITH A HISTORY OF TNF INHIBITOR TREATMENT: DATA FROM A KOREAN NATIONWIDE REGISTRY

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Background: The choice of second-line biologics for ankylosing spondylitis (AS) patients previously treated with a tumour necrosis factor inhibitor (TNFi) remains unclear

Objectives: Here, we compared drug retention and clinical efficacy between AS patients who switched biologics to secukinumab and those who switched to a different TNFi.

Methods: AS patients enrolled in the Korean College of Rheumatology BIOlogics registry were included. Patients with previous TNFi exposure were divided into the secukinumab group and the TNFi switching group. Drug retention and clinical efficacy (BASDAI50, ASAS20, ASAS40, ASDAS <2.1, ASDAS clinically important improvement, and ASDAS major improvement) were assessed at the 1 year follow-up. Propensity score (PS)-matched and covariate-adjusted logistic regression analyses were performed.

Results: 246 had available 1 year follow-up data. Secukinumab as third- or later-line biologics was more frequent than alternative TNFi (54% vs. 14%). PS-matched and multiple covariate-adjusted analyses showed that the odds ratio (OR) for drug discontinuation was comparable between the secukinumab and TNFi switching groups (OR=1.136; 95% CI, 0.843–1.531 and OR=1.000; 95% CI, 0.433–2.308, respectively). The proportion of patients who achieved BASDAI50 was also comparable between the two groups (OR=0.833; 95% CI, 0.481–1.441 in PS-matched analysis). Other clinical efficacy parameters were also comparable. In the subgroup analysis of AS patients with previous TNFi discontinuation due to ineffectiveness, all clinical efficacy parameters were comparable between the two groups.

Conclusion: In AS patients with previous exposure to a TNFi, switching biologics to secukinumab and switching to an alternative TNFi resulted in comparable drug retention and clinical efficacy.

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AB0467

EFFECTIVENESS OF GOLIMUMAB AFTER TNF-INHIBITOR FAILURE IN PATIENTS WITH ACTIVE RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, OR AXIAL SPONDYLOARTHRITIS: RESULTS AT 3 MONTHS FROM THE GO-BEYOND ITALY STUDY

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Background: Golimumab showed trial efficacy in subjects with active rheumatoid arthritis (RA) previously treated with TNF-inhibitors (TNFi); no trial data are available for psoriatic arthritis (PsA) and axial spondyloarthritis (axSpA).

Objectives: To assess the effectiveness of golimumab after TNFi failure in patients with RA, PsA, or axSpA in a real-world setting.

Methods: GO-BEYOND-Italy is an ongoing, multicenter, prospective, observational study of RA, PsA, or axSpA patients starting golimumab after TNFi failure. Patients were enrolled between July 2017 and December 2019, and followed for 1 year, with evaluations at 3, 6, and 12 months. This interim analysis estimates the effectiveness after 3 months of golimumab therapy. Differences from baseline were tested by paired t-tests.

Results: 193 patients were enrolled: 38 (19.7%) with RA (median age 54 years; median disease duration 9.5 years), 91 (47.2%) with PsA (median age 53 years; median disease duration 9.0 years) and 64 (33.2%) with axSpA (median age 54 years; median disease duration 7.2 years). Majority of the RA (73.7%), PsA (51.6%) and axSpA (53.1%) were females. Previous TNFi treatment included etanercept (44.6% of patients), adalimumab (42.0%), infliximab (8.8%) and certolizumab (4.7%). The main reason for switching to golimumab was loss of efficacy of TNFi (78.9% in RA, 83.5% in PsA, 75% in axSpA). Comorbidities were highly prevalent (RA 65.8%, PsA 65.9%, axSpA 75%); hypertension (31.1%), dyslipidaemia (13.5%), fibromyalgia (10.4%) were the most common ones. DAS28-CRP significantly reduced in RA and PsA (p<0.01) after 3 months of treatment. In RA, rates of DAS28-CRP remission and low disease activity (LDA) were 29.6% and 22.2%, respectively, and 65.2% of patients achieved good/moderate EULAR response. As for PsA, good/moderate EULAR response was observed in 78.8% of patients and 28% of patients achieved minimal disease activity. In axSpA, ASDAS-CRP (p<0.01), BASDAI (p<0.01) and ASAS-HI (p=0.032) significantly reduced; rates of ASDAS-CRP inactive disease and LDA were 15.2% and 26.1%, respectively; 14% of patients had a ≥50% improvement in baseline BASDAI. After 3 months of golimumab treatment, there was a decrease in the prevalence of enthesitis (32.9% to 16.5%), nail (17.6% to 12.9%) and skin psoriasis (42.4% to 34.1%) in PsA patients; the frequency of extra articular manifestations tended to decrease also in axSpA patients.

Conclusion: Preliminary results of the GO-BEYOND-Italy study showed a good short-term effectiveness of golimumab in RA, PsA and axSpA after TNFi failure.