Conclusion: Therapy with TNF alpha inhibitor golimumab for 24 months in AS patients with coxitis was accompanied with statistically significant improvement of clinical scores with primary endpoint achieved (mean BASFI change -2.5 at 12 months), improvement of MRI and US findings without obvious structural progression measured with BASRI-hp score compared to baseline.

REFERENCES:

Disclosure of Interests: Sandor Eres Speakers bureau: Paid as a speaker during educational activities supported by pharmaceutical companies (MSD, Pfizer, AbbVie, BIOCAD), Ekaterina Agafonova Speakers bureau: Paid as a speaker during educational activities supported by pharmaceutical companies (MSD, Daria Rumiantceva Speakers bureau: Paid as a speaker during educational activities supported by pharmaceutical companies (Novartis), Satenik M. Hwang1, M. Weisman2, L. S. Gensler3, A. Tahanan4, M. Ishimori2, T. Hunter5, R. Bolce5, J. Lisse5, M. Rahbar6, M. Shan7, J. D. Reveille7.

Methods:

Background: A recent study examining Commercial Claims Insurance database found that many patients with ankylosing spondylitis (AS) do not remain on their initial TNF inhibitor two years after initiation, particularly women and those taking opioid pain medication.

Objectives: To examine factors associated with switching from one TNF inhibitor (lagent to either another TNF, IL-17i or JAKi) before or after two years from first TNF initiation.

Results: Of those patients in PSOA who had at least two years of follow-up, 496 were prescribed anti-TNF, 34 anti-IL-17 and 3 anti-JAK agents. According to the multinomial logistic regression analysis, patients who switched from their original TNF inhibitor to another TNF, IL-17i or JAKi within two years after initiating their original TNF were more likely to be older, have higher baseline subjective disease activity (BASDAI), less radiographic severity by MSASSS, exercise > 120 minutes/week and less likely to be currently smoking. Patients who switched after two years were less likely depressed, had shorter disease duration, had greater subjective disease activity, were more likely to be exercising > 120 minutes/week, and had more comorbidities.

Conclusion: Different factors were encountered in AS patients who switched from their initial TNF to another TNF, IL-17i or JAKi within 2 years versus after 2 years of treatment.

Table 1. Factors Associated With Switching From One TNF to A Second TNF or IL-17i or JAKi Before or After Two Years Based On Multinomial Logistic Regression Model (N=496 Patients)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Switched within 2 years vs. not switched</th>
<th>p-value</th>
<th>Switched after 2 years vs. not switched</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (Male vs. Female)</td>
<td>0.99</td>
<td>0.98</td>
<td>0.96</td>
<td>0.87</td>
</tr>
<tr>
<td>Age at baseline (≥40 vs. &lt;40)</td>
<td>1.29 (1.301)</td>
<td>1.02 (0.662)</td>
<td>0.85</td>
<td>0.35</td>
</tr>
<tr>
<td>NSAID index (≥50 vs. &lt;50)</td>
<td>1.85 (2.128)</td>
<td>1.27 (0.478)</td>
<td>1.63</td>
<td>0.10</td>
</tr>
<tr>
<td>Exercise (&gt;20 minutes/week)</td>
<td>0.63 (1.548)</td>
<td>0.35</td>
<td>0.07</td>
<td>0.03</td>
</tr>
<tr>
<td>Number of comorbidities</td>
<td>1.00 (1.057)</td>
<td>0.97 (1.062)</td>
<td>1.03</td>
<td>0.03</td>
</tr>
<tr>
<td>Current smoker (Yes vs. No)</td>
<td>0.85 (1.23)</td>
<td>0.27</td>
<td>0.43</td>
<td>0.77</td>
</tr>
</tbody>
</table>

*p-values calculated based on multinomial logistic regression model when switching is defined as being prescribed a second TNF or taking IL-17i or JAKi after or before 2 years from first TNF initiation.

Disclosure of Interests: Mark Hwang Consultant of: UCB, Novartis, Michael Weisman, the activities supported by pharmaceutical companies (Novartis), Satenik M. Hwang4, J. D. Reveille Consultant of: AbbVie, GlaxoSmithKline, Eli Lilly, Novartis, Pfizer, UCBER Pharma, Amirali Tahanan: None declared, Marko Ishimori: None declared, Theresa Hunter Employee of: Eli Lilly, Rebecca Bolce Employee of: Eli Lilly, Jelissa Libby, Mohammad Rahbar: None declared, Mingyang Shan Employee of: Eli Lilly, Mohammad Rahbar: None declared, Shinya Shiozawa Employee of: Eli Lilly, John D Reveille Consultant of: UCB, Grant/research support from: Eli Lilly.

Background: Assessment of SpondyloArthritis international Society (ASAS) response criteria and AS Disease Activity Score (ASDAS) are both commonly used in clinical practice and incorporate composite indices consisting of components. However, comparison of rates of response among patients with AS difference can be due to differences in physicians' responses. Hence, the absence of standard methods for assessing and comparing responsiveness of individual ASAS and ASDAS core components, as they are used in clinical practice.

Objectives: To study the association of ASAS PR and ordinal ASDAS disease categories (including ABSAS ID, which is the most stringent category of this score) in upadacitinib-treated patients with AS.

Results: Of those patients in the SELECT-Axis 1 (NCT03178487) study, biologic DMARD naïve-patients (pts; n=188) with active AS and intolerance/contraindication or inadequate response to ≥2 NSAIDs were randomized 1:1 to Upa 15 mg once daily (QD) or placebo (PBO). At wk 14, pts entered an open-label extension (OLE) of Upa 15 mg QD; pts randomized to PBO were switched to Upa. This post hoc analysis assessed the responsiveness of individual ASAS and ASDAS core components among pts who achieved ASAS PR. The association of ASAS PR with achievement of ASDAS (≥1.3), ASDAS LDA (≤1.21 ≤1.3) or ASDAS high disease activity (≥1.7) was also assessed by measures including Youden index, distance to perfect point, and sensitivity/specificity.

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