in activities and work productivity. These results suggest there is a need for treatments that provide fast and sustained improvement in pain to reduce the impact pain has on patients' daily life as well as societal costs.

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OP0108 INHIBITION OF RADIOGRAPHIC PROGRESSION IN PSORIATIC ARTHRITIS BY ADALIMUMAB INDEPENDENT OF THE CONTROL OF CLINICAL DISEASE ACTIVITY

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Background: Patients (pts) with psoriatic arthritis (PsA) may experience structural damage and irreversible functional impairment if not treated appropriately. Treatment with TNF inhibitors in rheumatoid arthritis (RA) pts showed inhibition of radiographic progression larger than expected based on the control of clinical disease activity.[1] Preliminary results showed that such a disconnect phenomenon may also be observed in PsA pts following treatment with adalimumab (ADA).[2]
Objectives: The objective of this analysis was to further examine the relationship between inhibition of radiographic progression and control of clinical disease activity using different disease activity measures following treatment with originator ADA versus placebo (PBO) in pts with active PsA.
Methods: ADEPT[3] was a 24-week (wk), randomized, double-blind trial comparing the safety and efficacy of ADA with PBO in pts with active PsA. In this post hoc analysis, radiographic progression, defined as change from baseline (BL) to wk 24 in modified total Sharp score (ΔmTSS) >0.5, was calculated in pts with evaluable radiographs at both time points. Pts were classified based on achieving minimal disease activity (MDA) and different subcategories of disease activity (remission, low, moderate, or high) based on time-averaged (TA) DAS28(CRP), DAPSA, and PASDAS. The associations between ΔmTSS and disease activity were assessed by Pearson (r_p) or Phi (r_φ) correlation coefficients.
Results: Of the 296 pts (ADA, N=144; PBO, N=152) included in this analysis, higher proportions of pts receiving ADA compared with PBO achieved MDA and remission/low disease activity status across all the outcome measures.

Table Change from Baseline to Week 24 in modified Total Sharp Score (ΔmTSS) categorized by Disease Activity Status Across Each Outcome Measure in ADA and PBO Treated Patients.

Outcome measure Mean (SD)	ΔmTSS		P-value*
	ADA	PBO	
TA-DAS28 (CRP)†	n = 144	n = 152	
Remission (≤2.6)	-0.3 (1.3)	0.1 (0.7)	.135
Low disease activity (>2.6–3.2)	-0.2 (1.3)	0.6 (1.7)	.054
Moderate disease activity (>3.2–5.1)	0.2 (1.3)	1.5 (3.6)	.085
High disease activity (>5.2)	1.7 (2.9)	4.9 (8.2)	.893
TA-DAPSA†	n = 144	n = 152	
Remission (≤4)	-0.1 (0.5)	0.0 (0.0)	.824
Low disease activity (>4–14)	-0.2 (1.0)	0.0 (0.0)	.741
Moderate disease activity (>14–28)	-0.2 (1.4)	0.4 (1.0)	**.044**
High disease activity (>28)	-0.1 (1.8)	1.4 (3.5)	**.002**
TA-PASDAS†	n = 136	n = 150	
Low disease activity (≤3.2)	-0.1 (0.9)	0.2 (0.4)	.373
Moderate disease activity (>3.2–<5.4)	-0.4 (1.5)	0.4 (1.3)	**.001**
High disease activity (≥5.4)	0.2 (1.9)	2.0 (4.3)	**.039**
MDA‡	n = 139	n = 146	
Yes	-0.2 (1.6)	0.0 (0.0)	.884
No	-0.2 (1.3)	1.1 (3.1)	**<.001**

*P-value for difference between treatment groups is based on ANCOVA.
†Time averaged (TA) variable is calculated as area under the curve (AUC) of that variable and standardized by length of study (24 weeks).
‡Minimal disease activity (MDA) was calculated in patients with at least 5 out of 7 MDA components available.
ADA = adalimumab, PBO = placebo; TA = time-averaged; DAS28(CRP) = 28-joint disease activity score based on C-reactive protein, DAPSA = disease activity index for psoriatic arthritis, PASDAS = psoriatic arthritis disease activity score; index, MDA = minimal disease activity; ANCOVA = analysis of covariance.

There was a significant interaction between treatment and disease activity status with respect to radiographic progression (P<.001 for all outcome measures). In addition, treatment with ADA for 24 wks compared with PBO resulted in significantly lower mean ΔmTSS even in pts with moderate or high disease activity (TA-DAPSA or TA-PASDAS) or not achieving MDA (Table). Radiographic progression showed a weak, but significant correlation with disease activity status in pts treated with PBO ($r_p \geq 0.3$, P<.001 for TA-DAS[CRP], TA-DAPSA, and TA-PASDAS; $r_\varphi = -0.14$ [95% CI:–0.20 to –0.09 for MDA), but not ADA.
Conclusions: The results showed that the relationship between disease activity as determined by various outcome measures differed between ADA and PBO treated pts. ADA provided inhibition of radiographic progression which was somewhat larger and independent of the control of clinical disease activity. This supports the disconnect phenomenon in PsA following ADA treatment.

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OP0109 IS MENTAL HEALTH COMPARABALE IN RHEUMATOID AND PSORIATIC ARTHRITIS PATIENTS? A COMPARATIVE ANALYSIS OF REAL LIFE LONGITUDINAL DATA FROM THE NOR-DMARD STUDY

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Background: Only few studies have compared health related quality of life (HRQoL) between rheumatoid arthritis (RA) and psoriatic arthritis (PsA) patients.
Objectives: To compare the Medical Outcomes Survey Short Form-36 (SF-36) Physical Component Summary (PCS) and Mental Component Summary (MCS) in RA and PsA patients from a large prospective observational registry.
Methods: We included RA and PsA patients from the prospective observational multicenter Norwegian-Disease-Modifying Antirheumatic Drug (NOR-DMARD) study, who started first-time tumour necrosis factor inhibitors or DMARD naïve patients starting methotrexate between year 2000 and 2012. Continuous variables were compared using independent t-test (normally distributed data). Prespecified ANCOVA analyses adjusted for age, gender and years since diagnosis were performed to compare SF-36 PCS and MCS between the RA and PsA patients at baseline and after 3 and 6 months follow-up.
Results: A total of 2735 RA and 1236 PsA patients were included. Mean (SD) age was 55.0 (13.5)/ 48.3 (12.4) years, median (25th-75th percentile) years since diagnosis 0.7 (0.02–6.4)/ 1.3 (0.09–7.7), 69.7/48.4% were women and 31.7/29.8% current smokers. Mean (SD) 28-joint Disease Activity Score was higher in RA vs. PsA patients at baseline (4.9 (1.4)/ 4.2 (1.3)) and at 3 (3.6 (1.5)/ (3.1 (1.4)) and 6 months follow-up (3.3 (1.4)/ 3.0 (1.3)), respectively ($p \leq 0.001$). Unadjusted means (SD) of SF-36 PCS and MCS were similar between the RA and PsA patients (Table 1).
In adjusted analyses SF-36 PCS was slightly higher and SF-36 MCS similar between RA and PsA patients at 3 and 6 months follow-up (Table 2).
Conclusions: Mental HRQoL reflected through SF-36 MCS was similar between RA and PsA patients at all time points, in spite of slightly worse physical HRQoL reflected through lower SF-36 PCS in the PsA group at 3 and 6 months follow-up.
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