

Support Your Registers!

Impact of BSRBR-RA 2001 - 2025

Important questions answered using your BSRBR-RA data

How are biologics and biosimilars used in the NHS?

- **Most patients start TNFi as their first biologic drug** (*Kearsley-Fleet et al, 2018*)
- **Patients moving to a biosimilar from an originator drug do just as well compared to those who stay on the originator** (*Kearsley Fleet et al, 2024*)
- **Patients starting etanercept biosimilar do just as well as those starting etanercept originator, showing biosimilars are similar** (*Kearsley-Fleet et al, 2023*)
- **Treatment persistence over time is similar by class of drug (ABA, TNFi, IL-6, JAKi)** (*Lauper et al, 2022*)
- **Many patients with RA will eventually benefit after repeated trials of biologic or targeted therapies up to the 6th line of therapy** (*Zhao et al, 2022*)
- **Not all moderate disease in RA is the same and some people have moderate disease with high disability that may benefit from treatment with biologic therapy** (*Pan et al, 2019*)

Do biologics/biosimilars increase the risk of cancer?

- **Linking BSRBR-RA data to the NHS Cervical Screening Programme in England showed no increased risk of severe cervical screening abnormalities compared to the general population. Screening attendance was higher in women with RA** (*Chadwick et al, 2019*)
- **No evidence that TNFi therapy increases the risk of a new cancer compared to non-biologic DMARDs** (*Mercer et al, 2015*)
- **Non-melanoma skin cancer risk is not increased over the long term with TNFi compared to non-biologic DMARDs** (*Mercer et al, 2012*)

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Do biologics/biosimilars increase the risk of serious infection?

- **The overall risk of infections does not increase depending on how many different biologics a patient has tried** (*Lauper et al, 2024*)
- **TB is rare but screening remains important, especially for those starting biologics for the first time** (*Lauper et al, 2024*)
- **Absolute risk of serious infections in TNFi compared to non-biologic DMARDs is one additional infection per 100 patients treated per year** (*Galloway et al, 2011*)
- **Risk of infection is higher in the first 6 months of treatment then decreases** (*Galloway et al, 2011*)

What questions remain for the BSRBR-RA?

- **Long-term data on JAKi therapy:** More data are needed! This is why the BSRBR-RA is still so important 25 years on. Please keep registering new patients and providing follow-up data.
- **Patient Reported Outcomes and Quality of Life data:** Collection of follow-up data electronically directly from participants began in early 2025. This is alongside the collection of data from NHS sites, and will allow a greater understanding of quality of life and work disability data for patients in the study.
- **Continue to monitor impact of longer-term life events such as cancer and death:** We can link BSRBR-RA data to NHS England data to continue to look at these important outcomes.

Thank you for supporting the BSRBR-RA

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