68.5% (n=37) in PsA and 45.7% (n=21) in PsO. US synovitis was more frequently found than clinical assessment. The most common sites of inflammatory synovitis were the wrist. US enthesopathy was found in 87.0% (n=47) in patients with PsA 56.5% (n=26) in patients with PsO. US enthesitis was also more frequently found than clinical assessment. The most common sites of enthesopathy were the enthesis in lateral epicondyle, quadriceps and Achilles tendon.

Conclusions: Our results showed that US was able to detect a high prevalence of inflammatory synovitis in peripheral joints and enthesis in patients with PsA. Moreover, subclinical inflammatory findings were also found in patients with PsO by US. US examination is useful to detect the inflammatory condition in patients with PsA and PsO than clinical examination.

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Disclosure of Interest: None declared

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SAT0478 RAPID3 QUESTIONNAIRE HAS HIGH DISCRIMINATING ABILITY IN MINIMAL DISEASE ACTIVITY ATTAINMENT IN PATIENTS WITH EARLY PSORIATIC ARTHRITIS TREATED ACCORDING TO TIGHT CONTROL STRATEGY IN DAILY CLINICAL PRACTICE (RESULTS OF ONE-YEAR OPEN-LABEL REMARCA STUDY)

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Background: RAPID3 is an instrument based on patient's report outcomes (PROs) for the assessment of remission and disease activity in rheumatoid arthritis. The advantages of this questionnaire in treat-to-target (T2T) strategy in early psoriatic arthritis (EPsA) have not been studied properly.

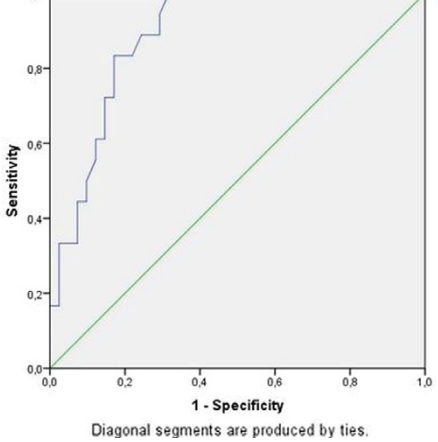
Objectives: to study discriminating ability of RAPID3 in minimal disease activity (MDA) attainment in patients with EPsA treated during one year according to tight control strategy.

Methods: 61 (M/F–29/32) patients (pts) with active EPsA, according to CASPAR criteria, mean age 37±10.6 years, PsA duration 11.3±10.2 months, psoriasis duration 75.4±80.9 months were included. All pts signed a consent form for participation in the open-label REMARCA study. At baseline and after 1year (yr.) of therapy all pts underwent evaluation of PsA activity by Tender Joint count (TJC78), Swollen Joint Count (SJC76), physician's global disease activity (PhGA) VAS, DAS, CRP (mg/l) and by PROs - patient pain global assessment VAS, Patient global disease activity (PGA) VAS, Health Assessment Questionnaire (HAQ) and RAPID3. The dose of Methotrexate (MTX) subcutaneous (s/c) was escalated by 5 mg every 2 weeks from 10 mg/wk up to 20–25 mg/wk. If pts did not achieve MDA after 3–6 months of MTX mono-therapy, combination therapy (CoT) of MTX+Adalimumab (ADA) was started in a standard regime; CoT was continued up to 1 yr. The proportion of pts who achieved MDA was calculated. M±SD, Me [Q25;Q75], %, Spearman rank correlation R, W-test, U-test, ROC-curve analysis were performed. All $p<0.05$ were considered to indicate statistical significance.

Results: By 1 yr. of therapy 36 out of 61 pts (59%) and 25 out of 61 pts (41%) were treated with MTX and with MTX+ADA accordingly. Significant improvements in PsA activity and PROs from baseline up to 1 yr. were observed: DAS 3.93 [3.20–4.58]/1.36 [0.82–2.25], SJC 7 [5–11]/1 [0–3], TJC 8 [6–1]/1 [0–3], PhGA 56 [48–69]/10 [5–20] and VAS pain 54 [48–68]/11 [1–20], PGA 55 [49–68]/14 [7–24], HAQ 0.75 [0.50–1]/0 [0–0.63] accordingly (for all W-test $p<0.001$). Significant positive correlations between RAPID3 and PsA activity, PROs and CRP are shown in table 1 (for all R $p<0.001$).

MDA was seen in 43 out of 61% pts (70.5%). At the same time RAPID3 and CRP significantly decreased from 12.7 [9.2–16.8] to 4.3 [2.0–7.8] and from 16.6 [8.6–34.6] to 2.1 [0.9–6.7] mg/l accordingly (for all W-test, $p<0.001$). Among those who have achieved MDA RAPID3 was in "near remission" status and significantly less compared to pts that did not achieve MDA-2.5 [1.3–5.3] and 8.1 [6.0–15.1] accordingly (U-test, $p<0.001$). According to the results of ROC-curve analysis RAPID3 score had a high discriminating ability for the presence of MDA - AUC 0.888 [0.808–0.969] (Fig. 1).

ROC-curve analysis: association of RAPID-3 values and presence of MDA



Diagonal segments are produced by ties.

Parameters	R
DAS	0.74
TJC78	0.68
SJC76	0.63
PGA VAS	0.82
Pain VAS	0.83
PtGA VAS	0.81
CRP	0.69

Conclusions: RAPID3 based on PROs is a simple instrument for evaluating PsA activity. RAPID3 has shown high discriminating ability in MDA attainment in EPsA pts treated according to tight-control strategy, and could be useful in daily clinical practice.

Disclosure of Interest: None declared

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SAT0479 INCREASED CAROTID INTIMA-MEDIA THICKNESS CAN DISCRIMINATE SIGNIFICANT CORONARY ARTERY STENOSIS BY CORONARY CT ANGIOGRAM IN PATIENTS WITH PSORIATIC ARTHRITIS

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Background: PsA patients have increased morbidity & mortality due to cardiovascular disease (CVD). However, their CV risk were underestimated by various CV risk score[1]. Subclinical carotid atherosclerosis may be considered as surrogate marker of coronary artery disease (CAD) in the general population[2]while it remained uncertain for PsA patients

Objectives: To assess the relationship between carotid artery disease by ultrasound (US) and CAD by coronary computed tomography angiography (CCTA) and identify US parameters predictive of significant CAD

Methods: 91subjects (56 males; age: 50±11 years; disease duration 9.4±9.2 years) without overt CVD who underwent CCTA & carotid US (interval between two exams:2 [1–7] months) were recruited. Carotid intima-media thickness (cIMT)& the presence of plaque were determined by high resolution US in the distal CCA, bulb & proximal ICA bilaterally. Significant coronary artery stenosis was defined as stenosis of the lumen >50%

Results: Carotid plaque was present in 33 (36%) patients & coronary plaque was present in 55 (60%) patients while 9 (10%) patients had significant coronary artery stenosis. 36 (40%) patients had non-zero calcium score (CAC+ group).The mean cIMT was significantly higher in CAC+ group compared to CAC=0 group [0.70±0.11mm vs0.64±0.11mm, p=0.031]. There was a trend suggesting the mean cIMT increases with increasing CAC score, while the prevalence of carotid plaque increased significantly with rising calcium score (Table1). The mean cIMT increased significantly with number of coronary vessels habouring plaque, while there was a trend suggesting the max cIMT and the prevalence of carotid plaque may increase in patients with rising number of coronary vessels harboring plaques The mean & max cIMT were significantly higher in SS+ group than SS- group [mean cIMT: 0.76±0.07mm vs0.65±0.12mm, p=0.011; max cIMT: 0.93±0.14mm vs 0.80±0.16mm, p=0.020] (Table1). The prevalence of carotid plaque was similar between SS+ & SS- group [29 (35.4%) vs 4 (44.4%), p=0.421]. Using multivariate logistic regression, mean & max cIMT were independent explanatory variable of significant coronary stenosis after adjusting age, gender, disease duration & damaged joint count. The OR of significant coronary stenosis of every 0.01mm increase in mean & max cIMT were 1.07 (95% CI: 1.00–1.15, p=0.042) and 1.06 (95% CI: 1.00–1.11,p=0.036). Mean cIMT of 0.66mm was the optimal cut off

	Coronary Artery Calcium (Agatston Score)						
	Normal (CAC=0) (n=55)		Minimal-mild (1-399) (n=25)		Severe (400+) (n=11)		p
Mean carotid IMT, mm	0.64 ± 0.11		0.70 ± 0.13		0.70 ± 0.07		0.099
Maximum carotid IMT, mm	0.79 ± 0.16		0.84 ± 0.16		0.86 ± 0.15		0.223
Carotid Plaque, n, %	16	29.1%	10	40.0%	7	63.6%	0.031
	Number of coronary artery with any plaques						
	0 (n=36)		1-2 (n=43)		3 (n=12)		p
Mean carotid IMT, mm	0.63 ± 0.12		0.68 ± 0.11		0.69 ± 0.08		0.029
Maximum carotid IMT, mm	0.77 ± 0.17		0.83 ± 0.17		0.83 ± 0.15		0.065
Carotid Plaque, n, %	10	27.8%	16	37.2%	6	58.3%	0.068
	Significant coronary artery stenosis						
	No (n=82)				Yes (n=9)		p
Mean carotid IMT, mm	0.65 ± 0.12				0.76 ± 0.07		0.011
Maximum carotid IMT, mm	0.80 ± 0.16				0.93 ± 0.14		0.020
Carotid Plaque, n, %	29	35.4%			4	44.4%	0.421

Table 1. Relationship between carotid artery disease by ultrasound and coronary artery disease by coronary computed tomography angiography.