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SAT0475 RECENT ONSET PSORIATIC ARTHRITIS: BASELINE DATA FROM THE REAPSER STUDY

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Background: The natural history of psoriatic arthritis (PsA) is very little known and the information regarding prospective cohorts is very scarce worldwide, including our country. REAPSER (Spanish Rheumatology Society Registry of Psoriatic Arthritis) is the first registry of Spanish patients with recent onset PsA.

Objectives: To describe the baseline characteristics of patients included in the REAPSER cohort.

Methods: Observational, multicentric study (34 centers), with consecutive inclusion. We included adults of both sexes 18 years of age or older with PsA that met CASPAR criteria, and duration of less than two years since the appearance of symptoms attributed to PsA. Annual follow-up visits will be carried out for 5 years. Measurements: socio-demographic data; employment status and impact of the disease; family history of PsA and other inflammatory diseases; comorbidities and treatment; lifestyle; use of health services; clinical status at the time of diagnosis of PsA; anthropometric data; clinical evaluation of PsA manifestations; radiographic evaluation; analytical determinations; treatment of PsA. The study has been approved by the ethical committees of the participating centers.

Results: Two hundred and fifteen consecutive patients were included, mean age 49.8±13.9 years.

Baseline characteristics of the cohort

Parameter	N: 215
Men	67.4%
Women	32.6%
Active worker	59.5%
Unemployed	12.1%
Retired/pensioner	17.7%
Job change last year	4.7%
University studies	20%
Smoking	30.2%
BMI	27.7±5.2
Weekly alcohol consumption	0 SDU (0-4)
Family history of psoriasis	41.4%
Family history of PsA	9.3%
Family history of other arthritis	6.5%
Charlson's Comorbidity Index	0: 46.5%. 1-2: 35.3%. 3-4: 14.4%. >4: 3.8%
Psoriasis at baseline	88%
PASI	1.5 (0.6-4.3)
Joint pattern	Peripheral: 81.5%. Axial: 5.2%. Mixed: 13.3%
TJC68	4 (2-8)
SJC66	2 (1-4)
BASDAI	3.9 (3-4.4)
Dactylitis	41.9%
Enthesitis	25%
Uveitis	0.5%
Pain	5 (3-7)
Patient's global disease activity	5 (3-7)
PsAID	3.8 (1.8-6)
Steinbrocker Index (0-168)	0 (0-4)
Cardiovascular events	5.7%
HLA-B27	12.3%
ESR	13 (6-25)
NSAIDs	75%
GC	28.3%
Synthetic DMARDs	53.2%
Biological DMARDs	1.5%

Values are expressed as percentages, means with standard deviation and medians with their IQR (interquartile range). SDU: Standard Drink Units. PsAID: Psoriatic Arthritis Impact of Disease.

Conclusions: The baseline situation of Spanish patients with newly diagnosed PsA corresponds to that of a disease with slight cutaneous involvement and predominance of oligoarticular arthritis. Unsurprisingly, structural damage is scarce but not zero. The impact of the disease is still low in these early stages, however 18% of patients have a high Charlson's comorbidity index (>3) and almost 5% of patients have had to change their employment status in the last year due to its PsA.

Disclosure of Interest: None declared

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SAT0476 DEMOGRAPHIC, CLINICAL, AND LABORATORY CHARACTERISTICS OF ELDERLY ONSET PSORIATIC ARTHRITIS

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Background: Psoriatic arthritis (PsA) is a chronic inflammatory disease characterized with axial and peripheral joints involvement. It is rarely affects patients older than 65 years old.

Objectives: The purpose of this study is to compare and evaluate the demographic, clinical and laboratory features of elderly-onset psoriatic arthritis (EOPsA) and young-onset (YOPsA) patients.

Methods: One hundred and eighty patients diagnosed with PsA according to CASPAR criteria and followed-up in single center were included in this study. The patients with initial symptoms started after age 65 were accepted as EOPsA. Demographic, clinical, and laboratory data and the medications which the patients received were recorded and retrospectively evaluated.

Results: Nineteen (10.5%) of 180 patients were diagnosed as EOPsA, and 161 (89.5%) patients were evaluated as YOPsA. Mean patient age was 42.1 years for YOPsA group and 68.3 years for elderly onset group. Mean duration of disease was 5.6 years for early onset group and 1.3 years for elderly onset group (p=0.001). Fourteen (73.3%) of 19 EOPsA patients were female and 5 of them were male. Higher rates of fatigue, pain scores, comorbid diseases and acute phase reactants were detected in EOPsA patients comparing to YOPsA (p=0.000, p=0.000, p=0.001 and p=0.001 respectively). YOPsA patients have more dactylitis, nail involvement, elevated PASI scores, and smoking habitus when compared with EOPsA patients (p=0.019, p=0.03, p=0.005, p=0.004 respectively). In terms of the treatment options chosen, there was no significant difference in the use of non-steroidal anti-inflammatory drugs (NSAIDs), corticosteroids (CS), methotrexate (MTX), and sulfasalazine (SSL), but there was a more frequent use of anti-tumor necrosis factor -alpha in YOPsA group.

Conclusions: Herein we showed that YOPsA and EOPsA patients may have different demographic, clinical, and laboratory features. EOPsA patients are characterized with higher rates of fatigue, pain scores, comorbid diseases, and acute phase reactants and less dactylitis, nail involvement and anti-TNF-alpha usage.

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SAT0477 THE COMPARISON OF ULTRASOUND SYNOVITIS AND ENTHESITIS FINDINGS AND CLINICAL FINDINGS IN PATIENTS WITH PSORIATIC ARTHRITIS AND SKIN PSORIASIS

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Background: Conventionally, the assessment of affected joint count in patients with psoriatic arthritis (PsA) was relied for the detection of swelling and tenderness in the joints and enthesitis by clinical physical assessment. To date, the modern imaging tool such as ultrasound (US) can detect inflammation in the joint and enthesitis more sensitively than clinical assessment.

Objectives: The aim of this study was to research the prevalence of US synovitis and enthesitis findings in patients with PsA and psoriasis (PsO) comparing with clinical assessment.

Methods: Total 100 patients, 54 patients with PsA and 46 patients with PsO, were consecutively included. HI VISION Ascendus (HitachiAloka Medical, Tokyo, Japan) was used with a 18-MHz linear array transducer. US examination was performed in MCP, PIP, DIP and wrist joints in both hand. Grayscale (GS) and power Doppler (PD) US were scored on a 0-3 semiquantitative scale for each joint. Moreover, the US assessment of enthesitis was performed. Lateral epicondyle, triceps enthesitis, the proximal and distal patella tendon enthesitis, Achilles tendon and fascia plantaris tendon enthesitis was scanned in both GS and PD assessment. Abnormal findings of enthesitis was defined structure thickness, bursitis erosion, calcification and power Doppler signal.

Results: US synovitis was found in 81.5% (n=44) and 60.9% (n=28) by GS, 66.7% (n=36) and 45.7% (n=21) by PD assessment, respectively in patients with PsA and PsO. Active synovitis (GS grade ≥ 2 and/or PD grade ≥ 1) was found

	PsA (n=54)	PsO (n=46)	P value
Male (%)	26 (48.1%)	26 (56.5%)	0.429
Age (years)	55.4±15.0	57.5±15.3	0.508
Height (cm)	161.6±9.8	161.6±9.5	0.969
Weight (kg)	62.7±15.5	63.1±13.9	0.905
BMI	23.8±3.9	24.0±3.6	0.883
Duration of psoriasis (years)	15.6±13.6	17.5±19.7	0.584
PASI	11.7±13.4	8.9±7.5	0.432
PASE	45.8±14.6	29.8±11.9	<0.001
Active US synovitis (GS≥2, PD≥1)	37 (68.5%)	21 (45.7%)	0.026
US enthesitis (any pathological findings)	47 (87.0%)	26 (56.5%)	<0.001

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 enthesitis 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 enthesitis 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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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 1 year (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 [6–11]/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

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

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

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).

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 score¹. Subclinical carotid atherosclerosis may be considered as surrogate marker of coronary artery disease (CAD) in the general population² 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: 91 subjects (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 vs 0.64±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 (Table 1). The mean cIMT increased significantly with number of coronary vessels harbouring 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 harbouring plaques. The mean & max cIMT were significantly higher in SS+ group than SS- group [mean cIMT: 0.76±0.07mm vs 0.65±0.12mm, p=0.011; max cIMT: 0.93±0.14mm vs 0.80±0.16mm, p=0.020] (Table 1). The prevalence of carotid plaque was similar between SS+ & SS- group [29 (35.4%) vs 4 (4.4%), 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)			p
	Normal (CAC=0) (n=55)	Minimal-mild (1-399) (n=25)	Severe (400+) (n=11)	
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			p
	0 (n=36)	1-2 (n=43)	3 (n=12)	
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			p
	No (n=82)	Yes (n=9)		
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.