for discriminating patients with significant coronary stenosis (sensitivity: 100%; specificity: 44%). ROC analyses demonstrated that mean cIMT (AUC=0.801, p=0.003)has higher power than Framingham CVD risk score (FRS) (AUC=0.756, p=0.012)

Conclusions: Increased cIMT is associated with the presence & severity of coronary calcification & obstructive coronary disease on CCTA in PsA patients. cIMT measurement can discriminate PsA patient with significant coronary stenosis better than FRS. PsA patients with moderate CVD risk should have carotid US for better CV risk stratification

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SAT0480 COMPARATIVE EFFECTIVENESS OF SECUKINUMAB AND INFLIXIMAB IN PSORIATIC ARTHRITIS ASSESSED BY MATCHING-ADJUSTED INDIRECT COMPARISON USING PIVOTAL PHASE 3 CLINICAL TRIAL DATA

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Background: Therapeutic options with discrete modes of action are now available for psoriatic arthritis (PsA). Clinicians require evidence to guide decision-making. No head-to-head RCTs have compared secukinumab 150 mg (SEC; anti-IL-17A) with infliximab 5 mg/kg (INF; TNFi) in patients with PsA. Matching-Adjusted Indirect Comparison (MAIC) can be used to estimate comparative effectiveness and enables treatment outcomes to be compared across effectively balanced trial populations. MAIC is an established method in health technology assessments, with NICE having recently published guidance.

Objectives: To use MAIC to assess the comparative effectiveness of SEC and INF for up to 1 year using pooled FUTURE 1 (F1) and FUTURE 2 (F2) individual patient data (IPD) and published aggregate IMPACT 2 data, respectively.

Methods: Pooled F1 and F2 data were used to maximize the effective sample size (ESS) for SEC. IPD from the SEC arms of F1 and F2 (n=302) were weighted to match selected baseline characteristics of the INF arm of IMPACT 2 (n=100). Placebo arms were also matched; placebo-adjusted comparisons were possible only until week 16 because patients could receive active treatment from this time point onwards. Logistic regression was used to determine weights for age, sex, race, body weight, methotrexate use, presence of psoriasis (≥3% body surface area), mean PASI score, dactylitis, enthesitis, mean HAQ-DI score and previous TNFi therapy. Recalculated outcomes from F1 and F2 (SEC, ESS=91; placebo, ESS=59) were compared with data from IMPACT 2 (INF, n=100; placebo, n=100). Pairwise comparisons using odds ratios (ORs [95% CIs]) were performed for ACR 20, 50 and 70 responses at nearest-equivalent time points across trials: weeks 6/8, 14/16, 24 and 54/52. Mean changes from baseline in SF-36 Physical and Mental Component Summary (MCS) scores were also compared. Strict thresholds were avoided when interpreting p values, in line with American Statistical Association 2016 guidance.

Results: There was no evidence of differences in ACR 20, 50 and 70 responses between SEC and INF at weeks 6/8, 14/16 (both placebo-adjusted) and 24 (non-placebo-adjusted). At week 54/52, ACR 20 and 50 responses were higher with SEC than INF (OR [95% CI]: 4.05 [1.98–8.30], p<0.001 and 1.90 [1.05–3.44], p=0.034, respectively). Improvements in SF-36 MCS scores were greater with SEC than INF at weeks 14/16 (p=0.063), 24 (p=0.001) and 54/52 (p<0.001). A sensitivity analysis that added PsA duration, swollen joint count and CRP levels to the matching parameters yielded similar results.

Conclusions: In this MAIC, SEC showed evidence of superiority for symptomatic improvement (non-placebo-adjusted ACR 20 and 50) over INF for active PsA at 1 year. This was accompanied by greater improvements in SF-36 MCS scores. At earlier time points, there was no evidence of differences in ACR responses between SEC and INF.

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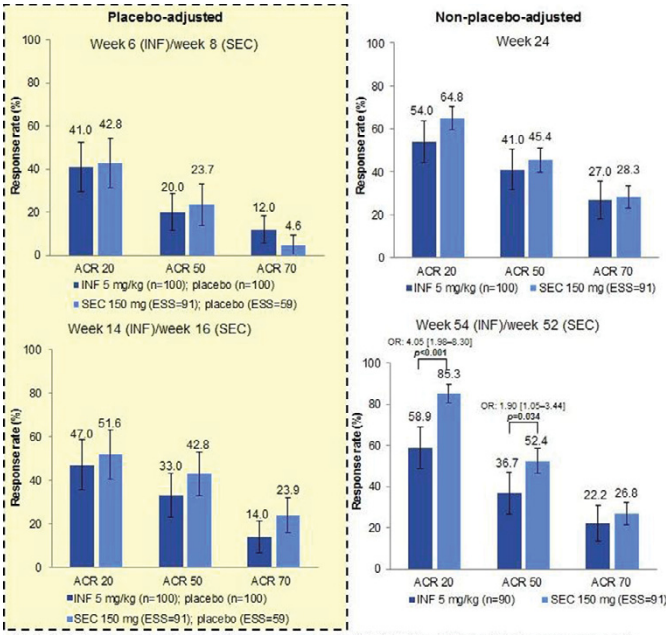

ACR 20/50/70 responses are the absolute mean response rate (IMPACT 2) and the predicted mean response rate (FUTURE 1 and FUTURE 2). Error bars show 95% CIs.
ACR, American College of Rheumatology; ACR 20/50/70, at least a 20%/50%/70% improvement according to the ACR response criteria; CI, confidence interval; ESS, effective sample size; INF, infliximab; OR, odds ratio, SEC, secukinumab.

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SAT0481 THE RELATIONSHIP BETWEEN THE PATIENT ACCEPTABLE SYMPTOM STATE (PASS) AND DISEASE ACTIVITY IN PATIENTS WITH PSORIATIC ARTHRITIS (PSA)

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Background: PASS is the highest level of symptoms beyond which patients consider themselves well. Psoriatic Arthritis Disease Activity Score (PASDAS) is a recently developed composite disease activity measure that summarizes a patient's disease in a single 0–10 score.

Objectives: In this study, we aimed to identify the PASDAS cut-off points for PASS, and to examine the agreement between PASS and the PASDAS thresholds for low (<3.2), moderate (3.2–5.4), and high disease activity (>5.4).

Methods: Patients were prospectively recruited from the University of Toronto PsA clinic. A standard protocol including physician assessment and patient-reported outcomes was used to record variables required to calculate PASDAS. In addition, each patient was asked to "think about all the ways your PsA has affected you during the last 48 hours. If you were to remain in the next few months as you were during the last 48 hours, would this be acceptable to you?" to assess PASS. For analysis, the PASDAS threshold for PASS was identified with the ROC analysis to maximize specificity and sensitivity. Furthermore, the agreement between PASS and low, moderate, and high PASDAS disease activity cut-offs were evaluated.

Results: 169 patients [61% male, mean age 56.1, mean disease duration 16.9 years, mean (SD) PASDAS 3.25 (1.1)] were recruited. The PASDAS threshold for the patient acceptable symptoms state (PASS+) was identified to be 3.84 (AUC – 0.88, sensitivity 0.82, specificity 0.94) using ROC curve analysis. 91% of patients with low disease activity (PASDAS <3.2) considered their symptoms state acceptable (PASS+), and 100% of the patients with high disease activity (PASDAS >5.4) considered their symptom state as unacceptable (PASS-). Furthermore, the mean (SD) PASDAS was 4.5 (1.0) in the PASS- group and 2.8 (1.1) in the PASS+ group.

Conclusions: The PASDAS threshold for patient acceptable symptoms state is 3.84, which is within the moderate disease activity range. Thus with a PASDAS of 3.84 or lower, PsA patients consider their symptom state acceptable for the next few months. This cut-off should be considered for shared decision making regarding treatments in PsA patients.

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