cardiovascular, were common. Compared to patients treated with TNFi, UST was more often given as 2nd or 3rd line bDMARD and in patients with more axial and skin disease. Among patients who switched to a 2nd or 3rd line bDMARD, those not on concomitant csDMARDs preferentially received UST.

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SAT0338

PREDICTION OF CARDIOVASCULAR EVENTS IN PATIENTS WITH PSORIATIC ARTHRITIS: PERFORMANCE OF FIVE RISK ALGORITHMS IN AN ITALIAN BICENTRIC STUDY

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Background: The burden of cardiovascular (CV) risk in patients with psoriatic arthritis (PsA) is increased. Prediction of CV risk and consequent preventive strategies play a pivotal role in management of PsA. Recently, EULAR recommendations suggested to use a multiplication by the factor of 1.5 of original CV risk algorithms in patients with rheumatoid arthritis and other inflammatory arthritis.¹

Objectives: To evaluate the performance and calibration of five original and adapted according to EULAR recommendations CV risk algorithms in PsA: SCORE, CUORE, Framingham Risk Score (FRS), QRISK2, and Reynold's Risk Score (RRS).

Methods: Prospectively collected data from two Central-Southern Italian cohorts of patients with an history of PsA of almost 10 years at November 2017 and without a personal history of CV disease (CVD) at baseline has been used. The primary outcome was the first CV event: sudden cardiac death, coronary artery diseases (CAD) (stable and unstable angina pectoris, myocardial infarction), cerebral vascular accident (CVA), transient ischaemic attack (TIA), peripheral artery disease (PAD) and heart failure (HF). Discriminatory ability for CV risk prediction was evaluated by the area under the receiver operating curve (ROC). Calibration between predicted risk and observed events was assessed by Hosmer-Lemeshow (HL) tests and calibration plots. Fisher's exact test has been used for analysis of contingency table 1, while Mann-Whitney test has been used to compare ranks. Sensibility, specificity, and odds ratio were calculated for low-to-intermediate risk cut-off (1% for SCORE, 10% for all the other algorithms) and for intermediate-to-high risk cut-off (5% for SCORE, 20% for all the other algorithms).

Results: 155 patients (57±10.57 years) were enrolled with an observation of 1550 patient/year. During follow-up, 21 patients had a CV event (1.35 events per 100 patient/years): 8 cases of myocardial infarction or unstable angina pectoris, 3 cases of stable angina pectoris, 2 cases of TIA, 4 cases of PAD, 4 cases of HF. No fatal events were reported. Area under the ROC were 0.7679 (95% CI 0.64768 to 0.88812), 0.864 (95% CI 0.79675 to 0.93278), 0.7575 (95% CI 0.65784 to

0.85708), 0.8660 (95% CI 0.79428 to 0.93772), and 0.7183 (95% CI 0.57795 to 0.85862) for SCORE, CUORE, FRS, QRISK2, and RRS, respectively, suggesting fair to good discriminative ability between patients with or without a CV event (figure 1). HL tests demonstrated poor model fit ($p<0.05$) for SCORE, CUORE, and RRS, but not for FRS and QRISK2 ($p>0.05$). Discriminative ability and calibration were not improved by adaption of the algorithms according to EULAR indications. A large amount of patients who experienced a CV event was at "low risk" (minimum 17.6% for SCORE and maximum 81.8% for RRS) or at "low-intermediate" risk (minimum 52.9% for SCORE and maximum 95.2% for FRS).

Conclusions: Adaption of the CV risk algorithms according to EULAR indications did not provide improvement in discriminative ability and calibration in patients with PsA from Centre and South of Italy. In PsA, an excess of CV events has been observed in patients at "low risk" or "low-intermediate risk".

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SAT0339

IMPACT OF ALTERNATE MECHANISM OF ACTION BIOLOGICS ON TUMOUR NECROSIS FACTOR INHIBITOR (TNF) PRESCRIBING IN PSORIATIC ARTHRITIS: RESULTS FROM A NATIONAL PATIENT CHART AUDIT

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Background: Tumour Necrosis Factor-inhibitor (TNF) therapy has long been the standard of care for adult patients diagnosed with moderate to severe psoriatic arthritis (PsA), though several new biologics and small molecules have recently received FDA approval for the treatment of PsA.

Objectives: This research sought to understand the extent to which biologics and small molecules with a different mechanism of action (MOA) have been adopted for the treatment of PsA and their impact on the use of well-established TNFs in the United States.

Methods: We conducted a retrospective chart review of patients diagnosed with PsA (n=1,008), who had switched from one biologic therapy or apremilast to another in the prior twelve weeks. Data were collected in April 2017 and included clinical and non-clinical patient demographics, as well as physician demographics and attitudinal survey responses. This study was a non-longitudinal trending analysis to a 2016 audit following the same methodology.

Results: 78% of the participating rheumatologists reported recent changes to the management of their patients with PsA. The two most commonly recalled treatment shifts were: more aggressive use of biologics in general and an increased use non-TNF agents for the treatment of PsA. With increased treatment options, US rheumatologists are switching patients more frequently and faster than previously recorded. In 2017, US rheumatologists reported that, over the course of a year, 29% of their biologic and apremilast treated patients are switched to a