dl; $p=0.04$). Compared to AS group, PsA patients were characterised by higher IL-18 (235 vs 208 pg/ml; $p<0.05$) but lower OPG (815 vs 1660 pg/ml; $p<0.05$) serum levels. In PsA patients without CHD, serum OPG positively but moderately correlated with LDL ($r=0.3$; $p=0.05$), TG ($r=0.43$; $p=0.007$) and AI ($r=0.45$; $p=0.004$). Moreover, in this PsA patients subgroup we confirmed previously observed¹ inverse correlation of IL-18 with HDL levels ($r=-0.34$; $p=0.05$) and positive correlation of this cytokine with both TG levels ($r=0.37$; $p=0.04$) and AI values ($r=0.53$; $p=0.002$). Interestingly, similar but stronger associations of IL-18 with HDL levels ($r=-0.88$; $p=0.004$) and AI values ($r=0.88$; $p=0.004$) were presently found in PsA patients with accompanied CHD. Consistently with our previous report,¹ we failed to find any correlations between CV risk, lipid profile, and tested cytokines serum concentrations in patients with AS.

Conclusions: We report that in PsA, but not AS, patients serum IL-18 and OPG concentrations are correlated with an altered and pro-atherogenic lipid profile. These associations are stronger in patients with concomitant CHD. Thus, present results explain partially the way by which these cytokine contribute to CV complications in PsA.

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SAT0311

PREVALENCE AND FACTORS RELATED TO INAPPROPRIATELY HIGH LEFT VENTRICULAR MASS IN PATIENTS WITH PSORIATIC ARTHRITIS WITHOUT OVERT CARDIAC DISEASE

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Background: Early cardiovascular (CV) involvement has been found in patients with psoriatic arthritis (PsA). These patients may have a high prevalence of subclinical left ventricular (LV) dysfunction, even without established CV disease and in the absence of traditional CV risk factors. However, currently, the factors associated with LV dysfunction in PsA are unknown. Patients with inflammatory disorders are exposed to the development of excessive left ventricular mass disproportionate to the need to compensate left ventricular load, a condition named 'inappropriately high left ventricular mass' (iLVM). Previously, we have shown that iLVM is associated with unfavourable prognosis in patients with rheumatoid arthritis independent of traditional CV risk factors.

Objectives: In this cross-sectional study, we assessed the prevalence and factors associated with iLVM in a cohort of patients with PsA and tested the hypothesis that PsA is *per se* related to iLVM.

Methods: We evaluated 101 non-institutionalised patients >18 years of age diagnosed with PsA according to CASPAR criteria and consecutively recruited between March 2014 and December 2016. All PsA patients were free of symptoms or signs of cardiovascular disease. Patients with PsA were compared with 101 controls matched for age, sex, BMI, prevalence of hypertension and diabetes. Left ventricular chamber dimensions and wall thicknesses were measured according to the American Society of Echocardiography guidelines and predicted LVM was calculated using a validated equation considering height, sex and left ventricular work. iLVM was defined as measured/predicted LVM ratio above the 95% percentile of a reference population of healthy controls.¹

Abstract SAT0311 – Table 1. Variables significantly related to iLVM in the entire study population (101 patients with PsA and 101 matched controls).

Predictors	OR	95% CI	P value
Psoriatic arthritis	6.91	2.80–17.06	<0.001
Waist circumference	1.04	1.00–1.07	0.047
Dyslipidemia	0.85	0.39–1.89	0.696
Hypertension	1.29	0.56–2.96	0.547
Diabetes mellitus	2.42	0.60–9.79	0.214
Age	1.02	0.98–1.07	0.291
Sex (male)	1.27	0.57–2.84	0.559

Results: iLVM was detected in 58% of patients with PsA and 18% of controls ($p<0.001$). In multivariable logistic regression analysis considering only patients with PsA, the variables independently associated with iLVM were left ventricular

systolic dysfunction (LVSD) measured as mid-wall shortening and concentric left ventricular geometry. In multiple regression analyses considering the entire study population (patients with PsA and matched controls), the diagnosis of PsA was significantly associated with iLVM independent of traditional cardiovascular risk factors (OR 6.91, 95% CI 2.80–17.06, $p<0.001$; table 1).

Conclusions: More than 50% of patients with PsA have a disproportionate increase in their LVM. An inappropriately high LVM in PsA is associated with LV systolic dysfunction and LV concentric geometry.

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SAT0312

INCIDENCE OF INFECTIONS IN CLINICAL TRIALS OF TILDRAKIZUMAB FOR MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS

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Background: Risk of infections is a concern with cytokine inhibitor treatments.

Objectives: This analysis assessed infections during phase 2 and 3 trials of tildrakizumab (TIL), a high-affinity, humanised, immunoglobulin G1/κ monoclonal antibody against IL-23p19 under development for moderate to severe chronic plaque psoriasis.

Methods: Patients were randomised in P05495 (phase 2; NCT01225731), reSURFACE 1 (phase 3; NCT01722331), and reSURFACE 2 (phase 3; NCT01729754). In Part 1 (Weeks 1–16) of P05495, patients received subcutaneous (SC) TIL 5, 25, 100, or 200 mg or placebo (PBO) at Weeks 0 and 4 and were rerandomized to various TIL doses in Part 2 (Weeks 16–52). In Part 1 (Weeks 1–12) of reSURFACE 1 and 2, patients received SC TIL 200 mg, TIL 100 mg, or PBO at Weeks 0 and 4. Patients were rerandomized in Part 2 (Weeks 12–28) and Part 3 (Weeks 28–64 or –52 in reSURFACE 1 and 2, respectively). Etanercept (ETN) 50 mg was an active control in Parts 1–2 of reSURFACE 2. Treatment-emergent adverse event (AE) data pools (n=2081) for the PBO-controlled and full trial periods (52 weeks for P05495/reSURFACE 2; 64 weeks for reSURFACE 1) were analysed. Severe infections met the regulatory definition of a serious AE or required intravenous antibiotics.

Results: In the PBO-controlled period, incidences of infections were comparable for TIL 100 mg and 200 mg (23% and 22%, respectively) and PBO (23%); all were comparable with ETN (24%). Incidences of severe infections were low for all treatment groups (range, 0.0%–0.3%; $TIL \geq 0.6$ vs PBO). In the full trial period, exposure-adjusted rates (patients/100 patient-years) for infections with TIL 100 mg and 200 mg (48.9 and 52.6, respectively) were lower than with PBO and ETN (79.5 and 86.0, respectively). Exposure adjusted rates for severe infections were 1.10, 1.61, 1.96, and 0.91 for TIL 100 mg, TIL 200 mg, ETN, and PBO, respectively. In total, 33 severe infections were identified (respiratory: TIL 100 mg, 4 events; TIL 200 mg, 2 events; ETN and PBO, 0 events; skin: TIL 100 mg, 3 events; TIL 200 mg, 6 events; ETN, 2 events; PBO, 3 events; gastrointestinal: TIL 100 mg, 4 events; TIL 200 mg, 5 events; ETN and PBO, 0 events; urinary tract: TIL 200 mg, 1 event; ETN, 1 event; TIL 100 mg and PBO, 0 events). One patient had bone tuberculosis (TIL 200 mg; original purified protein derivative test was negative); 1 sepsis event (TIL 200 mg) occurred months after ending TIL treatment.

Conclusions: Infection rates with TIL treatment were low and comparable to PBO and ETN during the PBO-controlled period. By Weeks 52/64, exposure-adjusted rates remained low for all groups.

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