Conclusion: The introduction of small molecule agents in the EU over recent years (upadacitinib and filgotinib) has provided new options for the treatment of RA, creating a shift in the switching arena from TNF cycling to more utilization of alternate mechanisms of action post first line therapy in favor of JAK inhibitors.
REFERENCES: None
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AB0420 UNINTENTIONAL MONOTHERAPY IN RHEUMATOID ARTHRITIS PATIENTS RECEIVING TOFACITINIB AND DRUG SURVIVAL RATE OF TOFACITINIB

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Background: Combination of MTX with a bDMARDs or tsDMARDs is considered the most effective treatment regimen currently available for patients with RA who have failed to respond to conventional DMARDs. However, approximately 30% of patients receive bDMARDs as monotherapy in daily clinical practice. Studies in the literature do not assess unintentional monotherapy in general. However, it is thought that some patients may switch to monotherapy unintentionally. In other words, some patients who are prescribed combination therapy switch to monotherapy without informing their physicians.
Objectives: To determine the rate of unintentional monotherapy in rheumatoid arthritis (RA) patients receiving tofacitinib and to evaluate tofacitinib survival rate.
Methods: This national, multicentre, retrospective study included patients' data from the TURKBIO Registry. Data on demographics, clinical characteristics, disease duration and activity, comorbidities, and treatment were analysed.
Results: Data of 231 RA patients (84.8% female, median age, 56 years) were included; 153 were initially prescribed combination therapy and continued to their therapies; 31 were initially prescribed combination therapy but switched to monotherapy of their own will (unintentional monotherapy); 21 were initially prescribed monotherapy and switched to combination therapy; 26 were initially prescribed monotherapy and continued to their therapies. The combination and unintentional monotherapy groups did not differ regarding remission rate assessed by DAS28-CRP (60.5% and 70%, respectively, p=0.328). The rate of comorbidities at the time of data retrieval was significantly higher in the unintentional monotherapy group compared with the combination group (83.3% vs. 60.3%, p=0.031). Presence of comorbidities was a significant factor affecting switching to monotherapy (p=0.039, Odds ratio: 3.29, 95% CI: 1.06-10.18). Drug survival rates of the unintentional monotherapy and combination groups did not differ. The median drug survival duration of tofacitinib was 27+ months with a 1-year and 4-year drug survival rates of 89.6% and 60.2%, respectively, in the unintentional monotherapy group.
Conclusion: Although 13.4% of the study population started monotherapy unintentionally, drug survival rates of the unintentional monotherapy and combination groups were not different. Comorbidity was an important factor affecting transition from combination therapy to monotherapy. This study was sponsored by Pfizer.
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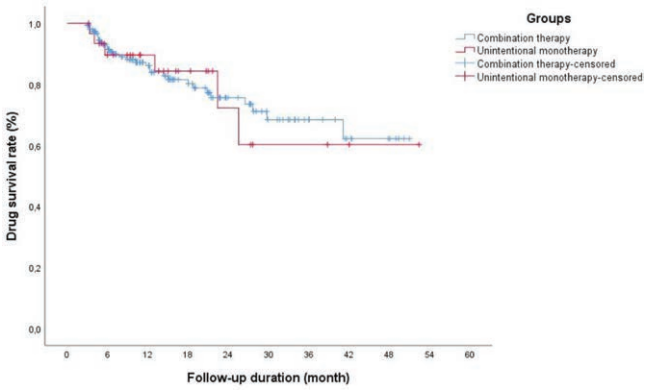

Figure 1.

AB0421 ASSESSEMENT OF LIVER STIFFNESS IN RHEUMATOID ARTHRITIS PATIENTS UNDER METHOTREXATE

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Background: Methotrexate (MTX) is recommended as a first-line disease-modifying antirheumatic drug for treating rheumatoid arthritis (RA) in monotherapy or combinational therapy. A concern about MTX-related liver fibrosis in patients with rheumatoid arthritis (RA) is still unsolved.
Objectives: The aim of the study cutoff of cumulative dose discriminating patients with normal from those with abnormal liver stiffness.
Methods: We conducted a cross-sectional study including consecutive RA patients diagnosed according 2009 ACR-EULAR criteria. Liver stiffness (LS) was assessed by Fibroscan in the gastroenterology department by an experienced operator. The LS is measured in kilopascals (kPa). It is normal when < 6.2 kPa. Above this rate it is considered pathological. Substantial liver fibrosis was defined as liver stiffness of greater than 8 kPa. We collected the following parameters: age, disease duration, disease activity assessed by DAS28, cumulated dose of MTX and duration of this treatment, and the body mass index (BMI). Patients underwent blood testing exploring hepatic function: alkaline phosphatase (ALP), alanine transaminase (ALT), aspartate aminotransferase (AST), and gamma-glutamyl tansferase (GGT), total bilirubin (TB), albumin (ALB) and prothrombin time (PT). Statistical analysis was performed using SPSS software.
Results: There were 18 men and 36 women. The mean age was 51.9 + 11.49 [22-83]. The mean BMI was 27.27 + 3.40. The mean disease duration 8.08 + 6.28 years. The mean DAS28CRP was 3.96 + 1.49. The mean cumulative dose of MTX was 3670 + 3432.61mg and mean MTX duration was 55.75 + 50.89 months. The mean of LS was 4.6 + 1.64 kPa. The means of the liver blood tests are as follows: AST 20.83 + 8.58 UI/L, ALT 19.60 + 9.39 UI/L, ALP 84.65 + 38.68UI/L, TB 9.50 + 4.79 UI/L, GGT 25.88 + 14.26UI/L, ALB 35.19 + 5.47 g/L, PT 94.60 + 9.02. Eight patients had abnormal LS values and two patients had advanced liver fibrosis. However, hepatic blood tests (AST, ALT, GGT, TB, ALB, PT) were normal in these patients. A correlation was found between LS and following parameters: cumulative dose of MTX (r: 0.347, p: 0.013), the methotrexate duration (r: 0.363, p: 0.010) and total bilirubin rate (r:0.390, p: 0.005). Receiver Operator Curve (ROC) analysis showed the cut-off point of cumulative dose of MTX with the best accuracy in distinguishing patients with normal LS from those with LS higher than 6.2 kPA was 7330 mg, with a sensitivity of 50% and specificity of 91.3% (air under the curve (AUC) value: 0.732 (p=0.03).
Conclusion: Our study showed that LS correlated to both MTX duration and cumulative dose. Patients with a cumulative dose of MTX higher than 7330 mg required a close follow up of liver elastometry and monitoring of hepatic function.
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