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DOI: 10.1136/annrheumdis-2021-eular.960

AB0533

COMBINATION OF METHOTREXATE AND LEFLUNOMIDE IS SAFE AND HAS GOOD DRUG RETENTION AMONG PATIENTS WITH PSORIATIC ARTHRITIS

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Background: Among patients with psoriatic arthritis (PsA), there remains a considerable confusion regarding the effectiveness of conventional synthetic DMARDs (csDMARDs), especially methotrexate (MTX). The availability of biologic DMARDs and targeted synthetic DMARDs have revolutionised the management of psoriatic disease; however, it comes with a significant cost burden. We believe that combination of DMARDs, especially combining MTX and Leflunomide (LEF) provides a valuable low-cost treatment option for patients with PsA after failure of MTX monotherapy. Hence, in our practice, we are inclined to use combination of potent DMARDs after MTX failure, prior to considering biologic therapies. Little is known about the combination use of LEF and MTX in PsA, especially in the context of drug retention time and tolerability.

Objectives: We aimed to review our PsA cohort data especially examining the drug retention of first-line csDMARD monotherapy and combination csDMARDs.

Methods: In our centre, MTX is a preferred first line csDMARD, unless contraindicated, and patients are followed up with a protocol on 4-6 weekly basis unless complete remission is achieved. MTX if needed is escalated to the maximum tolerated dose (up to 25mg/week), and if PsA is still active then preferably LEF is added (usual starting dose for add-on therapy is 10mg a day and if needed escalated to 20mg a day, without any loading dose). Other csDMARDs, such as sulphasalazine are used, if needed. For this study, after written-informed consent, only those adult patients were included who had a follow up of at least 6 months with our rheumatology services, and were fulfilling CASPAR criteria. Moreover, only patients who were DMARD-naïve (no prior DMARD therapy for any cause, including psoriasis), and initiated DMARD as monotherapy after 1 April 2018 were included. If any patient had already been on any DMARDs prior to attending our rheumatology services was excluded.

Results: A total of 81 PsA patients [mean age 45.6±6 years; 52% male; mean PsA disease duration=9±4 years; 35% with dactylitis, 42% with enthesitis, 17% with sacroiliitis, median current PASI=2.6, median number of swollen joints=8.0, median number of tender joints= 11.0] fulfilled the inclusion and exclusion criteria. As regards first-line csDMARD monotherapy, 88% (n=71) of patients were commenced on MTX. In total, 79% (n=56 out of 71) of patients who were started on MTX as their first-line csDMARD therapy failed this monotherapy during follow-up (51=ineffective, 5=intolerance). After a median follow-up of 22 months, MTX median drug retention among all MTX monotherapy users (n=71) was only 7 months (IQR 5-7); and among MTX failures (n=56), MTX monotherapy median drug retention was 6.0 months (IQR 4-8). Eighty percent (n=45 out of 56) of the MTX monotherapy failure cohort was started on combination therapy of MTX and LEF (combo MTX+LEF); among them, only 7 patients needed escalation of therapy to bDMARDs, and the rest are still using combo MTX+LEF. It was noted that to date median drug retention time of combo MTX+LEF has been 8 months (IQR 7-11), and 84% (n=38 out of 45) of these patients are still using this combo therapy. Significantly more patients managed to continue the combo MTX+LEF therapy compared to MTX monotherapy (84% vs. 21%, p<0.001).

Conclusion: Among csDMARD naïve PsA patients, 79% of patients failed MTX monotherapy with median drug retention time of only 6 months. Combination of MTX and LEF was well tolerated and had good drug retention time, with 84% of patients having ongoing treatment to date. Our data provides initial evidence that MTX and LEF combination therapy could be an effective treatment option for PsA.

Disclosure of Interests: Muhammad Haroon Speakers bureau: Roche, Novartis, Grant/research support from: Abbvie, Pfizer, Shabnam Batool: None declared., Sadia Asif: None declared., Farzana Hashmi: None declared., Saadat Ullah: None declared.

DOI: 10.1136/annrheumdis-2021-eular.978

AB0534

THE IMPACT OF AXIAL INVOLVEMENT ON ACR RESPONSE IN PATIENTS WITH PSORIATIC ARTHRITIS: RESULTS OF SUBANALYSIS OF THE PATERA STUDY

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Background: Inflammatory back pain (IBP) is a common symptom of axial disease in patients with psoriatic arthritis (PsA). The reported prevalence of axial disease in patients with PsA is quite variable and must be taken into account while choosing treatment strategy. Netakimab (NTK) is an anti-interleukin-17A monoclonal antibody approved for psoriasis, ankylosing spondylitis, PsA in Russia and Belarus.

Objectives: A subanalysis was aimed to investigate the ACR (American College of Rheumatology) 20/50/70 response rate in PsA patients with/without the axial disease, defined by the presence of IBP according to self-reported ASAS IBP criteria, 2009 at baseline.

Methods: PATERA is an ongoing phase 3 international double-blind, placebo-controlled clinical study (NCT03598751). 194 adult patients with PsA (CASPAR criteria, 2006) with inadequate response to csDMARD or one TNFi, were randomly assigned to receive NTK 120mg or placebo at weeks 0,1,2,4,6,8,10,14,18,22. The ACR response was calculated in NTK-treated patients with IBP (IBP+) and NTK-treated patients without IBP (IBP-) according to self-reported ASAS IBP criteria, 2009. Patients with missing values for categorical variables were considered as non-responders in the analysis.

Results: 97 PsA patients (N=54 IBP+, N=43 IBP-) received NTK. Both subpopulations were comparable in gender, age, and PsA activity at baseline. There were no significant differences in ACR20 achievement between the groups (Figure 1). The percentage of patients with ACR50 was significantly (p<0.05) higher in the IBP(-) subpopulation at weeks 4-20 (data not shown), but not at week 24 with 63% IBP(+) and 79% IBP(-) responders (p≥0.05). Similarly, IBP(+) patients had a lower frequency of ACR70 response (Figure 1).

Conclusion: NTK is effective in PsA treatment irrespectively of the presence of axial disease. Both IBP(-) and IBP(+) subpopulations achieved ACR20/50/70 as well, however, the benefit in IBP(-) patients was more pronounced.

Figure 1 ACR response rates

Acknowledgements: This study was sponsored by JSC BIOCAD.

Disclosure of Interests: Tatiana Korotaeva Speakers bureau: Abbvie, Biocad, Eli Lilly, Johnson & Johnson, Janssen, Novartis, Pfizer, UCB, Inna Gaydukova