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SAT0313 LIPID PROFILE OF PSORIATIC ARTHRITIS PATIENTS. A FIVE-YEAR STUDY

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Background: Psoriatic arthritis (PsA) is an inflammatory arthritis associated with psoriasis. Many studies have shown alterations in lipid profile of PsA patients and an association with increased cardiovascular risk.

Objectives: To evaluate the changes of lipid profile in PsA patients treated with conventional synthetic disease modifying anti-rheumatic drugs (csDMARDs) and/or with biological DMARDs (bDMARDs) in a five-year period.

Methods: We studied 254 patients diagnosed with PsA according to CASPAR and ASAS (for those with axial disease) criteria. Patients were followed up at pre-defined time points [baseline, 24 weeks (wks), 48 and 240 wks after initiation of treatment. We recorded levels of Total Cholesterol (CHOL), Low Density Lipoproteins (LDL), High Density Lipoproteins (HDL) and Triglycerides (TGL). The disease activity was assessed by using Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Bath Ankylosing Spondylitis Functional Index (BASFI), disease activity score-28 (DAS) -C-Reactive Protein (CRP), DAS28-erythrocyte sedimentation rate (ESR), Health Assessment Questionnaire (HAQ), and inflammatory marker CRP and ESR. Patients were categorised in three treatment groups: patients treated with bDMARDs: anti-tumour necrosis factor alpha (TNFα) agents, patients treated with csDMARDs and combined therapy (bDMARDs and csDMARDs). Disease Phenotype and epidemiological features of PsA patients were also recorded.

Results: There were 137 male and 117 female patients. The (Mean ±SD) age of the patients was 56,11±14,64 years and the body mass index (BMI) was 27,86 ±5,12. Thirty-nine per cent of the patients presented as asymmetric oligoarthritis, 25,6% as symmetric polyarthritis while 27,6% had axial involvement with or without peripheral arthritis. Total CHOL and LDL levels were significantly associated with disease duration (p<0,05) while TGL and HDL were not significantly correlated. We found that HDL levels were significantly correlated with disease activity through time. More specific lower disease activity was associated with higher HDL levels for all disease activity scores and CRP at all time points (p<0,05). The significance was lost only for ESR. No association was found between the HDL levels and the different therapeutic option used. The rest of lipid profile levels did not show statistical significant association with disease activity at any time point for all disease activity indexes, including CRP and ESR.

Conclusions: Lipid profile of PsA patients seems to improve with better control of disease activity. More specifically high HDL levels are associated with low disease activity and these changes appear to be independent of the therapeutic choices.

Disclosure of Interest: None declared

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SAT0314 TO DESCRIBE AND CHARACTERISE THE PATIENT GROUP DEFINED AS COMPLEX IN A JOINT RHEUMATOLOGY/DERMATOLOGY CLINIC (PAIDER)

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Objectives: To describe and characterise the patient group defined as complex in a joint Rheumatology/Dermatology clinic (PAIDER).

Methods: We performed a retrospective chart review of patients evaluated between May 2012 and November 2017 at a weekly joint Rheumatology/Dermatology clinic at Hospital de Sant Pau (Autonomous University of Barcelona), Spain. We reviewed the medical records for demographic information, source of referral, complexity, cardiovascular risk factors and the number of visits. Complexity or complex patient was defined by at least one of the following characteristics: liver disease, neoplastic disease, psychiatric disorders, communication difficulties, adverse drug reactions to previous treatment, or paradoxical effects of biological therapy. The degree of complexity was a number (from 1 to 6) resulting from the sum of the previous characteristics. A descriptive analysis was carried out and the correlation between variables was studied through the application of nonparametric tests. The statistical package SPSS v. 21 was used to analyse the data.

Results: 494 patients were evaluated (52% women) with a total of 1110 visits. The mean age was 53 years. Patients were referred from Rheumatology, Dermatology, primary care physicians and other specialties in 47%, 40%, 6.5% and 5.5% of cases, respectively. The average number of visits per patient was 2.25. 164 patients (33%) were defined as complex with a total of 546 visits. 48.8% were women. The mean age was 55 years. They were referred from Rheumatology, Dermatology, primary care physicians and other specialties in 50.6%, 35.4%, 7.3% and 6.7% of cases, respectively. The mean number of following-up visits for the complex patients was 3.33.

The features that defined complexity and the number of visits required are shown in table 1.

Complexity features	Number of patients	Visits Mean±SD
Liver disease	47/164 (28.7%)	3.6±3.7
Psychiatric disorder	47/164 (28.7%)	3.4±4.7
Adverse drug reactions	46/164 (28%)	4.7±5.2
Paradoxical effects of biological therapy	37/164 (22.6%)	5.2±5.7
Neoplastic disease	27/164 (16.5%)	1.8±1.5
Communication difficulties	19/164 (11.6%)	4.1±4.9

The number of visits according to the degree of complexity is shown in table 2.

Degree of complexity	Number of patients	Visits Mean±SD
1	120/164 (73.2%)	2.8±2.9
2	32/164 (19.5%)	4.1±4.1
3	10/164 (6.1%)	6.4±7.3
4	1/164 (0.6%)	1
5	1/164 (0.6%)	1
6	0/164 (0%)	0

The complexity features that had a significant correlation with the number of visits were liver disease (p<0.001), serious adverse effects to previous treatments (p<0.001) and paradoxical effects of biological therapy (p<0.001). The degree of complexity was also correlated with the number of visits (Spearman's Rho=0.262, p<0.001).

Conclusions: A third of the patients visited in our joint clinic were defined as complex, although the great majority showed a low level of complexity. Of all the features used to define complexity, only a few were associated with a greater number of visits. However, the degree of complexity of the patients was associated with an increased number of visits.

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