in AR is 7.6 years and the time in BIO-1: 1.34 (2.2) years. BIO-1 was withdrawn in 19 of them (90.5 %), mostly glucocorticoids (n=13, 68.4%) alone or combined with methotrexate (n=3, 15.8%). Among the 14 patients with the available data, the TIS had completely resolved in 11 (78.6%); for all these last, the TNFβ was discontinued. No significant differences were observed between the TNFβ sub-classes of mononuclear antibodies or fusion proteins, regarding clinical presentation, median time to onset or outcome.

Conclusion: This second largest case-series shows that TIS are mostly encountered with etanercept, but without any difference in clinical or prognostic implications with the other TNFβ sub-classes.

REFERENCES:

Disclosure of Interests: None declared.

Figure 1. Survival probability in patients with rheumatoid arthritis who receive the first BIO-1. A. Between TNFβ drug vs Baricitinib. B. Between TNFβ vs Baricitinib 2 mg or 4 mg.

In patients <65 years, the greatest survival of BARJ is maintained (p=0.05), being significant in the first 24 months of treatment (p=0.02). In patients ≥65 years, significance was not reached throughout the overall period (p=0.05) and in the first 24 months of treatment (p=0.06). When comparing the BARI 2 mg (n= 23/38%) and 4 mg (n=40/64%) groups, the 2 mg group is significantly older at RA diagnosis (73 [SD: 2] years vs 56 [SD: 3] years; p=0.0001) and at the start of BIO-1 (72 [SD: 14] years vs 54 [SD: 28] years; p=0.0001). However, survival in the BARI 2 mg group was significantly higher in the first 24 months (p=0.003) (Figure 1B): BARI 2 mg HR: 0.14, 95% CI; 0.04-0.56; p=0.005, HR BARI 4 mg: 0.44 (95% CI; 0.20-0.96; p=0.038).

Conclusion: 1. Survival of BARI is superior to TNFβ during the first 4 years of treatment, especially during the first 24 months of treatment. 2. There are no differences between the cause that causes drug withdrawal. 3. The use of the 2 mg dose of BARI predominates in patients older than 65 years, with survival being greater than TNFβ, especially during the first 24 months of treatment.

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Disclosure of Interests: None declared.

Table 1. Characteristics of patients who receive Baricitinib (BARI) or anti-TNFβ as first BIO-1 (TNFβ).

<table>
<thead>
<tr>
<th>All</th>
<th>N: 96</th>
<th>BARI</th>
<th>N: 63 (66%)</th>
<th>TNFβ</th>
<th>N: 33 (34%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female, n (%)</td>
<td>82 (85%)</td>
<td>56 (89)</td>
<td>26 (79)</td>
<td>0.2</td>
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<tr>
<td>&gt; 65 years, n (%)</td>
<td>36 (37)</td>
<td>27 (43)</td>
<td>9 (27)</td>
<td>0.39</td>
<td></td>
</tr>
<tr>
<td>Metabolic syndrome, n (%)</td>
<td>57 (59)</td>
<td>37 (59)</td>
<td>20 (61)</td>
<td>0.08</td>
<td></td>
</tr>
<tr>
<td>BMI &gt; 30, n (%)</td>
<td>41 (43)</td>
<td>28 (44)</td>
<td>13 (39)</td>
<td>0.17</td>
<td></td>
</tr>
<tr>
<td>N: 96</td>
<td>BARI</td>
<td>N: 65 (68%)</td>
<td>TNFβ</td>
<td>N: 31 (32%)</td>
<td></td>
</tr>
<tr>
<td>Female, n (%)</td>
<td>82 (85%)</td>
<td>56 (89)</td>
<td>26 (83)</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>&gt; 65 years, n (%)</td>
<td>36 (37)</td>
<td>27 (42)</td>
<td>9 (29)</td>
<td>0.39</td>
<td></td>
</tr>
<tr>
<td>Metabolic syndrome, n (%)</td>
<td>57 (59)</td>
<td>37 (57)</td>
<td>20 (61)</td>
<td>0.08</td>
<td></td>
</tr>
<tr>
<td>BMI &gt; 30, n (%)</td>
<td>41 (43)</td>
<td>28 (43)</td>
<td>13 (42)</td>
<td>0.47</td>
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</tbody>
</table>

PO5658 TUMOR NECROSIS FACTOR BLOCKERS INDUCED SARCOIDOSIS: DESCRIPTION OF 31 CASES FROM THE FRENCH PHARMACOVIGILANCE DATABASE

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Background: Development of Tumor Necrosis Factor blockers (TNFβ) whose drug class has several mechanistic and pharmacologic sub-classes, have improved the management of autoimmune and inflammatory diseases, including sarcoidosis. With their increasing use, paradoxical reactions are described and one of the most frequent is sarcoidosis. However, the description of TNFβ-induced sarcoidosis (TIS) remains poor, because reported in few and only short case-series.

Objectives: We aimed to better describe the clinical spectrum of TIS, and the differential involvement of TNFβ sub-classes.

Methods: French pharmacovigilance database was used to collect data on TIS, excluding patients with previous idiopathic sarcoidosis. Statistical analyses were performed using the Mann-Whitney test for quantitative data and Fisher test for qualitative data. A p value < 0.05 was considered statistically significant.

Results: Data were obtained from 2002 to 2019 for infliximab, adalimumab, golimumab, certolizumab and etanercept. Thirty-one TIS patients were collected from the database, including 12 women (38%). In most cases, TNFβ was introduced for ankylosing spondylitis (58%), psoriasis (19.3%) or rheumatoid arthritis (16.1%). Median age at TIS occurrence was 54 [43.5; 61.5] years, with a median time to onset of 24 [6; 72] months. The most frequent involved TNFβ was etanercept (n=21, 67.8%). The two main clinical TIS manifestations were lymph node (n=27, 87.1%) and lung involvement (n=16, 51.6%). The culprit drug was discontinued in 26 (84%) patients, and a double-barreled inflammatory gun to control both initial and induced disorders was proposed in 19 of them (90.5 %), mostly glucocorticoids (n=13, 68.4%) alone or combined with methotrexate (n=3, 15.8%). Among the 14 patients with the available data, the TIS had completely resolved in 11 (78.6%); for all these last, the TNFβ was discontinued. No significant differences were observed between the TNFβ sub-classes of mononuclear antibodies or fusion proteins, regarding clinical presentation, median time to onset or outcome.

Conclusion: This second largest case-series shows that TIS are mostly encountered with etanercept, but without any difference in clinical or prognostic implications with the other TNFβ sub-classes.

PO5659 LONG-TERM DYNAMICS OF ANTIBODY RESPONSE TO ADALIMUMAB DETECTED WITH A DRUG TOLERANT ASSAY


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Background: Immunogenicity of adalimumab (ADL) has been the subject of extensive research with a major focus on its incidence, antibody titers and effects on clinical outcome. However, the temporal evolution of antibodies, i.e. dynamic and variation in titers, time point of emergent and persistence or transience of the response, remains under elucidated. To investigate this further, it is essential to collect samples at regular intervals and over a longer period of time. Also, a drug tolerant assay should be used to conquer with the phenomenon of drug interference (1).

Objectives: To evaluate the temporal evolution and to distinguish dynamic patterns of antibody response. Secondly, to assess the clinical impact and factors influencing these dynamic patterns.

Methods: ADA and adalimumab concentration were measured in sera of 511 consecutive ADL treated rheumatoid arthritis patients. Serum samples were drawn at week 0, 4, 16, 28, 52, 78 and 104. ADA were measured with a drug tolerant assay (Acid dissociation RadiolImmunAssay). Logistic regression analysis was carried out. Benjamini-Hochberg was used for multiple testing.

Results: Baseline characteristics are depicted in Table 1. Fifty-nine percent of patients (n=300) developed ADA. Based on visual observations patients were