in B cells (p=3e-26), CD8+ T cells (3e-12) and CD4+ T cells (p=9e-10).

A trans-pQTL for IFNGR1 level in monocytes (rs1801274 in FCGR2A; p=3e-23) and a suggestive significant pQTL (p<5.0e-5) for IFN-γ-induced STAT1 phosphorylation in monocytes (rs912784 in LRRRC63) were previously associated with SLE. Notably, none of the SNPs in TYK2, STAT4 or IRF5 reached the suggestive significant levels for the parameters studied, and no enrichment of SLE-associated SNPs were identified among pQTLs.

Conclusions We demonstrate a cell-type and stimuli-specific genetic regulation of the IFN system. Two SNPs previously linked to SLE were associated with alterations in the IFN-γ-receptor expression or response. Further studies to determine the underlying mechanisms of these associations are ongoing.

O24 FLARE ASSESSMENTS IN PATIENTS WITH ACTIVE SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) TREATED WITH ANIFROLUMB IN 2 PHASE 3 TRIALS

1Richard Furie, 2Eric F Morand, 3Anca Askanase, 4Ed Vital, 5Rubana N Kalyani, 6Gabriel Albreu, 7Lila Pineda, 8Raj Tummala. 1Zucker School of Medicine at Hofstra/ Northwell, Great Neck, NY, USA; 2Monash University, Melbourne, VIC, Australia; 3Columbia University College of Physicians and Surgeons, New York, NY, USA; 4University of Leeds, Leeds, UK; 5NHRI Leeds Biomedical Research Centre at Leeds Teaching Hospitals NHS Trust, Leeds, UK; 6AstraZeneca, Gaithersburg, MD, USA; 7AstraZeneca, Gothenburg, Sweden

Background Anifrolumab treatment improved BICLA response rates in patients with SLE in the phase 3 TULIP-2 and TULIP-1 trials (Morand et al, 2020; Furie et al, 2019). In addition, annualized flare rates were lower with anifrolumab vs placebo. TULIP-2 and TULIP-1 data were analyzed to assess effects of anifrolumab on the number of flares and time to first flare during 52 weeks of treatment.

Methods The randomized, double-blind, placebo-controlled TULIP-2 and TULIP-1 trials evaluated efficacy and safety of intravenous anifrolumab (300 mg Q4W) over 52 weeks in patients with moderate to severe SLE despite standard-of-care treatment. Flares were defined as ≥1 new BILAG-2004 A or ≥2 new (worsening) BILAG-2004 B domain scores compared with the prior month’s visit. Number of flares, time to first flare, and annualized flare rate were assessed.

Results In TULIP-2 (anifrolumab, n=180; placebo, n=182) and TULIP-1 (anifrolumab, n=180; placebo, n=184), fewer anifrolumab-treated patients experienced ≥1 flare (TULIP-2: 31.1%, n=56; TULIP-1: 36.1%, n=65) vs placebo-treated patients (TULIP-2: 42.3%, n=77; TULIP-1: 43.5%, n=80). Results favoring anifrolumab were observed in time to first flare (TULIP-2: hazard ratio [HR]=0.65, 95% confidence interval [CI] 0.46–0.91; TULIP-1: HR=0.76, 95% CI 0.55–1.06; figure 1) and annualized flare rates (TULIP-2: adjusted rate ratio=0.67, 95% CI 0.48–0.94; TULIP-1: rate ratio=0.83, 95% CI 0.60–1.14).

Conclusions Across 2 phase 3 trials, we observed reduced total number of flares and annualized flare rates, as well as prolongation of time to first flare with anifrolumab treatment vs placebo. These results support the potential of anifrolumab to reduce disease activity and reduce flares, benefiting patients with SLE.