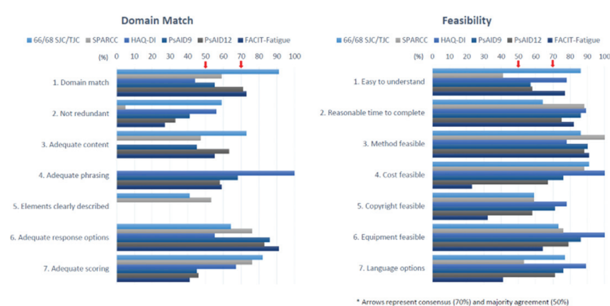

Abstract SAT0350 – Figure 1. GRAPPA stakeholders' ratings for OMERACT domain match and feasibility for 6 PsA instruments

Conclusions: The first two steps of the OMERACT Filter 2.1 instrument selection process for five candidate instruments have been completed. The first set of candidate instruments selected to undergo the next phase of the OMERACT Filter 2.1, construct validity and discrimination appraisal are 66/68 SJC/TJC, SPARCC enthesitis index, PsAID9, PsAID12, HAQ-DI and FACIT-Fatigue. Additional PsA instruments will undergo the OMERACT selection process.

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SAT0351 VERY LOW DISEASE ACTIVITY, DAPSA REMISSION, AND PATIENT-ACCEPTABLE SYMPTOM STATE IN PSORIATIC ARTHRITIS

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Background: The goal of treatment in psoriatic arthritis (PsA) according to the T2T strategy is remission, or at least, a low disease activity state[1]. Currently there is no clear agreement on how to measure these treatment goals.

Objectives: To explore the relationship between very low disease activity (VLDA) state, according to the MDA 7/7 criteria[2], and DAPSA remission[3], as well as its association with the impact of the disease evaluated by the PsAID questionnaire[4], in patients with PsA in routine clinical practice.

Methods: Post-hoc analysis of the MAAPs study[5]. We included patients who met CASPAR criteria, with at least one year of disease evolution, and treated with biological and/or synthetic DMARDs according to the usual clinical practice in Spain. Patients were considered in VLDA if they met 7/7 of the MDA criteria, and in DAPSA/cDAPSA remission (this last without CRP) if they had a value ≤4. A PsAID <4 represented a patient-acceptable symptom state (PASS). The frequency of these states and kappa (κ) agreement between them were analysed.

Results: Of the 227 patients included in the original study, 26 (11.5%), 52 (30.6%), 65 (36.9%) and 125 (55%) were in VLDA, DAPSA remission, cDAPSA remission, and PASS, respectively. There was a moderate agreement between VLDA and DAPSA remission (κ=0.52) or the cDAPSA remission (κ=0.42). Patients in VLDA had a lower impact of the disease measured by PsAID [mean total score (SD): VLDA 1.1 (1.2); DAPSA remission 1.3 (1.5); cDAPSA remission 1.7 (1.6)]. There was a moderate agreement between DAPSA remission or cDAPSA remission and PASS (κ=0.55 and κ=0.58 respectively), while fair agreement was found between VLDA and PASS (κ=0.18).

Conclusions: About one third of this series reached DAPSA remission, while only 11.5% reached VLDA state. On the other hand, more than half were in PASS situation. Agreement between VLDA and DAPSA was moderate. Although the MDA 7/7 criteria seem to be more stringent criteria for assessing remission, DAPSA remission shows better agreement with PASS. DAPSA and VLDA would be adequate treatment targets in daily practice.

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SAT0352 PREVALENCE AND CHARACTERISTICS OF CORONARY DISEASE AND CARDIOVASCULAR RISK FACTORS IN A COHORT OF PATIENTS WITH PSORIATIC ARTHRITIS

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Background: We performed a descriptive study of our patients with psoriatic arthritis (PsA) over 40 years old, attending to the presence of coronary disease and cardiovascular risk factors in each group of treatment (DMARDS vs biologic therapy).

Methods: Patients older than 40 years, diagnosed with psoriatic arthritis attending clinics at the Department of Rheumatology were analysed to determine how many of them presented coronary disease. The following information was recorded: age, sex, disease duration and age at the coronary event, HLA-B27 positivity, hypertension, type II diabetes and hyperlipidemia, on medical records and discharge reports for each patient.

Results: All 137 patients were identified from an electronic database. We found a male predominance: 57% versus 43% of women. Mean age 57.05±10.6 years. Of the 137 patients, 82% had only peripheral arthritis, while 18% also showed axial involvement. With regard to the latter subgroup, 16% patients had a positive HLA-B27 test, 56% were HLA-B27 negative and 28% showed lack of HLA-B27 test. Almost all patients (87%) were in DMARDs therapy, while 31% received biologic therapy: etanercept 42%, secukinumab 16%, adalimumab 12%, ustekinumab 12%, infliximab 9,5%, golimumab 4,7% and certolizumab 2%. About 7% of patients didn´t receive DMARDS neither biologic therapy, because of intolerance. Results regarding to cardiovascular risk factors, and coronary disease are as follows:

	DMARD therapy	Biologic therapy (±DMARDS)
Arterial Hypertension	43%	26%
Diabetes	19,5%	7%
Hyperlipidemia	47,5%	38%
Coronary disease	10,9%	2,4%

In DMARD subgroup, we found 6 myocardial infarction (all of them revascularized) and 3 angina, versus 1 myocardial infarction in biologic subgroup.

Conclusions: There is solid epidemiologic evidence linking PsA to cardiovascular risk factors and an increased risk of developing cardiovascular disease[1]. Furthermore, over the past two decades it has become increasingly clear that chronic inflammation is an independent risk factor for cardiovascular events. In our study the ratio of ischaemic heart disease for patients with PsA in DMARD therapy is four times higher than that of biologic treatment group. This may be due to the greater percentage of cardiovascular risk factors in the first group, although, the cardioprotective effect of biologic therapies, must be taken into account, as there are some studies that show association between antiTNF and significant reduction in carotid IMT[2]. Proper management of cardiovascular risk requires aggressive control of disease activity.

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