Table 1. Main general features at baseline.

	UIP (n=106)	NSIP (n=84)	p value
Age, years mean±SD	66±10	63±10	**0.049**
Women, n (%)	59 (56)	49 (58)	0.71
Smoker ever, n (%)	51 (48)	45 (54)	0.46
ILD duration up toABA, months, median [IQR]	16 [4-50]	11 [2-36]	0.57
RF	100 (94)	71 (85)	**0.041**
ACPA, n (%)	96 (91)	75 (89)	0.83
FVC (% of the predicted), mean±SD	82±21	89 ±19	**0.025**
DLCO (% of the predicted), mean±SD	63 ±19	65 ±16	0.46
ABA monotherapy, n (%)	45 (42)	41 (49)	0.38
ABA combined+ MTX // + other cDMARD, n (%)	15 (14) // 46 (43)	16 (19) // 27 (32)	0.17
Prednisone at baseline, mg/day, median [IQR]	7.5 [5-10]	10 [5-10]	0.20
Previous immunosuppressive therapy, n (%)			
MTX	81 (76)	68 (81)	0.45
Leflunomide	48 (45)	31 (37)	0.25
Sulfasalazine	16 (15)	5 (6)	**0.046**
Hydroxychloroquine	24 (23)	16 (19)	0.55
Anti-TNF drugs	37 (35)	30 (36)	0.80
Rituximab	19 (18)	15 (18)	0.99
Tocilizumab	12 (11)	12 (14)	0.54

ABA, abatacept; ACPA, anti-citrullinated protein antibodies; DMARD, disease-modifying anti-rheumatic drug, ILD, Interstitial lung disease; MTX, methotrexate; NSIP, non-specific interstitial pneumonia; RA, rheumatoid arthritis; TNF, tumor necrosis factor; UIP, usual interstitial pneumonia.

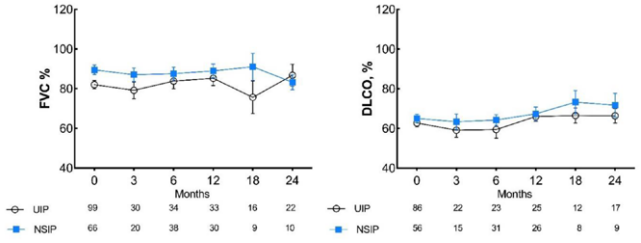


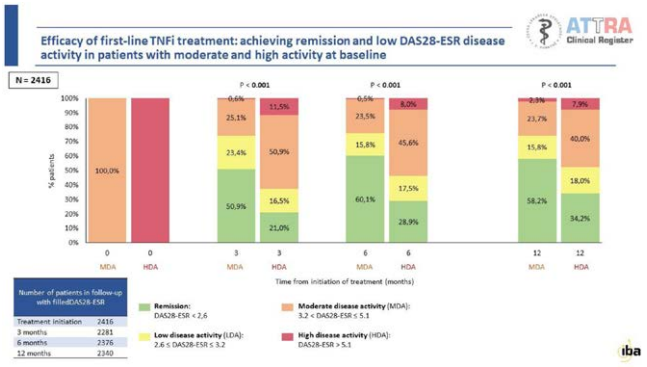
Figure 1. Evolution of pulmonary function tests in RA-ILD patients with UIP and NSIP patterns. FVC and DLCO are expressed as mean (95%CI) and compared between the 2 groups.

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POS0596 THE THERAPEUTIC TARGET IS REACHED MORE OFTEN IN RA PATIENTS STARTING TNF INHIBITORS WITH MODERATE ACTIVITY THAN WITH HIGH DISEASE ACTIVITY – AN ANALYSIS FROM THE ATTRA REGISTRY

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Background: Treat to target guidelines recommend achieving remission or low disease activity in rheumatoid arthritis (RA). In the Czech Republic, anti-TNF therapy has been reimbursed only for patients with highly active RA until 2019, when pts with LDA have been also included in the reimbursement policy.
Objectives: The aim of the study was to compare the results of treatment in patients with rheumatoid arthritis and moderate disease activity (MDA) or high disease activity (HDA) starting the therapy with the first anti-TNF drug in routine clinical practice.
Methods: This was a retrospective cohort study of patients treated with the first anti-TNF drug in the Czech Republic. Propensity score was used to match pts starting anti-TNF in MDA or HDA for other important predictive factors. The propensity score was obtained by logistic regression with 10 covariates (gender, age, disease duration, seropositivity, comedication with MTX, comedication with other csDMARDs, number of previosu csDMARDs, anti-TNF drug),.Within the paired groups, one-dimensional logistic models were then calculated to estimate the odds of remission / low activity after 6 and 12 months of treatment.
Results: A total of 2416 patients were analyzed in the study. 2231 patients had high activity (DAS 28> 5.1) and 185 patients had moderate activity (3.2 <DAS28 ≤ 5.1) at baseline. After 12 months, the low activity state (DAS28 < 3.2) was achieved by patients with MDA in 74.0% and patients with HDA in 52.2%, (p <0.001) (FIG 1). The differences btw groups were significant in all evaluated intervals of 0, 3, 6, 12 months. Furthermore, a comparison of patients with MDA and HAD by propensity score matching, who no longer differ in the baseline characteristics (except for disease activity and quality of life) was performed. Patients with MDA were 2.4x more likely to achieve remission or low activity according to DAS28-ESR after 6 months and 1.7x more likely to achieve remission or low activity after 12 months of treatment compared to patients with HDA at the beginning of treatment.



Conclusion: This analysis of the results of treatment with anti-TNF drugs in the ATTRA Registry has shown that starting anti-TNF therapy in patients with RA and MDA leads more often to the target of remission or low activity, than in pts with HDA.
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POS0597 EFFECTS OF RITUXIMAB IN PATIENTS WITH RHEUMATOID ARTHRITIS-RELATED INTERSTITIAL LUNG DISEASE: A SINGLE-CENTRE EXPERIENCE FROM TURKEY

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Background: Rheumatoid arthritis-related interstitial lung disease (RA-ILD) is the most common type of lung involvement in rheumatoid arthritis (RA). The existence of RA-ILD is associated with worse survival. There is no mainstay treatment for RA-ILD. However, in recent studies, rituximab (RTX) seems to be effective in RA-ILD.
Objectives: To determine the effects of RTX in patients with RA-ILD from a single-centre.
Methods: In our biological treatment outpatient clinic, a retrospective study was conducted in patients with RA who were treated with RTX. Among them, patients with RA-ILD were analysed. For lung response to RTX, progression was defined as a decline of 10% ≥ in forced vital capacity (FVC) and/or a decline of 15% ≥ in diffusion capacity of carbon monoxide (DLCO). Computed tomography of the chest (chest-CT) were integrated to lung response so as to constitute missing data of pulmonary function tests (PFTs).
Results: A total of 165 patients who are followed-up in our biological treatment outpatient clinic have been using RTX for their RA diagnosis. Among 165 patients, 26 (15.8%) patients with RA-ILD were initiated RTX. Five patients were diagnosed with RA-ILD while using RTX (incidence rate 3%). Patients' characteristics were demonstrated in table 1. Of 26 patients, the most commonly used concomitant disease-modifying antirheumatic drugs was leflunomide (46.2%) followed by mycophenolate mofetil (11.5), methotrexate (11.5%) and azathioprine (3.8%). Twenty-four (92.3%) patients used steroids. For the evaluation of lung response, 20 patients who had follow-up PFTs and/or chest-CT were compared.

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Median DLCO values for pre- and post RTX were 71.0% (60.0-77.0) and 63.0% (47.0-74.0), respectively (p= 0.061). Median pre and post-RTX FVC were 74.0% (61.0-99.0) and 84.0% (63.0-100.0), respectively (p= 0.28). After a median of 2.7 years, 11 (55.0%) patients had stable disease, 2 (10.0%) patients had regression of RA-ILD and 7 (35.0%) patients had progressive disease. Sex, age, seropositivity and radiographic patterns were not associated with progression. In total, 23 adverse events were detected in 11 (42.3%) patients. Five of them were serious infections requiring hospitalization, mostly pneumonia. Other adverse events were simple infections and surgeries such as arthroplasty. RTX was stopped in 4 (15.4%) patients due to infections secondary to hypogammaglobulinemia in 2, malignancy in 1 and allergic reaction in 1.

Conclusion: RTX seems to achieve stabilization/improvement of RA-ILD with fewer adverse events. However, given that RA-ILD develops post-RTX, it is not a panacea; therefore, we need more effective treatment modalities in the case of RA-ILD.

Table 1. Characteristics of 26 patients with RA-ILD treated with rituximab

Age at first RTX infusion, median (IQR), years	61.2 (57.1-65.1)
RA disease duration at first RTX, median (IQR), years	10.1 (4.3-29.7)
ILD disease duration at first RTX, median (IQR), years	1.9 (0.1-4.5)
Age at RA diagnosis, median (IQR), years	51.1 (40.0-60.6)
Age at ILD diagnosis, median (IQR), years	58.3 (53.9-63.3)
Male patient, n (%)	16 (61.5)
RF positivity, n (%)	25 (96.2)
ACPA positivity, n (%)	20 (90.9)
CRP levels,mg/L, mean (SD)	40.3 (58.9)
ESR levels, mean (SD)	37.7 (18.2)
Smoking status, n (%)	16 (64.0)
Prior TNF inhibitor treatment, n (%)	5 (19.2)
DAS28 at first RTX infusion, mean (SD)	5.3 (1.5)
Radiographic pattern, n (%)	
UIP	7 (26.9)
NSIP	8 (30.8)
OP	2 (7.7)
Indeterminate	8 (30.8)
Others	1 (3.8)
Follow-up duration, median (IQR), years	2.5 (1.2-3.7)

RA-ILD= Rheumatoid arthritis-related interstitial lung disease, RTX= rituximab, RA= rheumatoid arthritis, RF= rheumatoid factor, ACPA= anti-citrullinated protein antibody, TNF= tumor necrosis factor, CRP= C-reactive protein, ESR= erythrocyte sedimentation rate, UIP= usual interstitial pneumonia, NSIP= non-specific interstitial pneumonia, OP= organizing pneumonia

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POS0598 COMPARISON OF INJECTION SITE REACTIONS AND INJECTION SITE ERYTHEMA BETWEEN YLB113 AND ETANERCEPT REFERENCE PRODUCT FROM PHASE 3 ACTIVE COMPARATOR STUDY (STUDY NO. YLB113-002)

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Background: YLB113 is an etanercept biosimilar approved in all indications of its etanercept Reference Product (RP). Therapeutic equivalence in terms of clinical efficacy, safety and immunogenicity was previously demonstrated in a pivotal multicenter, double-blind, randomized, parallel-group, active-control, comparative study (YLB113-002) in rheumatoid arthritis (RA) subjects.[1,2] Similar incidence of treatment emergent adverse events (TEAEs) was seen in both treatment arms except for injection site reactions (ISRs) and injection site erythema (ISE), both of which were less frequent in subjects treated with YLB113.

Objectives: This post-hoc analysis was performed to further evaluate the differences in the incidence of ISRs and ISE during the 24 week treatment when the subjects with RA were treated with 50 mg of YLB113 or RP given once a week as a SC injection along with methotrexate.

Methods: Safety analysis set (263 in YLB113 arm and 254 in RP arm) was considered for this analysis.

Local reactions at the site of injection were assessed at each of eight study visits. The number of subjects who experienced ISRs and ISE were statistically compared for YLB113 and RP. The risk difference and 95% confidence interval (CI) were computed between arms to understand the magnitude of difference in the incidence of events. The statistical significance of between group difference was tested using chi-square test.

Results: The result of this analysis showed a statistically significant difference in the incidences of ISRs and ISE between subjects who received YLB113 and RP. The risk difference between YLB113 and RP arms for ISR was -9.98% (95% CI, WALD -14.81%, -5.15%) and, for ISE it was -7.94% (95% CI, WALD -11.96%, - 3.92%; Table 1). This could be possibly explained by the absence of latex in the syringe needle cap of YLB113.[3]

Table 1. Differences in ISRs and ISEs between YLB113 and Reference Product (RP)

Event	YLB113 N=263	RP N=254	YLB113 vs RP	
	No of subjects with events [n(%)]	No of subjects with events [n(%)])	Risk Diff (95%CI, WALD)	P-value (Chi-Square)
Injection-site reactions	10 (3.8%)	35 (13.8%)	-9.98% (-14.81%, -5.15%)	<0.0001
Injection-site erythema	5 (1.9%)	25 (9.8%)	-7.94% (-11.96%, -3.92%)	0.0001

Conclusion: YLB113 has shown statistically significant lower incidences of ISRs (P-value <0.0001) and ISEs (P value 0.0001) compared to RP. This property may translate to a better acceptability by patients.

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POS0599 DISEASE ACTIVITY IN PATIENTS WITH RA BY SEROSTATUS AND TREATMENT LINE, FOLLOWING TREATMENT WITH ABATACEPT: RESULTS FROM AN INTERNATIONAL OBSERVATIONAL STUDY

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Background: RF and anti-citrullinated protein antibodies (ACPAs) are associated with a severe and aggressive disease course in patients with RA.[1] Abatacept is a selective co-stimulation modulator for the treatment of RA.[2] ASCORE (Abatacept SubCutaneOus in Routine Clinical PracticE; NCT02090556) was a 2-year, observational, prospective, multicentre study of SC abatacept for the treatment of RA in routine clinical practice.[3]

Objectives: To determine if serostatus and treatment line impacted disease activity in patients enrolled in the ASCORE study.

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