Subcutaneous golimumab for children with active polyarticular-course juvenile idiopathic arthritis: results of a multicentre, double-blind, randomised-withdrawal trial

Hermine I Brunner,1 Nicolio Rupert0,2 Nikolay Tzaribachev,3 Gerd Horneff,4 Vyacheslav G Chasnyk,5 Violeta Panaviene,6 Carlos Abd-Mendoza,7 Andreas Reiff8 Ekaterina Alexeeva,9 Nadina Rubio-Pérez,10 Vladimir Keltsev,11 Daniel J Kingsbury,12 Maria del Rocio Maldonado Velázquez,13 Irina Nikishina,14 Earl D Silverman,15 Rik Joos,16 Elzbieta Smolewska,17 Márcia Bandeira,18 Kirsten Minden,19 Annet van Royen-Kerkhof,20 Wolfgang Emminger,21 Ivan Foeldvari,22 Bernard R Lauwerys,23 Flavio Szteinbok,24 Keith E Gilmer,25 Zhenhua Chiang,25 Jocelyn H Leu,25 Lilianne Kim,25 Sarah L Lambeth,25 Matthew J Loza,25 Daniel J Lovell,1 Alberto Martini,2 for the Paediatric Rheumatology International Trials Organisation (PRINTO) and the Pediatric Rheumatology Collaborative Study Group (PRCSG)

ABSTRACT

Objective This report aims to determine the safety, pharmacokinetics (PK) and efficacy of subcutaneous golimumab in active polyarticular-course juvenile idiopathic arthritis (polyJIA).

Methods In this three-part randomised double-blinded placebo-controlled withdrawal trial, all patients received open-label golimumab (30 mg/dose) every 4 weeks together with weekly methotrexate during Part 1 (weeks 0–16). Patients with at least 30% improvement per American College of Rheumatology Criteria for JIA (AICR ACR30) in Part 1 entered the double-blinded Part 2 (weeks 16–48) after 1:1 randomisation to continue golimumab or start placebo. In Part 3, golimumab was continued or could be restarted as in Part 1. The primary outcome was JIA flares in Part 2; secondary outcomes included JIA ACR50/70/90 responses, clinical remission, PK and safety.

Results Among 173 patients with polyJIA enrolled, 89.0% (154/173) had a JIA AC

Clinical Trial Registration NCT01230827; Results.

INTRODUCTION

Juvenile idiopathic arthritis (JIA) is a group of diseases characterised by chronic immune-mediated arthritis of unknown aetiology with disease onset before age 16.1 First-line therapy for children with a polyarticular course of JIA (polyJIA) includes non-steroidal anti-inflammatory drugs (NSAIDs) and methotrexate (MTX). Children who are intolerant to MTX or fail to achieve adequate disease control may require treatment with biological disease-modifying antirheumatic drugs (DMARDs).2 3 Golimumab is a fully human, anti-tumour necrosis factor (TNF) monoclonal antibody that can be administered by either intravenous infusion or subcutaneous injection. Clinical trials in adults support the efficacy and safety of subcutaneous golimumab for the treatment of rheumatoid arthritis (RA), psoriatic arthritis, ankylosing spondylitis and ulcerative colitis.4 The objectives of the GO-KIDS study were to evaluate the efficacy, safety and pharmacokinetics of subcutaneous golimumab in children with active polyJIA despite MTX therapy. Here, we report efficacy through week 96 and safety results through the final database lock (325.6 patient-years (PY) of golimumab exposure).

METHODS

Study design
This three-part placebo-controlled, double-blind, randomised withdrawal trial was conducted by members of the Paediatric Rheumatology International Trials Organisation (PRINTO)5 and the Paediatric Rheumatology Collaborative Study

To cite: Brunner HI, Rupert N, Tzaribachev N, et al. Ann Rheum Dis 2018;77:21–29.

http://dx.doi.org/10.1136/annrheumdis-2016-210456

Protected by copyright.
Clinical and epidemiological research

Group (PRCSG) at 33 centres in 12 countries in Europe, Latin America, Canada and the USA.

Part 1 of the study was a 16-week, open-label, lead-in period in which all patients received subcutaneous golimumab dosed at 30 mg/m² of body surface area (maximum dose: 50 mg) every 4 weeks. At week 16, patients entered the double-blind withdrawal period (Part 2), provided they had a JIA American College of Rheumatology (ACR) 30 response, that is, >30% improvement in at least three of the six JIA ACR core response variables (CRVs) without ≥30% worsening in more than one of the remaining JIA CRVs compared with baseline. Patients who failed to achieve a JIA ACR30 response in Part 1 were discontinued from the study (see online supplementary material).

Upon entry in Part 2 (weeks 16–48), patients were randomly assigned 1:1, in a double-blind manner, to either receive placebo or continue golimumab. Randomisation, using an algorithm, was done via an interactive voice response system with stratification by geographic region (Europe, North America, Latin America), JIA disease type (psoriatic subtype vs other subtypes), prior anti-TNFα therapy and age at enrolment.

Patients continued in Part 2 until week 48, unless they experienced a JIA flare, that is, ≥30% worsening in at least three of the six JIA CRVs without >30% improvement in more than one of the remaining JIA CRVs' compared with week 16. After week 48, patients could enter Part 3 and receive open-label golimumab at the same dose received in Part 1. However, patients randomised to placebo in Part 2 who were in clinical remission at week 48 were discontinued from the study per protocol. Although Part 3 was scheduled to continue through week 248, the study was discontinued by the sponsor earlier because the primary and major secondary efficacy endpoints at week 48 (see online supplementary material) were not met. Site investigative personnel and patients were blinded to study allocation starting at week 16. The study was conducted in accordance with the Declaration of Helsinki; Good Clinical Practice Guidelines and local requirements. Enrolment commenced in December 2010, and the last patient completed Part 2 in August 2013; the study was discontinued with the last dose of study drug administered on 31 March 2014, and the last study-related procedure occurred on 27 May 2014.

The trial was registered with ClinicalTrials.gov (NCT01230827).

Patients

Patients aged 2–17 years diagnosed with rheumatoid factor (RF)-positive or RF-negative polyarticular, extended oligoarticular JIA, systemic JIA without systemic features or juvenile psoriatic arthritis (JPsA), and disease duration of ≥6 months were eligible. All patients had to have active JIA (≥5 joints with active arthritis; ie, the presence of joint swelling or, in the absence of swelling, limitation of range of motion (LROM) plus pain on motion and/or tenderness on palpation) despite ≥3 months of MTX treatment (10–30 mg/m²/week; ≥15 mg/ week for patients with body surface area ≥1.67). The study mandated that 80% of the enrolled patients be naïve to biologic DMARDs, while the remaining patients could have failed at most one anti-TNFα medication. Stable doses of NSAIDs, low-dose corticosteroids (maximum prednisone equivalent: 0.2 mg/kg/day or 10 mg, whichever was lower) were allowed. MTX and corticosteroid dosing were kept stable through week 48. Additional eligibility criteria are listed in the online supplementary material.

Assessments and outcome measures

Clinical assessments included the six JIA CRVs: number of joints with active arthritis, number of joints with LROM, visual analogue scale (VAS) of physician global assessment (PGA) of disease activity (range in cm: 0–10; 0=inactive JIA), VAS of parent assessment of the child’s overall well-being (PatGA) (range: 0–10 cm; 0=very well), physical function measured by the Childhood Health Assessment Questionnaire (CHAQ)-Disability Index (range: 0–3; 0=no disability) and the erythrocyte sedimentation rate (ESR) as a laboratory measure of inflammation. Clinically inactive disease was defined as a PGA indicating no disease activity (≤0.5 cm) plus absence of all of the following: joints with active arthritis, morning stiffness of ≥15 min, ESR >20 mm/h, active uveitis and systemic features attributable to JIA. Presence of clinically inactive disease continuously for ≥6 months constituted clinical remission while on medication for JIA. The primary efficacy endpoint was the proportion of patients with no JIA flare during Part 2, compared with week 16; however, we report here the proportion of patients with JIA flare, consistent with the prevailing literature. Secondary endpoints included JIA ACR30/50/70/90 responses, changes in the JIA-CRVs compared with baseline and the presence of inactive disease and clinical remission.

For post-hoc exploratory analysis, we calculated the Juvenile Arthritis Disease Activity Score using erythrocyte sedimentation rate (JADAS71-ESR; range: 0–101; inactive JIA: ≤1.0; minimal JIA activity: ≤2.0). Evaluations of JIA flare (primary outcome), JIA ACR response rates, inactive disease or clinical remission were all performed in real time by independent blinded evaluators at the coordinating centres of PRINTO and PRCSG, according to validated criteria. The analyses presented in the manuscript are based on in-house analyses.

Pharmacokinetics, antibodies to golimumab and biomarkers

Blood samples for pharmacokinetics (PK) and immunogenicity were collected throughout the study. PK analyses were conducted at week 8 for a subset of 30 patients, for 121 patients at week 16 and for all patients at week 48. Serum golimumab concentrations were measured by a validated electrochemiluminescent assay and compared with those previously found efficacious in adults with RA receiving subcutaneous golimumab. Antibodies to golimumab were assayed using a highly sensitive, drug-tolerant, enzyme immunoassay that was recently developed and validated (data on file). Patients who were positive for antibodies to golimumab were then tested for neutralising antibodies.

Serum biomarkers, including interleukin-6, C reactive protein (CRP), serum amyloid A (V-PLEX platform, Meso Scale Diagnostics, Rockville, Maryland, USA) in patients with paired samples drawn at baseline and week 16 (n=147) were also evaluated.

Statistical analysis

The study report followed the CONSORT statement. Primary endpoint analysis used the Cochran-Mantel-Haenszel (CMH) test, stratified by JIA disease categories, prior anti-TNFα therapy and age. Intention-to-treat analysis was performed. For continuous variables, missing changes from baseline were imputed using the median change from baseline for all patients in the same stratum, and the last-observation-carried-forward methodology was used for missing postbaseline data. For secondary endpoints, the CMH test was used to determine statistical significance for differences in JIA ACR30/50/70/90 responders at week 48 relative to baseline. After week 48, no data imputation was performed for study visits, hence only observed data are
available. Survival analysis was performed and Kaplan-Meier estimates calculated. The log-rank test, adjusted for stratification criteria, was used to test for significant differences between treatment groups in the median time to flare in Part 2. Post-hoc analyses were performed to identify predictors of flares.

The safety population included all enrolled patients (n=173). Serious infections were defined in accordance with the definition of serious adverse events (SAEs) in the International Conference on Harmonisation guidelines.

Sample size estimation assumed flare rates of 37% for the golimumab group and 65% for the placebo group in Part 2, based on published data. Assuming an 85% JIA ACR30 response rate in Part 1, it was estimated that enrolment of 170 patients was needed so that ≥134 patients (67 per group) entered Part 2 to achieve ≥90% power to detect a significant difference in JIA flare rates between groups using a two-sided significance test with α=0.05. Two planned interim analyses were performed: at week 8, in the first 30 patients enrolled for futility analyses and for PK comparison of golimumab exposure in JIA with target exposures determined to be similar to those in adults with RA; and at week 16, for population PK and to test whether the planned enrolment suffices to yield an adequate number of patients to enter Part 2. Results of these interim analyses (data not shown) indicated the study should continue as planned.

RESULTS

Patient disposition and baseline characteristics

In Part 1, 173 patients were enrolled and received golimumab (figure 1); of these, 19 patients discontinued the study before
week 16, with 154 (89%) entering Part 2 to be randomised to placebo (n=76) or golimumab (n=78). A total of 145 (84%) patients continued in Part 3. Prior to study termination, 25 patients were discontinued due to Sponsor decision. Reasons for discontinuation are listed in figure 3A. All six JIA CRVs, core response variables; DMARD, disease-modifying antirheumatic drug; ESR, erythrocyte sedimentation rate; JADAS71-ESR, Juvenile Arthritis Disease Activity Score using ESR; JIA, juvenile idiopathic arthritis; LROM, limitation in range of motion; PGA, physician global assessment of disease activity; PatGA, global assessment of patient overall well-being; RF, rheumatoid factor.

Response to open-label golimumab in Part 1

Patients improved on golimumab as early as week 4, and JIA ACR30/50/70/90 response rates increased over time during Part 1. At week 16, 154 of 173 (89.0%) patients were JIA ACR30 responders, and 137 (79.2%), 114 (65.9%) and 63 (36.4%) were JIA ACR50/70/90 responders, respectively, with 59 (34.1%) achieving clinically inactive disease (figure 2A). All six JIA CRVs markedly improved from baseline to week 16 (figure 2B). Through week 16, response to golimumab was comparable in patients with JPsA (n=15) to that of the other 158 patients (data not shown); however, interpretation of these results is limited by the small number of patients with JPsA.

Response to double-blind study medication in part 2

The primary endpoint at week 48 was not met. The proportions of patients with JIA flares were comparable in both treatment groups (placebo vs golimumab: 36/76=47.4% vs 32/78=41.0%; p=0.41; see online supplementary table S1). The median time to flare was similar between groups (placebo: 95.6 weeks; golimumab: 108.4 weeks; figure 3A). At week 48, and irrespective of treatment allocation in Part 2, the majority of patients were improved compared with baseline. There was no difference in the frequency of clinical remission between treatment groups (placebo vs golimumab: 36/76=47.4% vs 32/78=41.0%; p=0.41; see online supplementary table S1).

Table 1  Summary of baseline patient demographic and disease characteristics

| JIA categories, n (%) | JIA ACR30/50/70/90 responders | JIA ACR30/50/70/90 response rates increased over time during Part 1. At week 16, 154 of 173 (89.0%) patients were JIA ACR30 responders, and 137 (79.2%), 114 (65.9%) and 63 (36.4%) were JIA ACR50/70/90 responders, respectively, with 59 (34.1%) achieving clinically inactive disease (figure 2A). All six JIA CRVs markedly improved from baseline to week 16 (figure 2B). Through week 16, response to golimumab was comparable in patients with JPsA (n=15) to that of the other 158 patients (data not shown); however, interpretation of these results is limited by the small number of patients with JPsA.

Response to double-blind study medication in part 2

The primary endpoint at week 48 was not met. The proportions of patients with JIA flares were comparable in both treatment groups (placebo vs golimumab: 36/76=47.4% vs 32/78=41.0%; p=0.41; see online supplementary table S1). The median time to flare was similar between groups (placebo: 95.6 weeks; golimumab: 108.4 weeks; figure 3A). At week 48, and irrespective of treatment allocation in Part 2, the majority of patients were improved compared with baseline. There was no difference in the frequency of clinical remission between treatment groups (placebo vs golimumab: 36/76=47.4% vs 32/78=41.0%; p=0.41; see online supplementary table S1).

Table 1  Summary of baseline patient demographic and disease characteristics

| JIA categories, n (%) | JIA ACR30/50/70/90 responders | JIA ACR30/50/70/90 response rates increased over time during Part 1. At week 16, 154 of 173 (89.0%) patients were JIA ACR30 responders, and 137 (79.2%), 114 (65.9%) and 63 (36.4%) were JIA ACR50/70/90 responders, respectively, with 59 (34.1%) achieving clinically inactive disease (figure 2A). All six JIA CRVs markedly improved from baseline to week 16 (figure 2B). Through week 16, response to golimumab was comparable in patients with JPsA (n=15) to that of the other 158 patients (data not shown); however, interpretation of these results is limited by the small number of patients with JPsA.

Response to open-label golimumab in part 1

Patients improved on golimumab as early as week 4, and JIA ACR30/50/70/90 response rates increased over time during Part 1. At week 16, 154 of 173 (89.0%) patients were JIA ACR30 responders, and 137 (79.2%), 114 (65.9%) and 63 (36.4%) were JIA ACR50/70/90 responders, respectively, with 59 (34.1%) achieving clinically inactive disease (figure 2A). All six JIA CRVs markedly improved from baseline to week 16 (figure 2B). Through week 16, response to golimumab was comparable in patients with JPsA (n=15) to that of the other 158 patients (data not shown); however, interpretation of these results is limited by the small number of patients with JPsA.

Response to double-blind study medication in part 2

The primary endpoint at week 48 was not met. The proportions of patients with JIA flares were comparable in both treatment groups (placebo vs golimumab: 36/76=47.4% vs 32/78=41.0%; p=0.41; see online supplementary table S1). The median time to flare was similar between groups (placebo: 95.6 weeks; golimumab: 108.4 weeks; figure 3A). At week 48, and irrespective of treatment allocation in Part 2, the majority of patients were improved compared with baseline. There was no difference in the frequency of clinical remission between treatment groups (placebo vs golimumab: 36/76=47.4% vs 32/78=41.0%; p=0.41; see online supplementary table S1). The median time to flare was similar between groups (placebo: 95.6 weeks; golimumab: 108.4 weeks; figure 3A). At week 48, and irrespective of treatment allocation in Part 2, the majority of patients were improved compared with baseline. There was no difference in the frequency of clinical remission between treatment groups (placebo vs golimumab: 36/76=47.4% vs 32/78=41.0%; p=0.41; see online supplementary table S1).
increasing baseline CRP levels for patients receiving placebo (figure 3D).

**Long-term response after week 48 in part 3**

Among the 76 patients randomised to placebo, 33 flared and received golimumab before week 48, 33 remained on placebo through Part 2 but switched to golimumab after week 48, while the remaining 10 patients were in clinical remission at week 48. The latter patients were discontinued as per protocol at week 48. Measures of treatment response and JIA activity observed at week 96 are summarised in table 2. At week 96, the randomisation groups did not differ significantly in the proportion
Clinical and epidemiological research

Biomarker analysis
In Part 1, higher JIA ACR response rates at week 16 were associated with lower baseline levels of inflammatory cytokines (e.g., interleukin-6, CRP, serum amyloid A), blood neutrophils and ESR (see online supplementary figure S1, supplementary table S2). Likewise, levels of inflammatory cytokines (baseline, week 16) were associated with week 48 JIA outcomes, positively with JIA flare rates and negatively with JIA improvement (inactive disease, clinical remission) in patients randomised to placebo but not those who continued golimumab in Part 2 (see online supplementary figure S2, supplementary table S3).

Safety
For the safety population (n=173) AEs and SAEs that occurred throughout the study are summarised in table 3, providing information on 325.6 PY of golimumab exposure. Overall during the study, 160 (92.5%) patients reported ≥1 AE and 39 (22.5%) patients reported 35 SAEs. AEs that occurred in ≥10% of patients included upper respiratory infections (28.3%), nasopharyngitis (23.4%), JIA flare (22.5%) and vomiting (14.5%). Rates of AEs and SAEs were similar across the two exposure groups in Part 2 (AEs/SAEs per 100 PY exposure; randomised to golimumab: 358.5/17.1, randomised to placebo: 526.3/32.5).

There were 116 AEs occurring in 88 patients that were considered possibly, probably or definitely related with golimumab treatment by the investigator and 12 AEs that were considered...
Table 2  Clinical efficacy outcomes at week 96

| Patients randomised to placebo in Part 2 (n=61) | Patients randomised to golimumab in Part 2 (n=68) |
|-----------------------------------------------|--------------------------------------------------|
| JIA ACR30 response                            |                                                   |
| 45/61 (73.8)                                  | 47/68 (69.1)                                     |
| JIA ACR50 response                            |                                                   |
| 45/61 (73.8)                                  | 47/68 (69.1)                                     |
| JIA ACR70 response                            |                                                   |
| 42/61 (68.9)                                  | 44/68 (64.7)                                     |
| JIA ACR90 response                            |                                                   |
| 32/61 (52.5)                                  | 33/68 (48.5)                                     |
| Inactive disease status                       |                                                   |
| 27/64 (42.2)                                  | 33/69 (47.8)                                     |
| Clinical remission*                           |                                                   |
| 33/76 (43.4)                                  | 35/78 (44.9)                                     |
| JADAS71-ESR, mean±SD                          |                                                   |
| 5.2±10.8                                      | 5.1±11.8                                         |

Data reported as n/N (%) and using observed data unless otherwise noted; week 96 is the latest follow-up time point to describe these efficacy results because the number of patients decreased considerably over time beyond week 96. At week 16, 76 patients were randomised to receive placebo; 10 patients remained on placebo through the week-48 database lock, 33 patients crossed over to golimumab before week 48 and 33 patients crossed over to golimumab after week 48. After week 48, no data imputation was performed for study visits that occurred after the study termination date.

*Patients who achieved protocol-defined clinical remission at any time from week 24 through the final database lock.

JADAS71-ESR, Juvenile Arthritis Disease Activity Score using erythrocyte sedimentation rate; JIA ACR30/50/70/90, ≥30%/50%/70%/90% improvement in the American College of Rheumatology juvenile idiopathic arthritis response criteria.

DISCUSSION

Results of this study demonstrate that subcutaneous golimumab dosed at 30 mg/m² body surface area (maximum: 50 mg) every 4 weeks resulted in a rapid response to open-label therapy, had an acceptable safety profile and yielded a similar PK profile as that achieved in adults with RA. On background medications, including mandatory MTX, after three doses of golimumab, 34.1% (59/173) of the patients reached clinical inactive disease status. Importantly, the primary endpoint of this trial was not met as the placebo and golimumab groups did not differ in JIA flare rates during the double-blinded period of the study (Part 2).

The randomised withdrawal design has been successfully used for the study of biological DMARDs in JIA, including those blocking TNFα. This trial design was introduced in JIA for ethical reasons to minimise placebo exposure and for sample size consideration, but the design also has limitations: the clinical effects of biological DMARDs often exceed their pharmacological half-life, resulting in delayed flare events in the placebo groups. The reasons for the sustained JIA control in patients receiving placebo in Part 2 remain unknown.

However, levels of inflammatory cytokines, especially at baseline, were significantly associated with JIA courses (high: JIA flare, low: inactive disease, clinical remission) at week 48 in the placebo arm but not the golimumab arm. Thus, the low inflammatory burden of the study population (mean baseline CRP: 1.0 mg/dL) may have contributed to the low frequency of flares in the placebo group during Part 2.

In addition, failure in achieving the primary and all major secondary endpoints could have been influenced by the mandatory MTX background therapy that might have helped maintain disease control. However, in previous randomised-withdrawal studies with optional MTX background therapy, up to 79% of patients with JIA received MTX, but randomisation groups differed in flare rates nonetheless.

Although not studied specifically, we do not think that the failure of this study in reaching the primary endpoint was due to inappropriate golimumab dosing based on exploratory PK analyses (data not shown); and drug levels in polyJIA were similar to those shown to be therapeutic in RA. In fact, exposure to medication for most prior clinical trials of biological DMARDs in polyJIA found to be efficacious in adults with RA also yielded a robust response in polyJIA.

The safety profile of golimumab was consistent with that observed in adults and other TNFα agents in JIA, with few patients discontinuing the study because of AEs. Although occurrence of MS in this study is a concern, it has been reported with other anti-TNFα DMARDs in both JIA and adult RA.
### Table 3  Summary of adverse events up to final database lock

|                  | Part 1  | Part 2  | Part 3  | Part 1–3 |
|------------------|---------|---------|---------|----------|
|                  | Golimumab | Placebo* | Golimumab | Placebo* | Golimumab | Total |
| Treated pts, n   | 173     | 76      | 78      | 73       | 72        | 173   |
| PY of follow-up  | 53.7    | 46.2    | 46.9    | 86.7     | 90.5      | 325.6 |
| Pts with ≥1 AE   | 118 (68.2) | 63 (82.9) | 61 (78.2) | 56 (76.7) | 59 (81.9) | 160 (92.5) |
| AE incidence/100 PY (95% CI) | 564.7 (502.9 to 632.0) | 526.3 (462.2 to 596.9) | 358.5 (306.3 to 417.0) | 261.7 (228.8 to 298.1) | 320.4 (284.6 to 359.5) | 339.4 (319.6 to 360.0) |
| Common AEs†      |         |         |         |          |
| Infections and infestations | 67 (38.7) | 48 (63.2) | 37 (47.4) | 41 (56.2) | 40 (55.6) | 135 (78.0) |
| Upper respiratory tract infection | 12 (6.9) | 21 (27.6) | 13 (16.7) | 12 (16.4) | 13 (18.1) | 49 (28.3) |
| Nasopharyngitis   | 16 (9.2) | 9 (11.8) | 6 (7.7) | 13 (17.8) | 12 (16.7) | 44 (25.4) |
| Gastrointestinal disorders | 34 (19.7) | 22 (28.9) | 12 (15.4) | 20 (27.4) | 21 (29.2) | 73 (42.2) |
| Vomiting          | 7 (4.0) | 5 (6.6) | 1 (1.3) | 7 (9.6) | 9 (12.5) | 25 (14.5) |
| Nausea            | 10 (5.8) | 4 (5.3) | 3 (3.8) | 3 (4.1) | 3 (4.2) | 22 (12.7) |
| Abdominal pain    | 8 (4.6) | 7 (9.2) | 1 (1.3) | 3 (4.1) | 0        | 17 (9.8) |
| Diarrhoea         | 6 (3.5) | 5 (6.6) | 1 (1.3) | 1 (1.4) | 5 (6.9) | 16 (9.2) |
| Musculoskeletal and connective tissue disorders | 19 (11.0) | 17 (22.4) | 14 (17.9) | 16 (21.9) | 21 (29.2) | 63 (36.4) |
| Worsening of JIA  | 6 (3.5) | 10 (13.2) | 10 (12.8) | 6 (8.2) | 13 (18.1) | 39 (22.5) |
| General disorders | 21 (12.1) | 16 (21.1) | 7 (9.0) | 10 (13.7) | 11 (15.3) | 54 (31.2) |
| Fever             | 8 (4.6) | 11 (14.5) | 4 (5.1) | 4 (5.5) | 3 (4.2) | 24 (13.9) |
| Nervous system disorders | 14 (8.1) | 6 (7.9) | 8 (10.3) | 5 (6.8) | 8 (11.1) | 33 (19.1) |
| Headache          | 10 (5.8) | 6 (7.9) | 6 (7.7) | 3 (4.1) | 6 (8.3) | 26 (15.0) |
| Pts with ≥1 SAE   | 8 (4.6) | 10 (13.2) | 8 (10.3) | 7 (9.6) | 13 (18.1) | 39 (22.5) |
| SAE incidence/100 PY (95% CI) | 16.8 (7.7 to 31.8) | 32.5 (18.2 to 53.6) | 17.1 (7.4 to 33.6) | 10.4 (4.8 to 19.7) | 24.3 (15.2 to 36.8) | 18.1 (13.8 to 23.4) |
| Musculoskeletal and connective tissue disorders | 4 (2.3) | 7 (9.2) | 4 (5.1) | 2 (2.7) | 7 (9.7) | 21 (12.1) |
| Worsening of JIA  | 3 (1.7) | 5 (6.6) | 3 (3.8) | 2 (2.7) | 5 (6.9) | 17 (9.8) |
| Arthritis         | 1 (0.6) | 2 (2.6) | 1 (1.3) | 0 | 2 (2.8) | 4 (2.3) |
| Infections and infestations | 2 (1.2) | 2 (2.6) | 1 (1.3) | 3 (4.1) | 3 (4.2) | 11 (6.4) |
| Pneumonia         | 0 | 1 (1.3) | 0 | 0 | 1 (1.4) | 2 (1.2) |
| Upper respiratory tract infection | 0 | 1 (1.3) | 0 | 0 | 1 (1.4) | 2 (1.2) |
| Gastrointestinal disorders | 0 | 0 | 1 (1.3) | 2 (2.7) | 0 | 3 (1.7) |
| Constipation      | 0 | 0 | 1 (1.3) | 1 (1.4) | 0 | 2 (1.2) |
| Pts with ≥1 injection site reaction | 10 (5.8) | 3 (3.9) | 2 (2.6) | 1 (1.4) | 6 (8.3) | 20 (11.6) |

Data are presented as n (%) unless otherwise noted.

1 At week 16, 76 patients were randomised to receive placebo; 10 patients remained on placebo through the week-48 database lock and were discontinued, 33 patients crossed over to golimumab before week 48 and 33 patients crossed over to golimumab after week 48.

2 Preferred terms occurring in >10% of all treated patients by system-organ class/preferred term.

3 AE, adverse event; CI, confidence interval; JIA, juvenile idiopathic arthritis; pts, patients; PY, patient-year; SAE, serious adverse event.

In conclusion, the primary study endpoint was not met. However, treatment with golimumab in children with active polyarticular course of JIA resulted in rapid clinically meaningful improvement that was maintained over time even in patients who received placebo after week 16. Golimumab was well tolerated, and no unexpected safety events occurred.

### Author affiliations

1 Cincinnati Children’s Hospital Medical Center, Cincinnati, Ohio, USA
2 Istituto Giannina Gaslini, Pediatrica II - Rheumatologia, PRIN TO, Genoa, Italy
3 Pediatric Rheumatology Research Institute, Bad Bramstedt, Germany
4 Department of Pediatrics, Asklepios Clinic Sankt Augustin, Sankt Augustin, Germany
5 Hospital Pediatric, State Pediatric Medical Academy, Saint Petersburg, Russian Federation
6 Centre of Pediatrics, Vilnius University, Vilnius, Lithuania
7 Regional Unit of Rheumatology and Osteoporosis, Central Hospital “Dr. Ignacio Morones Prieto” and Faculty of Medicine, Universidad Autónoma de San Luis Potosí, Mexico, San Luis Potosí, Mexico
8 Department of Rheumatology, Children’s Hospital of Los Angeles, Los Angeles, California, USA

9 Children’s Health of RAMS and IM Sechenov First Moscow State Medical University, Moscow, Russian Federation
10 Hospital Universitario, Universidad Autónoma de Nuevo León, Nuevo León, Mexico
11 Samara Regional Clinical Hospital, Samara, Russian Federation
12 Randall Children’s Hospital at Legacy Emanuel, Portland, Oregon, USA
13 Hospital Infantil de Mexico Federico Gomez, Distrito Federal, Mexico
14 Pediatric Department, V.A. Nasonova Research Institute of Rheumatology, Moscow, Russian Federation
15 Department of Rheumatology, The Hospital for Sick Children, Toronto, Canada
16 ZNA Jan Pallijn, Antwerpen, Belgium
17 Medical University of Lodz, Lodz, Poland
18 Hospital Puequeno Prinipe, Curitiba, Brazil
19 Department of Pediatric Rheumatology, Charité University Medicine, Berlin, Germany
20 Department of Paediatric Immunology, Wilhelmina Children’s Hospital, University Medical Center Utrecht, Utrecht, The Netherlands
21 University Children’s Hospital, Wien, Austria
22 Klinikum Eilbek, Hamburger Zentrum für Kinder- und Jugendrheumatologie, Hamburg, Germany
23 Pôle de pathologies rhumatismales systémiques et inflammatoires, Université catholique de Louvain, Institut de Recherche Clinique, Brussels, Belgium

28 Brunner HI, et al. Ann Rheum Dis 2018;77:21–29. doi:10.1136/annrheumdis-2016-210456

Ann Rheum Dis: first published as 10.1136/annrheumdis-2016-210456 on 15 May 2017. Downloaded from http://ard.bmj.com/ on 24 April 2018 by guest. Protected by copyright.
Correction notice  This article has been corrected since it published Online First. The PRINTO and PRCGSC statement has been added to the list of authors.

Acknowledgements  The authors thank the staff from the PRINTO and PRCGSC coordinating centres, and the remaining PRINTO and PRCGSC centres which enrolled patients in the GO-KIDS trial. Additional investigators include from Austria, Christopher Huenner MD; from Belgium, Carine Wouters MD; from Brazil, Claudia Magalhaes MD; from Canada, Adam Haber MD; from Finland, Paula Vahala Salo MD; and from the USA, Diana Mlocjiev MD, Edga Rabinovich MD. Hans-Iko Huppertz, MD, PhD, Bremen, Germany, declined the offered authorship of this paper but gave permission to include patients recruited from his centre to be considered in the analysis. The authors also thank Kim Hung Lo, PhD, for involvement in the trial design, Stephen Xu, MS, for additional statistical support Nancy Pefler, BS, and Carol Frank, BS, for biomarker data generation, all from Janssen Research & Development, LLC, and Rebecca Clemente, PhD, of Janssen Scientific Affairs, LLC, for editorial assistance. A special thanks to Dr Alan Mendelsohn, formerly of Janssen Research & Development, LLC for his contributions in study design and implementation and advocacy for all children enrolled in GO-KIDS.

Contributors  Study design: HIB, NR, AM, DJL; data collection and/or analysis: HIB, NR, NT, GH, VGC, VP, CAM, AR, EA, NRP, VK, DIX, MRMV, IN, EDS, RJ, ES, MB, KM, ARK, WE, IF, BRL, FS, KEG, XZ, JHL, KL, SLL, MII, DJL, AM; manuscript: All authors drafted and/or revised the manuscript and approved the manuscript for submission.

Funding  This study was funded by Janssen Research & Development, LLC, a wholly owned subsidiary of Johnson & Johnson, and Merck/Schering-Plough.

Competing interests  HIB has served as a consultant and steering committee member for Janssen Research & Development, a consultant to AstraZeneca, Pfizer and Takeda and received research support from Novartis, Roche and UCB. NR served on the speaker’s bureau and as a consultant for AbbVie, Amgen, Alter, AstraZeneca, Baxtera Biosimilars, Biogen Idex, Boehringer, BMS, Celgene, CrescendoBio, EMD Serono, F. Hoffmann-La Roche, Italfarmaco, Janssen, MedImmune, Medac, Novartis, Novo Nordisk, Pfizer, Sanofi Aventis, Servier, Takeda and UCB Biosciences GmbH. DJL has served as a consultant for Boehringer Ingelheim, Celgene, Janssen Research & Development and Novartis, as a trial investigator for AbbVie, Bristol-Myers Squibb, Janssen Research & Development, Roche, Pfizer and UBC and received research support from the National Institutes of Health. NRP received fees from AbbVie and Roche. FS received research support from Janssen. KM received research support from Pfizer, AbbVie, Roche and Deutsche Kinder-Rheumastiftung and fees from AbbVie, Genzyme, Medac, Pfizer and Pharm-Allergan. IN received fees from AbbVie, Bristol-Myers Squibb, Novartis, Pfizer and Roche and grants from Pfizer and Roche. EA received research support from AbbVie, Bristol-Myers Squibb, Janssen, Novartis, Pfizer and Roche and fees from AbbVie, Bristol-Myers Squibb, Medac, Merck Sharp & Dohme, Novartis, Pfizer and Roche. KEG, XZ, JHL, KL, SLL and MII are employees of Janssen Research & Development, LLC and own stock in Johnson & Johnson. AM received speaking and consulting fees from AbbVie, Boehringer, Celgene, CrescendoBio, Janssen, MedImmune, Novartis, Novo Nordisk, Pfizer, Sanofi Aventis, Vertex and Servier. Nothing to disclose: NT, GH, VGC, CAM, AR, DIX, EDS, VP, MRMV, ES, MB, ARK, VK, RI, WE, IF, BRL.

Ethics approval  Institutional Review Board or Ethics Committee at each site.

Provenance and peer review  Not commissioned; externally peer reviewed.

Open Access  This is an Open Access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/

© Article author(s) (or their employer(s)) unless otherwise stated in the text of the article) 2018. All rights reserved. No commercial use is permitted unless otherwise expressly granted.

REFERENCES  
1. Petty RE, Southwood TR, Manners P, et al; International League of Associations for Rheumatology. International League of Associations for Rheumatology classification of juvenile idiopathic arthritis: second revision, Edmonton, 2001. J Rheumatol 2004;31:390–2.
2. Beukelman T, Parkar NM, Saag KG, et al. 2011 American College of Rheumatology recommendations for the treatment of juvenile idiopathic arthritis: initiation and safety monitoring of therapeutic agents for the treatment of arthritis and systemic features. Arthritis Care Res 2011;63:465–82.
3. Hinze C, Gohar F, Foell D. Management of juvenile idiopathic arthritis: hitting the target. Nat Rev Rheumatol 2015;11:290–300.
4. Simponi package insert. Janssen Biotech, Inc. Horsham, PA, 2014.
5. Ruperto N, Martini A. International research network in pediatric rheumatology: the PRINTO perspective. Curr Opin Rheumatol 2004;16:566–70.
6. Giannini EH, Ruperto N, Raveli A, et al. Preliminary definition of improvement in juvenile arthritis. Arthritis Rheum 1997;40:1022–9.
7. Brunner HI, Lovel DJ, Finck BK, et al. Preliminary definition of disease flare in juvenile rheumatoid arthritis. J Rheumatol 2002;29:1038–64.
8. Wallace CA, Giannini EH, Huang B, et al; Childhood Arthritis Rheumatology Research Alliance; Pediatric Rheumatology Collaborative Study Group; Paediatric Rheumatology International Trials Organisation. American College of Rheumatology provisional criteria for defining clinical inactive disease in select categories of juvenile idiopathic arthritis. Arthritis Care Res 2011;63:929–36.
9. Declaration of Helsinki. Recommendations guiding physicians in biomedical research involving human subjects. BMJ 1996;313:1448.
10. Ruperto N, Raveli A, Pistorio A, et al; Paediatric Rheumatology International Trials Organisation. Cross-cultural adaptation and psychometric evaluation of the Childhood Health Assessment Questionnaire (CHAQ) and the Child Health Questionnaire (CHQ) in 32 countries. Review of the general methodology. Clin Exp Rheumatol 2001;19:51–9.
11. Consolati A, Braccolini G, Ruperto N, et al; Paediatric Rheumatology International Trials Organization. Remission, minimal disease activity, and acceptable symptom state in juvenile idiopathic arthritis: defining criteria based on the juvenile arthritis disease activity score. Arthritis Rheum 2012;64:2366–74.
12. Consolato A, Ruperto N, Bazzo A, et al; Paediatric Rheumatology International Trials Organisation. Development and validation of a composite disease activity score for juvenile idiopathic arthritis. Arthritis Rheum 2009;61:658–66.
13. Ruperto N, Giannini EH, Pistorio A, et al. Is it time to move to active comparator trials in juvenile idiopathic arthritis?: a review of current study designs. Arthritis Rheum 2010;62:3131–9.
14. Wallace CA, Ruperto N, Giannini E, et al; Childhood Arthritis and Rheumatology Research Alliance; Pediatric Rheumatology International Trials Organization; Pediatric Rheumatology Collaborative Study Group. Preliminary criteria for clinical remission for select categories of juvenile idiopathic arthritis. J Rheumatol 2004;31:2290–4.
15. Zhang Y, Xu Z, Frederick B, et al. Golimumab pharmacokinetics after repeated subcutaneous and intravenous administrations in patients with rheumatoid arthritis and the effect of concomitant methotrexate: an open-label, randomized study. Clin Ther 2012;34:77–90.
16. Schultz KT, Altmann DG, Moher D. CONSORT 2010 statement: updated guidelines for reporting parallel group randomised trials. BMC Med 2010;8:18.
17. Visvanathan S, Wagger C, Marini JC, et al; Inflammatory biomarkers, disease activity and spinal disease measures in patients with ankylosing spondylitis after treatment with infliximab. Ann Rheum Dis 2008;67:511–7.
18. Lovell DJ, Ruperto N, Goodman S, et al; Pediatric Rheumatology Collaborative Study Group; Pediatric Rheumatology International Trials Organisation. Adalimumab with or without methotrexate in juvenile rheumatoid arthritis. N Engl J Med 2008;359:810–20.
19. Keystone EC, Genovese MC, Klareskog L, et al; GO-FORWARD Study. Golimumab, a human antibody to tumour necrosis factor (alpha) given by monthly subcutaneous injections, in active rheumatoid arthritis despite methotrexate therapy: the GO-FORWARD Study. Ann Rheum Dis 2009;68:789–96.
20. Smolen JS, Kay J, Doyle MK, et al; GO-AFTER study investigators. Golimumab in patients with active rheumatoid arthritis after treatment with tumour necrosis factor alpha inhibitors (GO-AFTER study): a multicentre, randomised, double-blind, placebo-controlled, phase III trial. Lancet 2009;374:210–21.
21. Ruperto N, Brunner HI, Quartier P, et al; PRINTO; PRCGSC. Two randomized trials of canakinumab in systemic juvenile idiopathic arthritis. N Engl J Med 2012;367:2396–406.
22. Lovell DJ, Giannini EH, Reiff A, et al. Etaencartep in children with polyarticular juvenile rheumatoid arthritis. Pediatric Rheumatology Collaborative Study Group. N Engl J Med 2000;342:763–9.
23. Brunner HI, Ruperto N, Zuber Z, et al; Paediatric Rheumatology International Trials Organisation; Pediatric Rheumatology Collaborative Study Group (PRCGSC). Efficacy and safety of tocilizumab in patients with polyarticular-course juvenile idiopathic arthritis: results from a phase 3, randomised, double-blind withdrawal trial. Ann Rheum Dis 2015;74:1110–7.
24. Ruperto N, Lovell DJ, Quartier P, et al; Paediatric Rheumatology International Trials Organization; Pediatric Rheumatology Collaborative Study Group. Abatacept in children with juvenile idiopathic arthritis: a randomised, double-blind, placebo-controlled withdrawal trial. Lancet 2008;372:383–91.

Brunner HI, et al. Ann Rheum Dis 2018;77:21–29. doi:10.1136/annrheumdis-2016-210456

29

Ann Rheum Dis: first published as 10.1136/annrheumdis-2016-210456 on 24 April 2018. Downloaded from http://ard.bmj.com/ on 24 April 2018 by guest. Protected by copyright.