Among biologic monotherapies, greater ACR20/50/70 responses were observed with TCG IV than with TNFα inhibitors. When comparing biologics + MTX with biologic monotherapies, ACR20/ACR50, and ACR70 responses with TCX + MTX were similar to TCX as monotherapy (OR=1.04, 95% CI 0.92-2.80; OR=1.28, 95% CI 0.46-3.51; OR=0.97, 95% CI 0.38-2.49, respectively). Greater ACR20/50/70 responses were observed with TCX compared with TNFα monotherapy (OR=2.22, 95% CI 0.46-10.83, probability better=84%; OR=3.12, 95% CI 0.60-16.32, probability better=92%; OR=1.39, 95% CI 0.26-6.78, probability better=68%, respectively). Sensitivity analyses showed no change in results for the indirect comparisons between MTX versus tocilizumab. CONCLUSIONS: Results suggest that most of the novel DMARDs, in combination with MTX, have similar levels of efficacy in DMARD-IR patients. As monotherapy, TCX is likely to have a greater response than aTNFs and tocilizumab. TCX monotherapy also shows comparable results compared with aTNFs in combination with MTX showed greater ACR responses compared with aTNF monotherapy at 24 weeks.

PMS6
META-ANALYSIS OF EFFICACY OF ETANECETAN FOR PSORIATIC ARTHRITIS
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OBJECTIVES: Psoriatic arthritis (PA) is an inflammatory disease affecting joints and connective tissues. The anti-tumor necrosis factor (TNF) biologics are increasingly being used in patients who have failed traditional disease-modifying antirheumatic drugs. Etanecetan has shown efficacy in treatment of PA. METHODS: For this meta-analysis we included randomized controlled trials (RCTs) evaluating etanercept for the treatment of PA. Eligible RCTs were identified by searching PubMed, Embase, BIOSIS, and Cochrane Database. The primary outcome measures were pooled response rates for placebo for PsARC and HAQ. Other outcomes included pooled response rates for Etanercept for PsARC and HAQ, and patient-reported outcomes using the SF-36 (range: 0-100; higher scores better QoL); Both CSMG and Chinese Score for MG (CSMG; range 12-60; higher scores worse weakness), and QoL. Regression analysis was performed on a random double blind clinical trial. Consecutive MG patients enrolled, and are blindly separated into Chinese herb group and control group. The Chinese herb group is treated with Huangqi formula and control group with placebo. Treatment duration is four weeks. Muscle weakness is assessed by Chinese Score for MG (CSMG, range 12-60; higher scores worse weakness), and QoL as an additional outcome measure. The SF-36 are evaluated at the enrollment and after four-week treatment. RESULTS: Analysis is based on 248 patients (male 110, 44%; age=46.18 year), of whom 125 patients randomized into the Chinese herb group, and 123 finished the treatment. 123 in the control group and 120 finish the study. There is no significant difference in demographic and clinical characteristics between two groups (P>0.05), and no difference in CSMG (Chinese herb vs control groups: 24.1±5 vs 23.6±6) and SF-36 (P>0.05). However, no significant changes are found in SF-36 scores between the two groups at 12 weeks (56.7±1.61 and 57.8±1.59). CONCLUSIONS: This study proves that Chinese herb can relieve MG patients’ muscle weakness, but it is not enough to improve patients’ QoL in four weeks.

PMS9
FACTORS ASSOCIATED WITH THE INITIATION OF BIOLGIC DISEASE MODIFYING ANTIRHEUMATIC DRUGS IN TEXAS MEDICAI PATIENTS WITH RHEUMATOID ARTHRITIS
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OBJECTIVE: To examine if (1) time to initiation (TTI) of biologic DMARD therapy (B-DMARD) differs by DMARD (B-DMARD type, and therapy, and (2) likelihood of initiation of B-DMARD differs by NB-DMARD type and therapy while controlling for covariates. METHODS: Texas Medicaid medical and prescription, claims data from 2010 to 2012 were analyzed to identify patients who were diagnosed with rheumatoid arthritis (ICD-9 CM 714.0x) with use of at least two B-DMARDs was compared with patients receiving OPM. RESULTS: Time to B-DMARD therapy for MTX (356.9±28.9 days) was longer than with aTNF monotherapy (254.0±29.8 days) and tofacitinib (204.6±27.6 days). When comparing biologics to NB-DMARDs and tofacitinib showed conflicting results for the indirect comparison of tofacitinib with aTNF monotherapy (OR=0.97, 95% CI, 0.39-2.80, probability better=95%), but with aTNFs and TNFα inhibitors (OR=2.714) patients receiving OPM. CONCLUSIONS: The likelihood of initiating B-DMARD therapy for MTX (356.9±28.9 days) was longer than with aTNF monotherapy (254.0±29.8 days) and tofacitinib (204.6±27.6 days). When comparing biologics to NB-DMARDs and tofacitinib showed conflicting results for the indirect comparison of tofacitinib with aTNF monotherapy.