	Treatment Period	
	0 to ≤52 Weeks	APR-Exposure Period 0 to ≥156 Weeks Cumulative Events*
	APR30 n=1,905 Pt-Yrs=1,524.5	APR30 n=1,905 Pt-Yrs=3,527.5
	EAIR/100 Pt-Yrs	EAIR/100 Pt-Yrs
Major adverse cardiac events§		
Acute myocardial infarction	0.1	0.1
Myocardial infarction	0.1	0.1
Subarachnoid hemorrhage	0.1	0.1
Cardiac arrest	0.0	0.1
Cerebral infarction	0.0	0.1
Malignancies		
Hematologic	0.0	0.1
Non-melanoma skin cancer	0.9	0.5
Solid tumors‡	0.3	0.4
Serious infections	0.7ǂ	1.0#
Pneumonia	0.1	0.1
Urinary tract infection	0.1	0.1
Appendicitis	0.1	0.1
Diverticulitis	0.1	0.1
Sepsis	0.0	0.1
Bronchitis	0.0	0.1

*Each patient's total exposure is defined as the time interval between the date of the first and last dose of APR30, regardless of when treatment was initiated, through February 2015.
§No adjudication of major adverse cardiac events for the APR-exposure period.
‡Including malignant melanoma.
ǂSerious infections occurring in patients included pneumonia (n=2), urinary tract infection (n=2), appendicitis (n=1), and diverticulitis (n=1).
#Serious infections occurring in ≥2 patients included pneumonia (n=5), appendicitis (n =3), bronchitis (n=3), diverticulitis (n=2), sepsis (n=2), and urinary tract infection (n=2).
APR30=apremilast 30 mg BID; EAIR=exposure-adjusted incidence rate; PBO=placebo; Pt-Yrs=patient-years.

Conclusions: Incidence of MACE, malignancies, and SIs was low in pts with psoriasis and PsA receiving APR30 for ≥156 wks. No new safety signals or SOIs were observed over time with APR30.

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AB0744 DOES TIMING OF INITIATION OF ANTI-TNF AGENTS AFFECT THE QUALITY OF LIFE OUTCOMES IN PATIENTS WITH PSORIASIS AND PSORIATIC ARTHRITIS?

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Background: Psoriatic Arthritis (PsA) affects up to 30% of people with psoriasis[1]. While Tumor Necrosis Factor inhibitors (TNFi) are effective agents for PsA, the relationship between early treatment and patient reported outcomes in a real world setting has not been reported previously.

Objectives: To assess whether timely treatment with TNFi leads to better improvement in quality of life outcomes than delayed treatment.

Methods: This was a retrospective analysis of patients with PsA and/or Psoriasis (PsO) using TNFi with or without methotrexate, and who had a minimum of 2 visits at the Center of Excellence for Psoriasis and Psoriatic Arthritis at our university. Detailed demographic and clinical characteristics of this cohort have been published previously[2]. Demographics, quality of life measures (e.g. Routine Assessment of Patient Index Data – RAPID3, Psoriasis Quality of Life – PQoL12, Short Form 12 – SF-12), and clinical data (percent of body surface area involved with PsO – BSA%) were collected from patient-reported questionnaires and electronic medical records. Only those patients who had a chronological overlap of treatment exposure and QoL measures such as RAPID3, BSA, SF12 and PQOL were included. To ascertain treatment effects, a mixed-effects model was fitted to estimate the trend of each QoL outcome of a patient separately. Then, for all estimated trends of an outcome, a linear regression model was employed to explore the association between the magnitude of estimated trends and timeliness of TNFi treatments.

Results: The quality of life measures were not affected by how early after the disease onset TNFi treatment was started (in other words, no statistically significant associations between the effectiveness of TNFi treatment and disease duration) for RAPID3 (p=0.285), SF-12 (p=0.674), or BSA (p=0.078). For PQoL, there was a significant association between the trend of treatment effects and timeliness of treatment. A day of delay into treatment was resulted in a reduction of 4.4×10^{-4}/day in the trend of PQoL scores (p=0.007).

Conclusions: In this sample of PsA & PsO patients, timing of starting TNFi in patients with PsA had significant impact on improvements in the PQoL but not other quality of life measures such as RAPID3, SF-12 and BSA. A relatively short treatment history might have led to the negative correlations.

References:

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AB0745 SUBCLINICAL ATHEROSCLEROSIS EVOLUTION IN PSORIATIC ARTHRITIS PATIENTS TREATED WITH ANTI-TNF ALPHA: 5 YEARS FOLLOW UP

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Background: Psoriatic arthritis (PsA) is associated with increased morbility and mortality and an accelerated atherosclerosis. Influence of anti-TNFalpha treatment (a widely used therapy in PsA) in subclinical atherosclerosis is still unclear.

Objectives: The aim of this study was to evaluate subclinical atherosclerosis progression before, during and after 5 years of anti-TNFalpha treatment.

Methods: Twenty-seven consecutive PsA patients were evaluated before TNF blockers therapy (T0), after 2 years (T1) and after 5 years (T2) of treatment. Subclinical atherosclerosis was evaluated through carotid duplex scanning, analyzing intima-media thickness (IMT) and flow-mediated dilation (FMD). IMT values were expressed as IMT mean (cumulative mean of all the IMT mean in every analyzed carotid segment) and M-MAX (cumulative mean of all the higher IMT in every analyzed carotid segment). Response to therapy was studied by the evaluation of tender and swollen joints (Tj and Sj), DAS 28 (disease activity score), erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP). Metrologic and metabolic data were collected. For the statistical evaluation of parameters over time (T0 vs T1, T1 vs T2) Student's T test for paired data was used.

Results: From T0 to T1 a deterioration in IMT-mean and M-MAX ($p<0.01$) was

Table

	T0	T1	T2
IMT-mean	0.72±0.15	0.91±0.37*	0.92± 0,34
M-MAX	0.89±0.18	1.06±0.39*	1.10±0.35**
FMD	5.40±1.93	5.37±1.66	5.40±1.89
Tender joints (n)	8.10±5.56	2.09±2.32*	1.72± 2.05
Swollen joints (n)	3.85±3.84	0.25±0.72*	0.50±0.92
CRP	11.25±9.16	2.91±1.72*	2.73 ±2.51
DAS28	4,16±0.67	2.30±0.82*	2.40±0,9

Legend: IMT= intima-media thickness; M-MAX= cumulative mean of all the higher IMT in every analyzed carotid segment; FMD= flow-mediated dilation; CRP= C Reactive Protein; DAS28=Disease Activity Score 28joints; *= p<0.01 with respect to the previous determination; **=p<0.05 with respect to the previous determination