the entire study period (mean [±SD] exposure to secukinumab of 1025.1±372.7 days), the exposure-adjusted incidence rate with secukinumab for serious infections/infestations, candida infections, Crohn's disease, and malignant/unspecified tumors was 1.7 (27), 1.2 (17), 0.1 (2), and 0.9 (14) per 100 pt-yrs, respectively.
Conclusions: Secukinumab provided sustained improvements in signs/symptoms and across multiple clinical domains of active PsA in pts who completed 3 yrs of therapy. Secukinumab was well tolerated with a favorable safety profile consistent with that previously reported.[1]
References:
[1] Kavanaugh A, et al. Arthritis Care Res. (Hoboken) 2016.
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SAT0471 TRENDS IN CLINICAL CHARACTERISTICS ASSOCIATED WITH ACHIEVEMENT OF MINIMAL DISEASE ACTIVITY IN RESPONSE TO BIOLOGIC THERAPY IN PSORIATIC ARTHRITIS – ANALYSES FROM THE CORRONA PSORIATIC ARTHRITIS/SPONDYLOARTHRITIS (PSA/SPA) REGISTRY

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Background: Achievement of minimal disease activity (MDA) may represent an objective target for treatment for patients with psoriatic arthritis (PsA).[1] A patient is considered to have achieved MDA when 5 of the following 7 criteria are met: tender joint count (TJC) ≤1, swollen joint count (SJC) ≤1, affected body surface area (BSA) ≤3%, patient pain VAS ≤15, patient global activity VAS ≤20, HAQ score ≤0.5 and tender entheseal points ≤1.[1]
Objectives: To retrospectively report the MDA and patient-reported outcomes (PROs) over time (baseline vs first follow-up [FU] visit vs second FU visit) that may contribute to achievement of MDA in responders versus non-responders to biologic treatment.
Methods: This analysis included all patients with PsA in the Corrona registry aged ≥18 years between March 2013 and March 2016 who received biologics (index biologics) at enrollment (baseline) and had ≥2 FU visits (at ≈ 6-month intervals, mean [SD] 2nd FU visit: 15.7 [3.7] months). Responders were defined as patients who achieved MDA at the second FU visit and remained on their index biologic. Demographics, clinical characteristics, PROs and treatment history were collected at enrollment and at both FU visits. Trend tests of MDA over time were performed using the Wilcoxon rank-sum nonparametric test for responders and non-responders separately.
Results: Of 148 patients who met the inclusion criteria (mean [SD] age, 54.7 [11.0] years; mean [SD] disease duration, 11.8 [10.1] years), 34 patients (23%) were classified as responders and 114 patients (77%) were non-responders at the second FU visit. The core components of MDA in these patients are shown in Table 1. Among responders, there were significant improvements in clinical characteristics and PROs such as mean TJC (3.4 vs 2.1 vs 0.6; P=0.004), SJC (2.5 vs 0.8 vs 0.5; P<0.0001), percentage of affected BSA (5.6% vs 2.4% vs 1.4%; P=0.03), patient pain (34.7 vs 26.1 vs 21.9; P=0.007) and HAQ scores (0.6 vs 0.4 vs 0.3; P=0.04); however, there were no significant changes over time for patient global assessment or enthesitis counts (P>0.05). Non-responders failed to have a significant improvement from baseline to the first and second FU visits in TJC, SJC, enthesitis, pain, patient global assessment and percentage of affected BSA (all P>0.05).
Conclusions: Only 23% of patients achieved MDA on their index biologic at the second FU visit and were considered responders. Over time, responders showed significant improvements in TJC and SJC, percentage of affected BSA, patient pain and HAQ scores; these most likely contributed to achievement of MDA response. A treat-to-target approach may be considered given the low number of patients in MDA.
References:
[1] Coates, LC et al. Ann Rheum Dis. 2010;69(1):48–53.
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Table 1. Clinical and patient-reported characteristics of patients with PsA in the Corrona registry stratified by response to index biologics over time

Characteristics*	At Enrollment		1st FU Visit		2nd FU Visit		*P* Value (R)	*P* Value (NR)
	R n = 34	NR n = 114	R n = 34	NR n = 114	R n = 34	NR n = 114		
MDA, n (%)†	0 (0)	0 (0)	17 (57)	13 (14)	34 (100)	10 (8.8)	< 0.0001	0.01
Tender joint count (0-68)	3.4 (5.3)	7.2 (11.0)	2.1 (5.1)	6.0 (8.2)	0.6 (1.4)	6.6 (11.7)	0.004	0.16
Swollen joint count (0-66)	2.5 (3.5)	2.8 (3.7)	0.8 (1.7)	2.5 (4.5)	0.5 (1.5)	2.3 (3.9)	< 0.0001	0.12
SPARCC enthesitis (0-16)	2.4 (0.5)	4.4 (3.3)	3.0 (2.8)	4.1 (3.3)	2.0 (1.4)	3.7 (1.9)	0.70	0.67
BSA, %	5.6 (8.1)	8.3 14.4)	2.4 (3.6)	5.1 (9.1)	1.4 (1.7)	4.8 (11.7)	0.03	0.006
Patient-reported pain (VAS 0-100)	35.7 (23.4)	51.2 (24.8)	26.1 (25.2)	54.6 (26.3)	21.9 (20.5)	54.6 (25.3)	0.007	0.28
Patient global assessment (VAS 0-100)	70 (17.8)	53.6 (24.0)	59.2 (30.2)	54.3 (24.5)	62 (31.4)	56.1 (22.5)	0.58	0.47
HAQ (0-3)	0.6 (0.5)	1.0 (0.6)	0.4 (0.5)	1.0 (0.6)	0.3 (0.4)	1.0 (0.6)	0.04	0.54

BSA, body surface area; FU, follow-up; HAQ, Health Assessment Questionnaire; MDA, minimal disease activity; NR, non-responders; R, responders; SPARCC, Spondyloarthritis Research Consortium of Canada; VAS, visual analog scale.
* All values are presented as "mean (SD)" unless otherwise stated.
† MDA was defined as "Yes" if a patient met ≥ 5 of the 7 following categories: tender joint count ≤ 1, swollen joint count ≤ 1, BSA ≤ 3%, patient pain VAS ≤ 15, patient global activity VAS ≤ 20, HAQ ≤ 0.5, tender entheseal points ≤ 1.

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SAT0472 UTILIZATION OF THE PSORIASIS EPIDEMIOLOGY SCREENING TOOL TO IDENTIFY SIGNS AND SYMPTOMS OF EARLY PSORIATIC ARTHRITIS AMONG THOSE WITH PSORIASIS: ANALYSIS FROM THE CORRONA PSORIASIS REGISTRY

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Background: The Psoriasis Epidemiology Screening Tool (PEST) is a 5-item questionnaire developed to help identify psoriatic arthritis (PsA) at an early stage, with a score ≥3 indicative of PsA.[1] A recent Korean study found that a PEST score of 2 may be a more favorable cutoff for screening patients with psoriasis (PsO).[2]
Objectives: To assess the risk of undiagnosed PsA among patients with PsO and characterize patients based on PEST scores in a US cohort.
Methods: This study included all patients enrolled in the Corrona PsO Registry with data on all 5 PEST questions. Demographics, disease characteristics, patient-reported outcomes (PROs) and medication use were analyzed at the time of enrollment and stratified by PEST score (0, 1, 2 or ≥3). Pairwise comparisons were made between PEST score =0 (reference) and other PEST score groups using t-tests for continuous variables and χ^2 tests for categorical variables.
Results: As of June 2016, 99.1% (1516/1529) of patients in the Corrona PsO Registry had data on all 5 PEST questions; 612 patients (40.4%) had dermatologist-reported PsA at enrollment. Among the remaining 904 patients, 421 patients (46.6%) had a PEST score =0, 225 (24.9%) had a PEST score =1, 146 (16.2%) had a PEST score =2 and 112 (12.4%) had a PEST score ≥3. Of patients with a PEST score ≥3, patients most commonly answered "yes" to "have you ever had a swollen joint (or joints)?" (89%) and "has a doctor ever told you that you have arthritis?" (86%). Compared with patients with a PEST score =0, patients with a PEST score ≥1 all had a higher BMI, longer duration of PsO, increased family history of PsA, increased prevalence of nail PsO and worse EQ-VAS at enrollment (all P<0.05; Table 1). In addition, patients with PEST scores ≥2 were older, more likely to be female, less likely to be employed and had an increased family history of PsO, worse pain and fatigue, worse dermatology-related quality of life and higher percentage impairment of daily activities due to psoriasis at enrollment vs patients with a PEST score =0 (all P<0.05). There were no significant differences across PEST scores in affected body surface area or PASI scores.
Conclusions: In this cohort of PsO patients with no diagnosis of PsA, patients with PEST scores ≥2 were significantly different from those with PEST scores =0