(median 12 (IQR 7.25–17) vs. 7.5 (5–9), $P < 0.001$), while the original MASEI did not differ significantly (Table 1). Confluent PD over a larger area was only seen in 8% of the established PsA patients. Structural damage on ultrasound was more pronounced in the patients compared to the healthy volunteers. Number of PD locations and PD score did not distinguish the two groups.

Table 1. Participant characteristics and sonographic enthesitis scores

	PsA patients (n=84)	Healthy Volunteers (n=25)
Male, n (%)	45 (54)	12 (48)
Age, mean (SD)	55 (11)	47 (6)*
Disease duration, median years (IQR)	8.0 (4.9–12.3)	
LEI, median (IQR)	0.5 (0–2)	0 (0–0)**
Ultrasound		
MASEI, median (IQR)	15.5 (11–22)	13 (9–18)
Modified MASEI, median (IQR)	12 (7.25–17)	7.5 (5–9)**
structural components	7 (3–10)	3 (1–6)**
inflammatory components	6 (3.5–8.5)	3.5 (2–5.5)
Power Doppler		
in any enthesitis, n (%)	74 (88)	22 (88)
score 3, n (%)	7 (8%)	0 (0%)
locations, median (IQR)	2 (1–3)	2 (1–3)
if positive, median (IQR)	1.5 (1.25–1.75)	1.5 (1.25–1.5)

PsA: Psoriatic Arthritis; SD: standard deviation, IQR: interquartile range; LEI: Leeds Enthesitis Index; MASEI: Madrid Sonographic Enthesitis Score; modified MASEI: MASEI with new PD scoring method (1: one spot of PD, 1.5: some spots of PD, 2: confluent signal, 3: severe signal) and without knee entheses thickness. Structural components: erosions, calcifications, structure. Inflammatory components: bursitis, thickness and PD signal. PD: Power Doppler. * $P < 0.01$, ** $P < 0.001$ (Wilcoxon rank sum test).

Conclusions: Inflammatory and structural changes of the entheses measured with ultrasound are common in both unselected PsA patients and healthy volunteers, but more pronounced in established PsA patients.

References:

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.3431

AB0770 CHANGE OF PSORIATIC ARTHRITIS IMPACT OF DISEASE (PSAID12) QUESTIONNAIRE RELATED TO CHANGE IN DISEASE ACTIVITY IN EARLY PSORIATIC ARTHRITIS

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Background: The Psoriatic Arthritis Impact of Disease 12-item questionnaire (PSAID12) has been developed to measure impact of Psoriatic Arthritis (PsA) for purposes of monitoring and clinical management. Although validated in patients with longstanding disease, data on validity and sensitivity to change in early PsA is lacking.

Objectives: We aim to relate change in disease activity to change in PSAID12 score in early PsA and evaluate which PSAID domains are more likely to change.

Methods: Patients with a new diagnosis of PsA were included in the Dutch southwest Early Psoriatic Arthritis cohort (DEPAR). For this analysis, patients that have PSAID12 (range 0–10) and Composite Psoriatic Disease Activity Index (CPDAI, range 0–15) data at two consecutive visits (i.e. 3 months apart) within the first year were included. In case multiple periods per patients were available, the first time period was chosen. The change in PSAID is compared to the change in disease activity over this period, measured with the CPDAI using Spearman's correlation coefficient. Change in score on individual domains of the PSAID was analysed in subgroups of patients that perceived improvement in health and those that perceived worsening. The SF-36 question on self-perceived change in health was used to determine these subgroups.

Results: 143 unique patients had at least one period with two PSAID and CPDAI measurements (67 from baseline-3 months, 26 3–6 months, 25 6–9 months and 25 9–12 months). Mean age was 51 (SD 13.7) and 70 (49%) were male. The initial median PSAID was 3.35 (IQR 1.4–5.1) and the subsequent score was 2.25 (0.95–4.8 with a mean delta of 0.52 ($P < 0.01$)). Median first CPDAI score was 4 (2–7) and 3 (1–5) for the second with a mean delta of 0.45 ($P < 0.05$). The difference in PSAID score was significantly but moderately correlated with the difference in CPDAI (Spearman's rho 0.267, $P = 0.0013$). 58 patients (41%) report a better health status compared to 3 months ago. Figure 1 shows that patients with self-perceived improvement of health have the highest improvement in pain and only domains of skin problems and embarrassment/shame did not improve

significantly. Patients reporting worsening of health (n=29) only have significantly lower scores in fatigue, discomfort and social domains.

Figure 1. Mean absolute differences in PSAID12 domains in patients with self-perceived improvement of health (n=58, black) and patients reporting worsening of health (n=29, grey). Shown as mean value and 95%-Confidence Interval

Conclusions: Improvement in CPDAI disease activity is significantly but moderately associated with improvement in PSAID score, with the biggest improvement in the pain domain in patients with a self-reported improvement of health.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.3817

AB0771 SAFETY AND EFFICACY OF APREMILAST THROUGH 104 WEEKS IN PATIENTS WITH MODERATE TO SEVERE PSORIASIS WHO CONTINUED ON APREMILAST OR SWITCHED FROM ETANERCEPT TREATMENT IN THE LIBERATE STUDY

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Background: Many patients (pts) with chronic plaque psoriasis exhibit nail and scalp involvement that can markedly affect quality of life and be difficult to treat.

Objectives: The phase 3b LIBERATE (Evaluation in a Placebo-Controlled Study of Oral Apremilast and Etanercept in Plaque Psoriasis) study (NCT01690299) evaluated the efficacy and safety of apremilast or etanercept vs. placebo in biologic-naïve pts with moderate to severe plaque psoriasis. Efficacy assessments included effects on preexisting nail and scalp disease and skin lesions.

Methods: In this double-blind, double-dummy study, pts were randomized (1:1:1) to placebo (PBO), apremilast 30 mg BID (APR), or etanercept 50 mg QW (ETN) through Week 16; thereafter, all pts switched to or continued APR (PBO/APR, ETN/APR, APR/APR) through Week 104. The primary end point was achievement of a $\geq 75\%$ reduction from baseline in Psoriasis Area and Severity Index (PASI) score (PASI-75) at Week 16 with APR vs. PBO; the secondary end point was PASI-75 achievement at Week 16 with ETN vs. PBO. Physician assessments were also conducted for overall disease activity (static Physician's Global Assessment [sPGA]); scalp disease activity (Scalp Physician Global Assessment [ScPGA], limited to patients with score ≥ 3 at baseline, indicating moderate to very severe scalp disease); and nail disease (Nail Psoriasis Severity Index [NAPSI], limited to patients with active disease [NAPSI ≥ 1] in the target nail at baseline). Responses were assessed at Week 104 using the last-observation-carried-forward (LOCF) methodology.

Results: The APR extension phase (Weeks 16 to 104) included 226 pts (PBO/APR n=73; APR/APR n=74; ETN/APR n=79). At Week 16, PASI-75 scores vs. PBO were significant for both APR and ETN; long-term treatment with APR maintained both PASI-75 and sPGA 0 or 1 response levels (Table). Improvements were seen in nail and scalp disease at Week 16, and responses continued to improve with APR treatment over 104 weeks and in pts who switched from ETN to APR (Table). ScPGA 0 or 1 was achieved by 50.0% to 59.2% of pts across treatment arms, and mean percent improvement from baseline NAPSI score ranged from -48.1% to -51.1% (Table); the proportion of pts achieving NAPSI-50 response ranged from 48.6% to 65.2%. Adverse events (AEs) occurring in $\geq 5\%$ of pts during Weeks 0 to 16 were diarrhea, nausea, nasopharyngitis, upper respiratory tract infection, and headache; long-term assessment by exposure-adjusted incidence rates (EAIR)/100 pt-yrs showed no increase with longer-term APR exposure. No increase in EAIR/100 pt-yrs of serious AEs occurred during the APR extension phase (3.45 to 5.49, across groups) vs. Weeks 0 to 16 (PBO 0.0; ETN 7.91; APR 12.57). Changes in laboratory parameters were infrequent and transient; EAIR/100 pt-yrs remained low across groups through 104 weeks.

Conclusions: APR demonstrated efficacy through Week 104 in pts who continued APR and pts who switched from PBO or ETN to APR at Week 16. The AE profile remained consistent with prolonged APR exposure, and no new safety or tolerability issues were observed through Week 104 in pts with moderate to severe plaque psoriasis.