Abstract AB0899 – Table 1

Pregnancy outcomes		Number of pregnancies (n=396)		p
before AS onset n=185	after AS onset n=211			
Childbirth: n/%	100/54%	143/67.8%		0.004
-vaginal delivery n	76 (76% of deliveries)	78 (54.5% of deliveries)		0.0005
- Caesarean section n	24 (24% of deliveries)	65 (45.5% of deliveries)		0.0008
Woman's choice abortion	61/33%	30/14.2%		0.0000
Unfavourable maternal outcome *	24/13%	38/18%		0.17
Neonate's birth weight [Me±IQR] (g)	3240 [3050:3600]	3.260 [2950:3600]		0.3
Neonate's birth length [Me±IQR] (cm)	52 [51:53]	51 [50:52]		0.02
Apgar score at 1 min after birth [Me±IQR]	8 [7:8]	8 [7:8]		0.8

* – non-developing pregnancies, spontaneous abortions, medical abortions and preterm births.

There were no pregnancies in 132 (41%) surveyed females (mean age 29.1 ±5.4 y).

Reasons and causes for not getting pregnant in 132 AS females:

- 48% cases – social, household/domestic and familial, including spouses' unwillingness to have children;

- 44% – presence of AS (fear of teratogenic effect of pharmacotherapeutic agents – 18%, fear of AS inheriting by the baby – 3%, physician's forewarnings – 8%, a combination of abovementioned causes – 15%);

- 8% – infertility.

Conclusions: Therefore, data from questionnaire survey of females with AS demonstrates that presence of AS does not increase the incidence of unfavourable maternal outcomes of pregnancies, or negatively affects anthropometric parameters of neonates. Of notice is the fact, that women's choice abortions become more rare after AS diagnosis is established. The rate of Caesarean sections is higher in AS patients. Fear of potentially harmful effects of the disease and it's therapy on the fetus and the baby underlies 30% of all not getting pregnant cases among AS female patients of child-bearing age.

Disclosure of Interest: None declared

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Psoriatic arthritis

AB0900 DESCRIPTIVE STUDY OF PSORIATIC ARTHRITIS IN A HISTORICAL COHORT OF 383 PATIENTS AT A UNIVERSITY HOSPITAL

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Background: There are few recent large cohort epidemiological studies that analyse the clinical profile of patients with psoriatic arthritis (PsA) who require biological treatment, as well as pharmacological survival and reasons for the suspension of these treatments.

Abstract AB0900 – Table 1

N	383	Basal radiological involvement	
Age at PsA (years), mean (SD)	45.9 (14.5)	Erosive arthritis (%)	33.1
Male sex, n (%)	203 (53)	Mutilating arthritis (%)	1.9
History of psoriasis (%)	84.8	Sacroiliitis (%)	21.2
Nail involvement (%)	46.3	Syndesmophytes (%)	5
Dactylitis (%)	32.9	Immunity	
Enthesitis (%)	36.9	RF positive (%)	6.3
DAS-28 (ESR), mean (SD)	3.5 (1.46)	ANA positive (%)	14.5
CRP mg/L, mean (SD)	8.11 (15.9)	HLA B27 positive (%)	14.1
ESR mm/h, mean (SD)	20.3 (19.2)	Treatment	
Comorbidities		NSAID (%)	96.7
Dyslipidemia (%)	34.2	csDMARDs (%)	84.8
AH (%)	20.9	bDMARDs (%)	32.3
Obesity (%)	28.2		

CRP: C-reactive protein; ESR: erythrocyte sedimentation rate; AH: arterial hypertension; RF: rheumatoid factor; ANA: anti-nucleotide antibodies; NSAID: non-

steroidal anti-inflammatory drugs; csDMARDs: conventional synthetic disease-modifying antirheumatic drugs; bDMARDs: biological disease-modifying antirheumatic drugs.

Objectives: To describe the clinical, demographic, epidemiological and radiographic characteristics of patients with PsA in our centre, as well as pharmacological survival and reasons for the suspension of different biological treatments.

Methods: Retrospective analysis of patients with PsA treated between 1985 and 2015 at a University Hospital with a referral area of 8 50 000 inhabitants. Demographic, clinical, laboratory and imaging data, as well as patients' clinical and medical treatment records.

Results: The main characteristics of the cohort are summarised in table 1:

Approximately one third of patients with PsA (32.3%) required treatment with a biological drug during the course of their disease. The most frequently prescribed first-line drugs (89.5%) were tumour necrosis factor- α inhibitors (TNFi).

During the course of their disease, 27 (21.9%) patients who started biological treatment received a biological drug other than TNFi. Of the 124 patients who started treatment with a biological DMARD, more than half (65, 52.8%) required a change to a second drug, and of these, 27 (41.5%) changed to a third, with up to 7 different biological drugs required in one case. The mean survival time for the first bDMARD was 42.8±42.3 months, with secondary failure the most frequent cause of treatment change (37.8%), followed by adverse effects (27.1%) and primary failure (18.9%). The adverse effects registered were: 20% infections, 20% appearance of neoplasms, 5% allergic reactions and 55% other causes.

Conclusions: PsA presents a similar distribution by sex and is usually diagnosed at around the age of 50, having been preceded by cutaneous involvement. PsA is an entity of considerable severity and up to a third of patients will require biological treatments during its evolution. More than half of them will receive a second biological treatment. The retention rate of each drug varies but tends to decrease with each drug change.

Disclosure of Interest: None declared

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AB0901 VASPIN AND LIPOCALIN2 LEVELS IN PSORIATIC ARTHRITIS

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Background: Psoriatic arthritis (PsA) is a type of spondyloarthropathies which is affiliated with psoriasis. Metabolic syndrome, diabetes mellitus and cardiovascular diseases are comorbid conditions associated with psoriatic arthritis. Adipokines are suggested to be playing proinflammatory or antiinflammatory roles in the proceeding of inflammatory situations.

Objectives: The aim of this study is to investigate the recently interested adipokines vaspin and lipocalin2 levels and their association with disease activity of patients diagnosed with psoriatic arthritis.

Methods: The study was conducted between October 2017 and January 2018 at the Rheumatology Clinic of Ankara Numune Training and Research Hospital, Turkey. The vaspin and lipocalin2 levels of 50 PsA patients, diagnosed according to the Classification Criteria for Psoriatic Arthritis (CASPAR), and 36 age- and sex-matched healthy subjects were analysed in current study. The disease activity was assessed by using Psoriasis Area Severity Index, Bath Ankylosing Spondylitis Functional Index, Bath Ankylosing Spondylitis Disease Activity Index and Disease Activity Index for Psoriatic Arthritis. Indexes were applied to the patients in order to evaluate the disease activity.

Results: No significant difference was found between groups with respect to age, sex and body mass index. There was significant difference between vaspin (p=0.001) and lipocalin2 (p=0.014) levels among the PsA patients and control groups. There was no significant difference between the groups in terms of disease activity (p>0.05).

Abstract AB0901 – Table 1. The clinical and laboratory parameters in two groups.

	PsA patients (n=50)	Healthy subjects (n=36)	P value
	Mean(±SD)	Mean(±SD)	
Males/Females	15/35	11/25	0.956
Age (years)	44.58 (13.88)	43.08 (11.03)	0.57
Vaspin (ng/L)	391.63 (436.4)	176.67 (122.75)	0.001
Lipocalin2 (ng/L)	5.2 (2.67)	1.94 (2.09)	0.014

PsA: Psoriatic Arthritis, SD:Standard deviation

Conclusions: The results of this study points out the possible role of vaspin and lipocalin2 in PsA. In our knowledge, this is the first study comparing the vaspin and lipocalin2 levels of patients with PsA to healthy subjects and these findings

may pioneer further studies investigating the usage of adipokines such as vaspin and lipocalin2 levels as biomarkers in the diagnose and disease course of PsA.

Disclosure of Interest: None declared

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AB0902

EFFICACY OF TOFACITINIB BY BACKGROUND METHOTREXATE DOSE IN PATIENTS WITH PSORIATIC ARTHRITIS: A POST-HOC ANALYSIS OF POOLED DATA FROM 2 PHASE 3 TRIALS

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Background: Tofacitinib is an oral Janus kinase inhibitor for the treatment of psoriatic arthritis (PsA). The efficacy of tofacitinib has been evaluated in 2 Phase 3 studies in patients (pts) with PsA.

Objectives: To describe the efficacy of tofacitinib by background methotrexate (MTX) dose in pts with PsA.

Methods: This post-hoc analysis utilised efficacy data pooled from 2 Phase 3, randomised, double-blind, placebo-controlled studies (OPAL Broaden [12 months; NCT01877668] and OPAL Beyond [6 months; NCT01882439]) in pts with a diagnosis (≥ 6 months) of active PsA (≥ 3 swollen and ≥ 3 tender joints). Pts in OPAL Broaden were tumour necrosis factor inhibitor (TNFi)-naïve and had an inadequate response (IR) to ≥ 1 conventional synthetic disease-modifying antirheumatic drug (csDMARD). Pts in OPAL Beyond had an IR to ≥ 1 TNFi. Pts were randomised to tofacitinib 5 or 10 mg twice daily (BID), placebo or adalimumab 40 mg subcutaneous every 2 weeks (OPAL Broaden; adalimumab data not shown). All pts received a stable dose of 1 csDMARD (eg MTX, leflunomide or sulfasalazine) as background therapy. The maximum dose of MTX allowed per protocol was 20 mg/week. Efficacy outcomes for tofacitinib at Month 3 were evaluated by background MTX dose (≤ 15 vs > 15 mg/week) and included: ACR20/50/70 response rates ($\geq 20/50/70\%$ improvement from baseline, respectively), Health Assessment Questionnaire-Disability Index (HAQ-DI) response rate (reduction from baseline ≥ 0.35 points) and mean change from baseline in HAQ-DI score. Analyses were based on the full analysis set for pts receiving MTX on Day 1; pts with missing data were considered as having a non-response for binary endpoints. No statistical testing was performed.

Results: In total, data from 556 pts who received tofacitinib plus MTX only or placebo plus MTX only (tofacitinib 5 mg BID, n=186; tofacitinib 10 mg BID, n=178; placebo, n=192) were included in this analysis. Most pts were treated with background MTX at doses ≤ 15 mg/week (n=371, 66.7%; mean [SD] dose, 12.6 [3.1] mg/week) vs > 15 mg/week (n=185, 33.3%; mean [SD] dose, 19.8 [0.8] mg/week). Baseline demographics and disease characteristics were generally similar between arms in MTX dose groups (table 1). At Month 3, tofacitinib 5 and 10 mg BID were generally associated with numerically greater ACR and HAQ-DI response rates and greater changes from baseline in HAQ-DI score compared with placebo. The magnitude of tofacitinib effects on efficacy outcomes appeared broadly similar between background MTX dose groups (table 1).

Abstract AB0902 – Table 1. Patient demographics and disease characteristics at baseline, and efficacy outcomes at Month 3 by MTX dose

	MTX dose ≤ 15 mg/week			MTX dose > 15 mg/week		
	Tofacitinib 5 mg BID (N=186)	Tofacitinib 10 mg BID (N=178)	Placebo (N=192)	Tofacitinib 5 mg BID (N=186)	Tofacitinib 10 mg BID (N=178)	Placebo (N=192)
Patient demographics and disease characteristics						
Female, n (%)	50 (26.9)	71 (39.9)	71 (37.0)	43 (23.1)	31 (17.4)	32 (16.7)
Age, mean (SD), years	49.9 (12.6)	48.7 (10.4)	48.8 (12.4)	49.8 (13.8)	47.4 (12.2)	46.9 (12.7)
Disease duration, mean (SD), years	8.4 (7.8)	7.8 (6.3)	8.6 (8.3)	9.3 (8.7)	7.4 (6.9)	6.7 (5.1)
Duration of swollen joints, mean (SD), joints	9.5 (9.4)	9.5 (9.4)	9.5 (9.4)	9.5 (9.4)	9.5 (9.4)	9.5 (9.4)
Duration of tender joints, mean (SD), joints	18.0 (14.0)	18.1 (14.0)	17.9 (14.0)	18.9 (14.0)	18.9 (14.0)	18.0 (14.0)
HAQ-DI, mean (SD)	1.1 (0.7)	1.2 (0.6)	1.2 (0.7)	1.2 (0.6)	1.3 (0.6)	1.2 (0.6)
CRP, mean (SD), mg/L	12.3 (21.5)	10.3 (21.1)	9.7 (21.1)	11.9 (20.0)	13.4 (22.4)	14.1 (23.6)
MTX dose, mean (SD), mg/week	12.6 (3.1)	12.6 (3.1)	12.6 (3.1)	19.8 (0.8)	19.8 (0.8)	19.8 (0.8)
Efficacy outcomes at Month 3						
ACR20 response rate, % (n/N)	47.4 (55/116)	54.9 (67/122)	34.3 (51/133)	51.4 (64/124)	51.8 (65/126)	38.0 (57/150)
ACR50 response rate, % (n/N)	27.8 (32/116)	39.3 (48/122)	21.3 (32/133)	35.7 (44/124)	35.6 (44/126)	23.3 (35/150)
ACR70 response rate, % (n/N)	12.4 (15/116)	19.7 (24/122)	6.3 (9/133)	24.3 (30/124)	24.3 (30/126)	10.3 (15/150)
HAQ-DI response rate (score ≥ 0.35), % (n/N)	47.4 (55/116)	54.9 (67/122)	34.3 (51/133)	51.4 (64/124)	51.8 (65/126)	38.0 (57/150)
HAQ-DI LSM (SD) change from baseline	-0.31 (0.40)	-0.40 (0.36)	-0.17 (0.40)	-0.39 (0.46)	-0.39 (0.45)	-0.18 (0.40)

*Among pts with baseline HAQ-DI score ≥ 0.35

Missing values for ACR20/50/70 response rates and HAQ-DI response rate were considered as non-response to treatment

LSM were calculated based on a mixed model for repeated measures without imputation for missing values

The maximum permitted dose of MTX was 20 mg/week

The analyses included all pts who received MTX as background therapy only on Day 1 in the FAS

ACR, American College of Rheumatology; BID, twice daily; CRP, C-reactive protein; FAS, full analysis set; HAQ-DI, Health Assessment Questionnaire-Disability Index; LSM, least squares mean; MTX, methotrexate; n, number of pts with response; N, number of pts included in the analysis; N1, number of pts included in the HAQ-DI response analysis; N2, number of pts evaluable for change from baseline in HAQ-DI at Month 3; pts, patients; SD, standard deviation; SE, standard error

Conclusions: The results of this pooled analysis suggest that the efficacy of tofacitinib in pts with PsA was greater than placebo and does not differ when evaluated by background MTX dose (≤ 15 vs > 15 mg/week), although small pt numbers in some groups may limit the conclusions that can be made. These results are consistent with findings from similar analyses of tofacitinib in pts with rheumatoid arthritis.

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AB0903

EFFICACY OF TILDRAKIZUMAB IN ETANERCEPT PARTIAL OR NONRESPONDERS

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Background: Etanercept (ETN) is an anti-tumour necrosis factor (TNF) medication that was among the first biologics approved for psoriasis. Additional medications have been developed or are in development for psoriasis, and patients who do not adequately respond to ETN may benefit from these more recent biologics.

Objectives: Here we report the efficacy of tildrakizumab (TIL), a humanised anti-IL-23p19 monoclonal antibody, as evaluated in patients with moderate to severe chronic plaque psoriasis who were partial (Psoriasis Area and Severity Index [PASI] ≥ 50 – < 75) or nonresponders (PASI < 50) to ETN and subsequently rerandomized to TIL in the phase 3 reSURFACE 2 trial (NCT01729754).

Methods: Patients with psoriasis ($\geq 10\%$ body surface area, Physician's Global Assessment [PGA], and PASI ≥ 12) participated in reSURFACE 2, a 3-part, 52 week, randomised controlled trial. In Part 1 (Weeks 0–12), patients were randomised to subcutaneous TIL 200 mg, TIL 100 mg, or placebo (PBO) administered at Weeks 0 and 4, or ETN 50 mg administered twice weekly. In Part 2 (Weeks 12–28), TIL and ETN patients remained on the same treatment (TIL administered at Week 16; ETN once weekly), whereas PBO patients were rerandomized to TIL 100 or 200 mg. In Part 3 (Weeks 28–52), ETN responders (PASI ≥ 75) were discontinued, and partial and nonresponders were switched to TIL 200 mg (administered at Weeks 32, 36, and 48). For this post hoc analysis, the proportion of patients ($\pm$ SD) with PASI response and PGA response (score of 0 [clear] or 1 [minimal]) with at least a 2-grade score reduction from baseline were determined at Week 52. Primary results from the trial have been previously reported.¹

Results: In total, 1090 patients were randomised. Of the 313 patients randomised to ETN, by Week 28 there were 83 partial responders and 39 nonresponders. At Week 52 (after 20 weeks of TIL treatment) for ETN partial responders, 75% $\pm$ 5%, 34% $\pm$ 5%, 15% $\pm$ 4%, and 58% $\pm$ 5% had achieved PASI 75, 90, 100, and PGA response of 0/1, respectively, with TIL 200 mg treatment. At Week 52 for ETN nonresponders, 54% $\pm$ 6%, 31% $\pm$ 5%, 10% $\pm$ 3%, and 56% $\pm$ 5% had achieved PASI 75, 90, 100, and PGA response of 0/1, respectively, with TIL 200 mg treatment. Adverse events were similar in patients switched from ETN to TIL at Week 28, compared with the patients who were maintained on TIL through Week 52.