P147 IS BELIMUMAB DOSE OPTIMIZATION POSSIBLE IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS? ANALYSIS OF THIS THERAPEUTIC STRATEGY IN A LARGE MULTICENTER COHORT OF PATIENTS FROM SPANISH RHEUMATOLOGY DEPARTMENTS

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10.1136/lupus-2024-el.201

Objective To assess the prevalence of dose optimization in patients with SLE treated with BLM, its modalities and its impact on disease activity control.

Methods Retrospective longitudinal and multicenter study of SLE patients treated with BLM in Spain. Activity (SLEDAI), treatments and outcomes (remission (DORIS-2021) and low disease activity (LLDAS) were collected at baseline (pre-optimization) (VB), at 6 (V6M) and at 12 months (V12M) post optimization. A comparative analysis was performed pre- and post-optimization.

Results 324 patients were included; mean age (±DS): 42.4 (±12.9) years. A total of 29 patients (8.9%) were optimized. Median time to optimization 2.7 (1.77–4.48) years. Mean time on optimization: 11.36 (±2.5) months. BLM was administrated intravenously (iv) in 20 patients and 9 used the subcutaneous route (sc). A total of 15/20 iv BLM patients had their dose reduced (from 10mg/kg to 5–9 mg/Kg). Other 5/20 iv BLM patients, had their administration interval increased (from 4 weeks to 5–6 weeks). All sc BLM patients increased the interval of administration (from 7 to 10–21 days).

Pre-optimization status (VB): 15/26 (57.7%) in DORIS-21 and 23/26 (88.5%) in LLDAS. Post-optimization: 2/24 (8.3%) and 3/22 (13.6%) patients lost DORIS-21 in V6M and V12M, respectively (no statistically significant differences). Regarding to LLDAS, 2/23(8.7%) and 2/21(9.5%) did so in V6M and V12M, respectively (no statistically significant differences). Out of 11/23(47.8%) and 9/21(42.9%) moved from SLEDAI 0 to SLEDAI >0 in V6M and V12M, respectively. In terms of disease activity, no significant differences were found pre- and post-optimization in any of the measures, except for hypocomplementemia (p = 0.0276). Changes in activity did not lead to relevant changes in treatment. Significantly fewer patients received GC in V12M, even though the median dose of GC was higher in V12M (5 (0.62–8.75) vs. 2.5 (0–5) in (VB) (table 1).

Conclusions It is possible to optimize doses of BLM without relevant changes in disease activity, at least in the short term, in a significant percentage of patients, and the most of them maintain the optimized dose. However, the increased clinical or serologic activity is possible in some patients. This makes a tighter post-optimization follow-up advisable.

Abstract P147 Table 1 Clinical, serological and treatment differences between pre and post BLM treatment

	VB (pre opBLM)	V6M (post opBLM)	V12M (post opBLM)
SLEDAI, median (p25-p75)	0 (0–2)	2 (0–49)	0 (0–2)
PGA (0–3), median (p25-p75)	0.33 (0–0,5)	0.28 (0–0,48)	0.2 (0–0.4)
Remission DORIS, N/total (%)	15/26 (57.7%)	14/22 (63.6%)	12/19 (63.2%)
LLDAS, N/total (%)	23/26 (88.5%)	20/22(90.9%)	17/19(89.5%)
CRP, median (p25-p75)	1.65 (0.4–5.5)	1.63(0.46–4.14)	0.7(0.25–3.9)
C3 or C4 low, N/total (%)	5/26(19.2%)	11/25(44%) #	7/20(35%) #
Anti-DNA antibodies, N/total (%)	5/26(19.2%)	2/24(8.3%)	0/20(0%)
Active serology *, N/total (%)	8/29(27.6%)	13/24(54.2%)	7/20(35%)
DMARDs, N/total (%)	17/26(65.4%)	14/25(56%)	10/20(50%)
Patients on GC, N/total (%)	15/26(57.7%)	12/24(50%)	8/20(40%) #
GC dose, median (p25-p75)	2.5 (0–5)	2.5 (0–5) #	1.25 (0–5) #

SLEDAI: Systemic Lupus Erythematosus Disease Activity Index
PGA: Physician Global Assessment
LLDAS: Lupus Low Disease Activity State
DMARDs: Disease-modifying anti-rheumatic drugs
GC: Glucocorticoids. CRP: C Reactive Protein. * Active serology means complements and or anti-DNA