different brand, a figure significantly up from 2016 (25%). Furthermore, a higher percent of the audited switched patients occurred within six months of initiating the prior agent compared to the prior year (56% vs. 40%).

In 2017, switching between TNF agents significantly decreased from 52% in 2016 to 41% in 2017, and switches from a TNF to an alternate MOA biologic significantly increased from 13% to 20%, respectively. The growth in the switching share of alternative MOAs was driven primarily by increased use of secukinumab, an Interleukin-17 inhibitor approved in January 2016. While most of the secukinumab patients originated from TNF inhibitors, ustekinumab switching share was also impacted. Indeed, rheumatologists indicated that 33% of the patients switched to secukinumab in 2017 would have been placed on ustekinumab if secukinumab had not been available.

Conclusions: Increased biologic and small molecule options for the treatment of PsA has resulted in US rheumatologists switching patients more frequently and faster than in the past. Though TNF inhibitors remain the predominant mechanism of action for the treatment of PsA, the introduction of secukinumab has had a direct impact on the PsA switching environment in 2017 and recent approvals in the form of tofacitinib, ixekizumab, and abatacept are hypothesised to further impact the PsA switching environment in 2018.

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SAT0340

PSA-DISK, A NOVEL VISUAL INSTRUMENT TO ASSESS THE BURDEN OF DISEASE IN PSORIATIC ARTHRITIS PATIENTS

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Background: The assessment of joint disease in psoriasis (PsO) patients is paramount, particularly where consensus among dermatology and rheumatology specialists is necessary.

Objectives: To evaluate the prevalence of psoriatic arthritis (PsA) in PsO patients and assess how a novel 16-item visual instrument (PsA-Disk) correlates with the disease and its clinical manifestations.

Methods: Data were prospectively collected from 8 dermatological/rheumatological centres across Italy. During their first dermatological visit, patients completed both PEST (Psoriasis Epidemiology Screening Tool) and PsA-disk questionnaires. Rheumatological visit was performed in order to confirm presence/absence of PsA. Clinimetric and disease activity variables were recorded.

Results: From a total of 239 PsO patients, 120 (50.2%) patients were diagnosed with PsA. More PsA-positive patients had nail PsO (54.2% vs. 42%, $p=0.05$) and a PEST score ≥ 3 vs. PsA-negative patients (77.5% vs. 37.8%, $p<0.001$). PsA-positive patients presented with significantly higher ESR (21.9 ± 17.1 vs. 15.9 ± 10.2 mm/h, $p=0.041$), NAPSI-feet (10.2 ± 9.7 vs. 3.9 ± 7.8 , $p=0.002$), NAPSI-(hands+feet; 9.3 ± 6.8 vs. 4.6 ± 7.9 , $p=0.007$), and PsA-Disk scores (73.9 ± 32.1 vs. 58.1 ± 39.8 , $p<0.001$) vs. PsA-negative patients. PsA-patients with axial involvement had higher PsA-Disk scores (86.7 vs. 72.5 , $p=0.088$) as well as patients with knee arthritis (98.4 vs. 71.5 , $p=0.006$). PsA-Disk scores were also positively correlated with number of swollen ($r=0.2$, $p<0.05$) and tender joints ($r=0.24$, $p=0.021$), patient- ($r=0.4$, $p<0.001$) and physician-pain-VAS ($r=0.33$, $p<0.001$), PGA-VAS ($r=0.23$, $p=0.025$), physician-HAQ ($r=0.38$, $p=0.011$), DAS-44 ($r=0.25$, $p=0.023$) and DAPSA scores ($r=0.31$, $p=0.005$) (figure 1A). Examples of the powerful visual use of this instrument can be seen in figure 1B.

Abstract – Figure 1. [A] Correlation between clinical variables and PsA-Disk score in PsA+ patients.

Figure 1 [A]. Correlation between clinical variables and PsA-Disk score in PsA+ patients.

Clinical characteristic	N	Mean±SD	Coefficient (r)	p-value
Time to diagnosis (years)	75	1.7±5.4	0.14	NS
CRP (mg/dl)	98	5.5±11.2	0.008	NS
ESR (mm/h)	102	21.9±17.1	-0.013	NS
N. swollen joints	105	3.2±4.3	0.2	0.05
N. tender joints	105	6.8±5.7	0.24	0.021
Pain-VAS – patients assessment	104	6.2±2.4	0.4	<0.001
Pain-VAS – physicians assessment	104	4.7±2.5	0.33	<0.001
PGA-VAS	105	5.8±2.2	0.23	0.025
HAQ	43	0.9±0.5	0.38	0.011
BASDAI	23	4.5±1.3	0.27	NS
DAS-44	89	2.7±1.1	0.25	0.023
CPDAI	49	5.4±2.2	0.18	NS
DAPSA	86	24.8±11.5	0.31	0.005

HAQ=Health Assessment Questionnaire; CRP=C-reactive protein; ESR=erythrocyte sedimentation rate; PGA=physician global assessment; VAS=visual analogue scale; DAS=Deakin Disease Activity Score; CPDAI=Composite Psoriatic Disease Activity Index; DAPSA= Disease Activity Score in Psoriasis; NS=not significant.

* Spearman rank correlation coefficient (r).

Conclusions: PsA-Disk is a novel instrument helping both dermatologist and rheumatologist in the rapid assessment PsA, facilitating in the timely therapeutic management of these patients.

Disclosure of Interest: None declared

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SAT0341

EFFICACY AND SAFETY OF IXEKIZUMAB IN PATIENTS WITH ACTIVE PSORIATIC ARTHRITIS AND PREVIOUS INADEQUATE RESPONSE TO TNF INHIBITORS: 52-WEEK RESULTS FROM A PHASE 3 STUDY

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Background: Ixekizumab (IXE) is a high affinity monoclonal antibody that selectively targets interleukin-17A. In patients with active psoriatic arthritis (PsA) who had an inadequate response to tumour necrosis factor inhibitors (TNFi), IXE was superior to placebo (PBO) in improving the signs and symptoms of PsA after 24 weeks of treatment (SPIRIT-P2; NCT02349295).¹

Objectives: The objective of this study is to report the Week 52 interim efficacy and safety findings of IXE treatment during the Extension Period (EP) of SPIRIT-P2 (Weeks 24–156).

Methods: SPIRIT-P2 is a Phase 3, multicenter, double-blind study. All 363 patients had an inadequate response to one or two TNFi or were intolerant to TNFi. During the Double-Blind Treatment Period (DBTP; Weeks 0–24), patients were randomly assigned 1:1:1 to subcutaneous administration of either 80 mg IXE every 4 weeks (Q4W; n=122) or every 2 weeks (Q2W; n=123) following a 160 mg starting dose at Week 0, or PBO (n=118). Of these, 310 patients completed the DBTP and entered the EP (Weeks 24–156). Patients randomised to IXE at Week 0 continued the same dose regimen in the EP. PBO patients were re-randomised (1:1) to IXE Q4W or Q2W at Week 16 (inadequate responders) or 24. In this interim analysis, efficacy (up to Week 52) and safety (up to Week 156) were analysed using the EP population, defined as all patients who received at least 1 dose of study drug in the EP. Missing values were considered non-response for categorical data and were imputed by modified baseline observation carried forward for continuous data.

Results: In the DBTP, a significantly higher percentage of patients achieved ACR20 at Week 24 with IXE Q4W (53%) or Q2W (48%) than with PBO (20%).¹ For patients who entered the EP, the mean age was 52 years, 47% were male, the mean time since PsA onset was 12 years, and mean tender and swollen joint counts at baseline (Week 0) were 23 and 12, respectively. For EP patients who were initially randomised to IXE Q4W or Q2W during the DBTP, ACR20 responses at Week 52 were 68% and 59%, respectively. For patients treated with PBO during the DBTP and re-randomised to IXE Q4W or Q2W during the EP, ACR20 responses at Week 52 were 61% and 50%, respectively. Additional efficacy measures are depicted in the Table. The frequency of adverse events (AEs) in the EP is presented in the Table; the majority were mild or moderate in severity. Serious AEs occurred in 15 patients, and one death occurred in the EP population: a myocardial infarction in a PBO/IXE Q2W patient 502 days after starting IXE.

Abstract SAT0341 – Table 1. Efficacy and safety results of an interim analysis of the extension period population of SPIRIT-P2.

	IXE Q4W (N=111)	IXE Q2W (N=107)	PBO/IXE Q4W (N=46)	PBO/IXE Q2W (N=46)
Week 52 Responder Rate, n/N (%), NRI				
ACR 20	75/111 (68)	63/107 (59)	28/46 (61)	23/46 (50)
ACR 50	51/111 (46)	41/107 (38)	20/46 (44)	16/46 (35)
ACR 70	32/111 (29)	22/107 (21)	11/46 (24)	7/46 (15)
MDA	42/111 (38)	29/107 (27)	14/46 (30)	13/46 (28)
LEI (0)^a	32/61 (53)	30/73 (41)	13/24 (54)	12/29 (41)
LDI-B (0)^b	21/26 (81)	11/16 (69)	7/7 (100)	2/6 (33)
PASI75^c	41/62 (66)	37/57 (65)	19/25 (76)	15/31 (48)
PASI90^c	34/62 (55)	27/57 (47)	18/25 (72)	14/31 (45)
NAPSI (0)^d	41/81 (51)	24/67 (36)	10/29 (34)	9/25 (36)
Week 52 Mean (SD) Change from Baseline, mBOCF				
HAQ-DI	-0.4 (0.5)	-0.4 (0.5)	-0.4 (0.4)	-0.2 (0.5)
DAS 28-CRP	-2.2 (1.5)	-1.9 (1.3)	-2.0 (1.3)	-1.6 (1.3)
Safety Overview (Weeks 24-156), n (%)				
TEAE	79 (71)	68 (64)	32 (70)	27 (59)
SAE	6 (5)	4 (4)	2 (4)	3 (7)
Discontinued due to AE	2 (2)	8 (8)	0 (0)	2 (4)

For efficacy analyses, baseline was defined as assessment recorded on or prior to Week 0. For analyses of TEAEs, baseline was defined as AEs that started prior to the study drug injection at Week 24. ^aAssessed only in patients with enthesitis and LEI >0 at baseline; ^bAssessed only in patients with dactylitis and LDI-B >0 at baseline; ^cAssessed only in patients with psoriatic lesions ≥3% of BSA at baseline; ^dAssessed only in patients with fingernail psoriasis at baseline. **Abbreviations:** ACR20/50/70=20/50/70% improvement in the ACR; ACR=American College of Rheumatology; BSA=body surface area; DAS28-CRP=Disease Activity Score based on a 28 joint count with C-reactive protein; HAQ-DI=Health Assessment Questionnaire-Disability Index; LDI-B=Leeds Dactylitis Index-Basic; LEI=Leeds Enthesitis Index; mBOCF=modified baseline observation carried forward; MDA=minimal disease activity; NAPSI=Nail Psoriasis Severity Index; NRI=nonresponder imputation; PASI75/90=Psoriasis Area and Severity Index 75/90; SAE=serious adverse event; TEAE=treatment-emergent adverse event

Conclusions: IXE demonstrated sustained improvement in the signs and symptoms of PsA across treatment groups during the EP. The safety profile of IXE observed in the EP population was consistent with the safety profile of the intent-to-treat population in the DBTP of SPIRIT-P2.¹

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SAT0342 INFLAMMATORY BACK PAIN IN PSORIATIC ARTHRITIS IS SIGNIFICANTLY MORE RESPONSIVE TO CORTICOSTEROIDS COMPARED TO BACK PAIN IN ANKYLOSING SPONDYLITIS: A PROSPECTIVE, OPEN-LABELLED, CONTROLLED PILOT STUDY

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Background: Inflammatory spinal disease is one of three inflammatory musculoskeletal manifestations which frequently occur in PsA. There is very limited data about the axial involvement in PsA, especially as regards treatment, with

treatment guidelines based largely on data from AS trials. The efficacy of corticosteroids in PsA patients with inflammatory back pain has not been studied to date. **Objectives:** In this controlled trial, we aimed to investigate the comparative performance of corticosteroids for active axial-PsA (AxPsA) versus those with active AS.

Methods: PsA patients (fulfilling CASPAR criteria), and AS as per the 1984 Modified New York Criteria, were suitable for inclusion. Among them, patients with active AxPsA and active AS ((naïve to biologic therapies) were recruited. The active disease was defined as patients with inflammatory back pain, with spinal pain score of ≥4 and BASDAI score ≥4 despite taking NSAIDs. Furthermore, only those AxPsA and AS patients with an MRI proven sacroiliac joint bone marrow oedema (MRI of sacroiliac joints performed within the 6 months prior to recruitment) were considered for inclusion. Hence, all recruited patients with AxPsA and AS had not only clinically active disease, but also had bone marrow oedema on MRI of sacroiliac joints. Moreover, we recruited a control group of non-inflammatory lower back pain. All patients received a single, intra-muscular dose of depot corticosteroid injection (Triamcinolone Acetonide 80 mg) at baseline. The intra-muscular corticosteroid option was used to overcome any drug compliance issues. Clinical outcome assessments were made at following time points: baseline, week-2, and week-4. The primary efficacy end point was the mean change in Ankylosing Spondylitis Disease Activity Score (ASDAS) at week-2. Key secondary outcome were the mean change of BASDAI, BASFI and ASQoL at week-2 and week-4.

Results: In total, 40 patients were recruited – AxPsA=15, AS=15, control=10. At week-2 following corticosteroid treatment, patients with AxPsA had significantly higher improvements in the mean ASDAS compared to patients with AS (1.43 ±0.39 vs. 1.03±0.30, p=0.004), and the same was the case when compared to controls (p<0.001, table-2, figure-1). At week-4, AxPsA patients also showed significantly higher improvements in the mean ASDAS compared to both AS patients (1.09±0.32 vs. 0.77±0.27, p=0.007) and controls (p<0.001). Similarly, the mean BASDAI, VAS spinal pain score, ASQoL and BASFI improved significantly among AxPsA patients compared to AS patients and controls at week-2, with this trend also largely maintained at week-4

Conclusions: Axial inflammation in PsA potentially responds significantly better to corticosteroids than in patients with AS. This furthers the argument and adds to the growing evidence that AxPsA and AS are distinct entities. Future studies should further investigate the use of corticosteroids and of sDMARD usage among patients with active IBP in PsA.

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SAT0343 CARDIOVASCULAR DISEASE RISK IN CLINICAL SUBTYPES OF PSORIATIC ARTHRITIS

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Background: Patients with psoriatic arthritis (PsA) have been shown to be at increased risk of developing cardiovascular disease (CVD), with one recent meta-analysis demonstrating an increased CVD risk of 43% compared to the general population. However PsA is a heterogeneous disease consisting of five different clinical subtypes. It is not known whether the risk of CVD varies between different PsA subtypes.

Objectives: To determine whether particular subtypes of PsA are associated with an increased risk of cardiovascular disease.

Methods: 114 patients with PsA attending the University Hospital of Wales were asked to complete a questionnaire about their cardiovascular risk factors. Anthropometric and biochemical measurements, including blood pressure, body mass index (BMI), C-reactive protein (CRP) and cholesterol, were also performed. Patients were grouped into one of the five PsA subtypes as described by Moll and Wright. The QRISK2 algorithm was used to determine the 10 year risk of developing CVD for each patient. Multivariate analyses using linear and logistic regression with QRISK2 score and QRISK2 score >10% as dependent variables were conducted and adjusted for known cardiovascular risk factors.

Results: Symmetrical polyarthritis was the most common subtype, no patients had arthritis mutilans. There were no statistically significant differences between the subtypes with regards to age, gender, BMI, blood pressure, smoking status, cholesterol or CRP. Statistically significant differences were found between the subtypes using Chi-square (χ²) tests for QRISK2 score >10% (p=0.031) as well as the presence of existing cardiovascular disease, diabetes mellitus and cholesterol lowering treatment (p=0.021, 0.021 and 0.037 respectively). The table 1 below lists the number of patients by subtype and these variables.