reports have demonstrated that tocilizumab (TCZ) may be efficacious for refractory and relapsing PMR.

Objectives: To determine the real-world efficacy of the 2015 EULAR/ACR algorism for the management of PMR plus introduction of TCZ for refractory and relapsing PMR.

Methods: Patients who had been diagnosed with PMR according to the 2012 EULAR/ACR provisional classification criteria for PMR were recruited in the study. Registered variables included demographic data, disease characteristics, prednisolone (PSL) dosage and duration, addition of methotrexate (MTX) and TCZ, adverse effects, and clinical outcomes.

Results: There were 101 patients who had originally diagnosed as PMR (50 males and 65 females) and followed up for at least one year; the mean ± SD age at onset was 73 ±11 years at onset, with the mean observational period being 44 ± 26 months. Their treatments were initiated with PSL of 15.5 ± 4.3 mg/day. 41 patients experienced disease recurrence after 9.6 ± 6.7 months (median 9 month) of GC therapy, while receiving PSL at 5 ± 4.5 mg/day (3.7 mg/day). Baseline factors that were associated with relapse in our cohort were higher-grade thrombocytosis and higher-dose of initial GC by multivariate analysis. In 30 of the 41 patients who failed GC monotherapy, MTX was added. Five patients reached GC-free remission, but 25 patients failed GC tapering. In such refractory patients to a combination of GC plus MTX, 8 patients agreed to add TCZ therapy, and 5 of them reached drug-free remission. At present, 67 of the total 101 patients maintained drug-free remission, but most others were still receiving low-dose GC and/or MTX (n=17). No significant adverse effects did not occur during therapy, except for GC-related adverse effects such as diabetes, dyslipidemia and osteoprotic fractures.

Conclusion: Our experience indicated that there is notable heterogeneity across PMR patients in terms of drug response, and the patients with severe inflammation, e.g. thrombocytosis, may need higher-dose of initial GC and addition of biologics such as TCZ on the 2015 EULAR/ACR algorism.

Acknowledgments: None

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.6233

FRI0267 CLINICAL CORRELATES AND RELEVANCE OF UCLA GIT 2.0 FOR ESOPHAGITIS AND INDICATION FOR ESOPHAGOGASTRODUODENOSCOPY IN REAL-LIFE PATIENTS WITH SYSTEMIC SCLEROSIS

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Background: The gastrointestinal (GI) tract is frequently involved in systemic sclerosis (SSc). The University of California Los Angeles Scleroderma Clinical Trial Consortium Gastrointestinal Tract Instrument 2.0 (UCLA GIT 2.0) is validated to capture GI morbidity in patients with SSc (1). The routine clinical investigation of GI involvement in these patients is not standardized and there is no consensus about when and how frequently an esophagogastroduodenoscopy (EGD) should be performed.

Objectives: The main aim of this study was to analyze the capacity of UCLA GIT 2.0 to identify patients with erosive esophagitis in an unselected, real-life SSc patients' cohort. Secondary aim was to determine whether the UCLA GIT 2.0 could discriminate SSc patients for whom an expert rheumatologist would recommend an EGD.

Methods: We selected patients fulfilling the ACR/EULAR 2013 criteria for SSc from the Zurich cohort, having completed at least once the UCLA GIT 2.0 questionnaire. We reviewed the medical charts of SSc patients from 2013 to 2019 and recorded data on EGD. We analyzed by univariable logistic regression several parameters, including UCLA GIT 2.0, considered as potentially associated with 1) the referral to EGD and 2) macroscopic esophagitis according to the Los Angeles criteria.

Results: We identified 346 patients (82.7% female, median age 63 years, median disease duration 10 years, 23% with diffuse cutaneous SSc) satisfying the inclusion criteria, who filled in 940 UCLA GIT 2.0 questionnaires.

From 940 visits, 31 were excluded because EGD was done within 3 months before completing the UCLA GIT 2.0. In the 909 remaining visits, EGD was recommended by the expert rheumatologists in 128 cases. In logistic regression, UCLA GIT 2.0 total score and some of its subscales, but also the modified Rodnan skin score (mRSS) and esophageal and stomach symptoms by past medical history, associated with the referral to EGD (Table 1).

Table 1. Logistic regression of factors associated with referral to EGD

	OR (95% CI)	p-value
mRSS	1.04 (1.01 - 1.06)	0.009
Hemoglobin (Hb)	1.00 (0.96 - 1.04)	0.978
Proton pump inhibitor (PPI)	0.37 (0.12 - 1.15)	0.086
Esophageal symptoms	3.37 (2.28 - 4.96)	<0.001
Stomach symptoms	2.93 (2.02 - 4.26)	<0.001
Reflux subscale	2.04 (1.52 - 2.73)	<0.001
Distention/bloating subscale	1.53 (1.24 - 1.89)	<0.001
Social functioning	2.20 (1.57 - 3.07)	<0.001
Emotional wellbeing	1.42 (1.03 - 1.97)	0.034
Total score of UCLA GIT 2.0	**2.27 (1.55 - 3.32)**	**<0.001**

We found data on 177 EGD performed in 150 patients, meaning that 49 EGD were performed on indication by another physician. In logistic regression, mRSS and esophageal symptoms correlated with esophagitis, while neither the total ULCA GIT 2.0 score nor the reflux subscale or any of the other subscales showed an association with esophagitis (Table 2).

Table 2. Logistic regression of factors associated with esophagitis

	OR (95% CI)	p-value
mRSS	1.09 (1.03 - 1.15)	0.001
Hb	1.03 (0.99 - 1.06)	0.126
PPI	0.52 (0.27 - 1.03)	0.059
Esophageal symptoms	2.92 (1.29 - 6.61)	0.010
Stomach symptoms	1.60 (0.80 - 3.21)	0.183
Reflux subscale	1.07 (0.60 - 1.93)	0.816
Distention/Bloating subscale	0.63 (0.39 - 1.01)	0.054
Social functioning	0.65 (0.31 - 1.35)	0.245
Emotional wellbeing	0.77 (0.36 - 1.61)	0.483
Total score of UCLA GIT 2.0	**0.67 (0.28 - 1.60)**	**0.367**

Conclusion: In a real-life setting, UCLA GIT 2.0 subscales (reflux, distention/bloating, social functioning, emotional wellbeing) and total score strongly associated with expert interpretation of gastroesophageal symptoms and consecutive referral to EGD. However, they showed no correlation with esophagitis on EGD. The main clinical association of esophagitis was the presence of esophageal symptoms.

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Disclosure of Interests: Norina Zampatti: None declared, Alexandru Garaiman: None declared, Suzana Jordan: None declared, Mike O. Becker: None declared, Britta Maurer Grant/research support from: AbbVie, Protagen, Novartis, congress support from Pfizer, Roche, Actelion, and MSD, Speakers bureau: Novartis, Rucsandra Dobrota: None declared, Oliver Distler Grant/research support from: Grants/Research support from Actelion, Bayer, Boehringer Ingelheim, Competitive Drug Development International Ltd. and Mitsubishi Tanabe; he also holds the issued Patent on mir-29 for the treatment of systemic sclerosis (US8247389, EP2331143)., Consultant of: Consultancy fees from Actelion, Acceleron Pharma, AnaMar, Bayer, Baecon Discovery, Blade Therapeutics, Boehringer, CSL Behring, Catenion, ChemomAb, Curzion Pharmaceuticals, Ergonex, Galapagos NV, GSK, Glenmark Pharmaceuticals, Inventiva, Italfarmaco, iQvia, medac, Medscape, Mitsubishi Tanabe Pharma, MSD, Roche, Sanofi and UCB, Speakers bureau: Speaker fees from Actelion, Bayer, Boehringer Ingelheim, Medscape, Pfizer and Roche, Carina Mihai: None declared

DOI: 10.1136/annrheumdis-2020-eular.4291

FRIDAY, 05 JUNE 2020

Spondyloarthritis - treatment

FRI0268 REMISSION IN AXIAL SPONDYLOARTHRITIS: IS THERE A DIFFERENCE BETWEEN NSAIDS AND BIOLOGICS IN THE REAL LIFE?

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Background: Randomized-controlled trials (RCTs) done in axial spondyloarthritis (AxSpA) patients have shown that remission in AxSpA and nonradiographic

axial SpA patients treated without biologics (BIOL) occurs infrequently (Ref 1, 2). Few are known about remission rate (RR) in daily clinical practice.

Objectives: Our aim was to assess the remission rate (RR) in AxSpA patients in Real life, and to compare the RR in AxSpA patients on NSAIDs to RR for those on Biologics (TNFα blockers or IL-17A blockers).

Methods: This cross-sectional study reviewed clinical data from a single center (St-Luc university hospitals, UCLouvain, Brussels) from 01/2013 to 03/2019. Last visit available for clinical assessment was evaluated. Disease activity was measured using the Bath Ankylosing Spondylitis disease activity index (BASDAI), and the Ankylosing Spondylitis disease activity score (ASDAS) using the C-reactive protein. Remission was defined as BASDAI < 4 and ASDAS < 1.3.

Results: Data from 551 AxSpA patients were reviewed. 353 were men (64.3%). In the entire cohort, 478 BASDAI and 317 ASDAS were recorded. The RR according to the BASDAI was 46.7% (n = 223), and 17.3% for the ASDAS (n = 55). To look for the treatment-related RR, we stratified by the treatment (NSAIDs vs Biologics). We had 285 patients on NSAIDs (177 men, 62.5%) and 266 on BIOL (176 men, 66%). 245 BASDAI were available for NSAIDs and 233 for BIOL. 110 patients on NSAIDs (44.9%) and 113 on BIOL (48.5%) were in remission for BASDAI. Regarding ASDAS (table below), data from 172 patients on NSAIDs and 144 on BIOL were available. Out of them, 27 (15.7%) and 28 (19.4%) were in remission for NSAIDs and BIOL respectively. Chi-square test: p = 0.853.

Table. Distribution of ASDAS values in both groups.

	ASDAS <1.3	ASDAS ≥ 1.3 < 2.1	ASDAS ≥ 2.1 < 3.5	ASDAS > 3.5
NSAIDs (n = 172)	N = 27 (15.7%)	N = 41 (23.8%)	N = 70 (40.7%)	N = 34 (19.8%)
BIOL (n = 144)	N = 28 (19.4%)	N = 30 (20.8%)	N = 57 (39.6%)	N = 29 (20.1%)

Conclusion: The real life RR in AxSpA seems to be higher on BIOL, even if compared to NSAIDs, the difference is not significant. However, many patients on NSAIDs achieve the remission.

References:

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Disclosure of Interests: Charlotte Baert: None declared, Charlene MOUAFO TOUKAM: None declared, Tatiana Sokolova: None declared, Adrien Nzeusseu Toukap Grant/research support from: AbbVie, Celgene Corporation, Janssen, Pfizer, UCB – grant/research support, Consultant of: AbbVie, Eli Lilly, Janssen, Novartis, UCB – consultant, Speakers bureau: AbbVie, Eli Lilly, Janssen, Novartis, UCB – advisory board member

DOI: 10.1136/annrheumdis-2020-eular.6462

FRI0269

CHARACTERIZATION OF PATIENTS WITH ANKYLOSING SPONDYLITIS WHO INITIATED SECUKINUMAB: ELECTRONIC HEALTH RECORDS DATA FROM THE COLUMBUS REPOSITORY

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Background: Secukinumab was the first anti-interleukin 17A monoclonal antibody treatment approved by the FDA for ankylosing spondylitis (AS). There is scarce information on the characteristics of secukinumab vs other biologic initiators with AS.

Objectives: To describe real-world physician and patient characteristics, and treatment patterns of secukinumab and tumor necrosis factor inhibitor (TNFi) initiators.

Methods: Electronic health records (EHR) data from adult patients with AS who initiated a biologic therapy between January 2018 and March 2019 (index date) were included from the Columbus Repository, a network capturing EHR data from 120 US rheumatology providers. Physician and patient characteristics, and treatment patterns were reported for patients who were prescribed secukinumab and TNFis (adalimumab, etanercept, certolizumab pegol, infliximab, infliximab-abda, and golimumab). Categorical variables were summarized using frequency counts and percentages and continuous variables were presented using means and standard deviations. Standardized mean differences and *P* values were used to compare treatment groups.

Results: As of March 2019, AS treatment data were available for 82 secukinumab initiators and 160 TNFi initiators. Regarding overall practice size, 33% of practices had a single physician, and 65% of physicians were located in the South US region. Secukinumab initiators were younger than TNFi initiators (47.4 vs 49.8 years) and had a similar prevalence of HLA-B27 positivity (≈ 55%; Table 1). Comorbid psoriatic arthritis (PsA) was more commonly reported among secukinumab initiators vs TNFi initiators (17% vs 9%), while hypertension (5% vs 11%), obesity (2% vs 11%), and uveitis (2% vs 9%) were less common (Figure 1). Secukinumab initiators were more likely to have prior opioid use vs TNFi initiators but were less likely to have prior methotrexate use (Figure 2**A**); 67% of secukinumab initiators and 49% of TNFi initiators were biologic experienced, of whom 73% and 76%, respectively, used 1 prior biologic, 25% and 20% used 2 prior biologics, and 2% and 4% used ≥ 3 prior biologics (Figure 2**B**). The most common reasons for discontinuation of prior biologics among secukinumab and TNFi initiators were because the biologic was no longer required (47% vs 41%) and lack of efficacy (20% vs 24%) (Figure 2**C**).

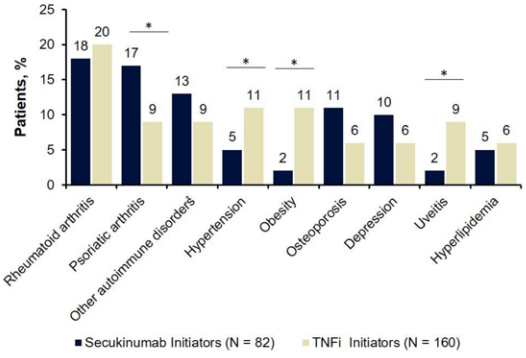
Table 1. Baseline Demographics and Disease Characteristics Among Patients With AS at the Index Date.

Characteristic	Secukinumab (N = 82)	TNFi (N = 160)	SMD*	*P* Value
Age, mean (SD), years	47.4 (12.8)	49.8 (14.6)	0.17	0.21
Female, n (%)	43 (52)	90 (56)	0.08	0.57
Race/ethnicity, n (%)	N = 65	N = 129	0.20	0.66
White	52 (80)	106 (82)		
Hispanic	8 (12)	13 (10)		
Black	3 (5)	8 (6)		
Asian	1 (2)	2 (2)		
Other	1 (2)	0		
Geographic distribution, n (%)			0.37	0.05
South	49 (60)	113 (71)		
Midwest	27 (33)	28 (18)		
West	5 (6)	16 (10)		
Northeast	1 (1)	3 (2)		
Health insurance, n (%)	N = 79	N = 156	0.41	0.39
Commercial	57 (72)	94 (60)		
Medicare	8 (10)	33 (21)		
Medicaid	2 (3)	4 (3)		
Other	12 (15)	25 (16)		
HLA-B27 positivity, n (%) [N]	14 (54) [N = 26]	31 (56) [N = 55]	0.05	1.00
Body mass index, mean (SD), kg/m^2	30.6 (6.1)	30.9 (7.7)	0.03	0.82

SMD, standardized mean difference.

* Comparisons with SMD > 0.1 were suggestive of clinically relevant differences.

Figure 1. Comorbidity Profile (≥ 5% of Patients) of Secukinumab vs TNFi Initiators With AS*



SMD, standardized mean difference.
* Comparisons with SMD > 0.1 were suggestive of clinically relevant differences.
† Including Sjögren syndrome, vitiligo, and systemic lupus erythematosus.

Conclusion: Secukinumab initiators with AS were younger and more opioid and biologic experienced, were more likely to have a PsA diagnosis, and were more likely to discontinue their previous biologic because the biologic was no longer required compared to patients who initiated TNFis.

Acknowledgments: This study was funded by Novartis Pharmaceuticals Corporation, East Hanover, NJ. Support for third-party writing assistance for this abstract, furnished by Kheng Bekdache, PhD, of Health Interactions, Inc, was provided by Novartis Pharmaceuticals Corporation, East Hanover, NJ.

Disclosure of Interests: Howard Busch Speakers bureau: AbbVie, Amgen, Crescendo, Exagen, Genentech, Mallinckrodt, Novartis, Primus, Sanofi/Regeneron, and UCB, Jeffrey Curtis Grant/research support from: AbbVie, Amgen, Bristol-Myers Squibb, Corrona, Janssen, Lilly, Myriad, Pfizer, Regeneron, Roche, UCB, Consultant of: AbbVie, Amgen, Bristol-Myers Squibb, Corrona, Janssen, Lilly, Myriad, Pfizer, Regeneron, Roche, UCB, Peter Hur Employee of: Novartis