Abstract AB0920 – Figure 1. Drug retention of psoriatic arthritis patients registered at Rheumatic Diseases Portuguese Registry (Reuma.pt), treated with a first (A) second (B) and third (C) tumour necrosis factor inhibitor (TNFi) and overall (D) TNFi drug retention.

Conclusions: PsA patients registered at Reuma.pt treated with a 1st TNFi had an overall drug retention of 49 months. We observed a decrease in the average retention of TNFi therapy of 13.0 months in PsA patients who switched to a 2nd TNFi or a 3rd TNFi. Lack or loss of response were the main reason for TNFi discontinuation, independently of TNFi position, responsible for more than half of the discontinuations. The observed short survival of TNFis in PsA, and the inability to regain drug expectancy when switching to another TNFi, highlights the limitations from recycling between TNFi when aiming at long-term disease remission.

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AB0921 IMPACT OF BASELINE DEMOGRAPHICS, DISEASE ACTIVITY AND CONCOMITANT MEDICATION ON AMERICAN COLLEGE OF RHEUMATOLOGY 20 RESPONSE RATE AND HEALTH ASSESSMENT QUESTIONNAIRE-DISABILITY INDEX SCORE WITH TOFACITINIB IN ACTIVE PSORIATIC ARTHRITIS: A POOLED SUBGROUP ANALYSIS OF 2 PHASE 3 STUDIES

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Background: Tofacitinib is an oral Janus kinase inhibitor for the treatment of psoriatic arthritis (PsA). In a pooled analysis of data from 2 Phase 3 trials in patients (pts) with active PsA, tofacitinib 5 and 10 mg twice daily (BID) significantly improved American College of Rheumatology (ACR) 20 response rates vs placebo (PBO) (50.0, 53.0 vs 28.0%, respectively; $p < 0.001$) and least squares mean (LSM) change from baseline (BL) in Health Assessment Questionnaire-Disability Index (HAQ-DI) score vs PBO (0.38, -0.38 vs -0.16, respectively; $p < 0.001$) at Month 3.¹

Objectives: To compare the efficacy of tofacitinib 5 and 10 mg BID vs PBO in predefined pt subgroups based on differences in BL demographics, disease activity and concomitant medication.

Methods: This was an analysis of pooled efficacy data from 2 Phase 3, randomised, double-blind, PBO-controlled studies (OPAL Broaden [12 months; NCT01877668] and OPAL Beyond [6 months; NCT01882439]) in pts with active

PsA (defined as ≥ 3 swollen and ≥ 3 tender joints). Pts in OPAL Broaden were tumour necrosis factor inhibitor (TNFi)-naïve with 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 receive tofacitinib 5 or 10 mg BID, subcutaneous adalimumab 40 mg every 2 weeks (OPAL Broaden; data not included) or PBO. Pts continued to receive a stable dose of a single csDMARD. ACR20 response rates and LSM change from BL in HAQ-DI at Month 3 (primary endpoint data) were evaluated by subgroup category (demographic and disease characteristics at BL or at screening). Analyses were based on the full analysis set (table 1).

Results: In total, 238, 236 and 236 pts received tofacitinib 5 mg BID, 10 mg BID, or PBO, respectively. Across all subgroups analysed, tofacitinib 5 and 10 mg BID were generally associated with greater improvements at Month 3 in ACR20 and change from BL in HAQ-DI score than PBO (table 1). In pts classified as current smokers, slightly lower ACR20 response rates and similar changes from BL in HAQ-DI score to corresponding PBO at Month 3 were observed relative to never- or ex-smokers; however, the sample size was small.

Abstract AB0921 – Table 1. Pooled efficacy at Month 3 by subgroup

Subgroup	Baseline category	ACR20 response rate (%) [n/N1]			LSM change from baseline in HAQ-DI [N2]		
		Tofacitinib 5 mg BID (N=238)	Tofacitinib 10 mg BID (N=236)	Placebo (N=236)	Tofacitinib 5 mg BID (N=238)	Tofacitinib 10 mg BID (N=236)	Placebo (N=236)
Race							
	White	48.7 (110/226)	51.4 (114/221)	38.4 (85/222)	-0.37 (224)	-0.37 (221)	-0.14 (221)
	Other	73.9 (8/13)	79.4 (11/13)	21.8 (3/13)	-0.40 (13)	-0.38 (13)	-0.14 (13)
Ethnicity							
	Hispanic/Latino	65.7 (23/35)	81.3 (13/16)	50.0 (15/30)	-0.48 (35)	-0.45 (34)	-0.34 (34)
	Non-Hispanic/Latino	47.3 (96/203)	50.9 (112/220)	34.8 (81/236)	-0.35 (203)	-0.35 (220)	-0.33 (236)
Gender							
	Male	53.6 (63/117)	53.2 (59/110)	27.9 (27/100)	-0.36 (117)	-0.40 (110)	-0.14 (109)
	Female	46.3 (46/111)	52.8 (72/136)	38.7 (59/136)	-0.37 (110)	-0.37 (136)	-0.38 (136)
Geographic region							
	US/Canada	50.0 (28/56)	48.2 (27/56)	24.9 (13/52)	-0.38 (56)	-0.38 (56)	-0.19 (54)
	Australia/N Europe	36.2 (21/58)	44.1 (24/55)	22.3 (10/45)	-0.22 (58)	-0.22 (55)	-0.04 (49)
	Rest of World	51.4 (48/93)	56.5 (54/95)	25.9 (29/112)	-0.39 (93)	-0.37 (112)	-0.31 (112)
PsA duration, years							
	<2	53.7 (22/41)	49.1 (27/55)	34.1 (15/44)	-0.34 (41)	-0.38 (55)	-0.20 (44)
	≥ 2	42.0 (27/137)	54.5 (88/161)	38.4 (64/167)	-0.39 (137)	-0.37 (161)	-0.32 (167)
Age, years							
	<65	47.7 (102/214)	54.0 (114/213)	27.9 (72/213)	-0.38 (213)	-0.39 (213)	-0.34 (210)
	≥ 65	70.8 (17/24)	42.9 (8/21)	36.0 (9/25)	-0.39 (24)	-0.37 (21)	-0.17 (25)
Baseline bodyweight, kg							
	<60	50.0 (25/50)	50.0 (25/50)	34.0 (15/44)	-0.39 (50)	-0.39 (50)	-0.20 (49)
	≥ 60	48.3 (83/172)	54.7 (97/177)	36.4 (49/134)	-0.38 (170)	-0.40 (171)	-0.38 (172)
BMI, kg/m ²							
	<25	41.2 (20/51)	35.1 (27/49)	27.9 (7/18)	-0.39 (50)	-0.47 (49)	-0.23 (48)
	≥ 25	48.3 (82/87)	55.7 (64/99)	36.4 (27/74)	-0.33 (87)	-0.34 (99)	-0.31 (72)
	≥ 30	51.8 (48/93)	56.8 (46/99)	27.4 (26/97)	-0.38 (93)	-0.37 (99)	-0.19 (91)
	≥ 40	44.1 (11/17)	47.1 (8/17)	12.7 (1/8)	-0.34 (17)	-0.38 (17)	NA
PsA subtype, number of joints							
	<4	61.0 (2)	88.6 (4/5)	43.4 (1/2)	NC ^a	NC ^a	NC ^a
	≥ 4	50.4 (118/234)	52.4 (121/233)	37.5 (83/225)	NC ^a	NC ^a	NC ^a
Digital interphalangeal joint involvement ^b							
	Yes	46.4 (71/153)	50.3 (76/151)	34.1 (51/134)	NC ^c	NC ^c	NC ^c
	No	56.1 (48/85)	57.1 (49/85)	39.4 (31/102)	NC ^c	NC ^c	NC ^c
Arthritis mutilans ^b							
	Yes	37.3 (6/16)	33.3 (3/9)	24.1 (6/25)	NC ^c	NC ^c	NC ^c
	No	50.9 (119/232)	54.6 (119/218)	38.2 (89/213)	NC ^c	NC ^c	NC ^c
Spondylitis ^b							
	Yes	42.4 (20/47)	44.4 (20/45)	22.7 (7/44)	NC ^c	NC ^c	NC ^c
	No	51.1 (98/188)	55.6 (105/189)	39.4 (59/150)	NC ^c	NC ^c	NC ^c
Smoking status ^b							
	Never smoked	51.1 (71/139)	54.3 (76/140)	24.7 (39/158)	-0.37 (137)	-0.39 (140)	-0.31 (137)
	Smoker	35.1 (13/37)	44.4 (20/45)	46.2 (18/39)	-0.34 (37)	-0.34 (45)	-0.38 (39)
	Ex-smoker	54.5 (23/42)	56.8 (28/51)	33.1 (9/29)	-0.40 (42)	-0.40 (51)	-0.33 (29)
Baseline CRP, mg/L							
	<2.7	53.6 (82/153)	60.1 (88/147)	27.3 (39/143)	-0.38 (152)	-0.40 (148)	-0.34 (142)
	≥ 2.7	43.2 (37/85)	49.3 (56/113)	29.8 (27/92)	-0.37 (84)	-0.37 (105)	-0.37 (93)
PASDA ^b							
	≤ 2	61.0 (2)	100 (0/1)	33.3 (3/9)	NC ^c	NC ^c	NC ^c
	≥ 3	50.8 (31/61)	51.6 (25/49)	29.9 (20/67)	-0.32 (61)	-0.30 (49)	-0.22 (67)
	≥ 4	51.8 (86/166)	53.3 (94/180)	27.3 (44/162)	-0.42 (167)	-0.40 (160)	-0.34 (166)
PASI score ^b							
	≤ 2	51.0 (75/147)	53.8 (72/135)	28.7 (44/148)	-0.37 (146)	-0.40 (139)	-0.34 (147)
	≥ 3	40.0 (89/19)	54.6 (112/203)	36.0 (59/163)	-0.37 (19)	-0.40 (203)	-0.37 (203)
DSS-0 ^b							
	Yes	47.2 (89/127)	52.8 (66/125)	27.3 (33/123)	-0.35 (127)	-0.40 (123)	-0.36 (126)
	No	52.7 (161/110)	52.7 (161/110)	39.9 (53/114)	-0.42 (109)	-0.39 (110)	-0.32 (114)
SPARCC -0 vs LEI -0 ^b							
	Yes	48.7 (91/187)	53.3 (104/195)	23.4 (41/180)	-0.38 (186)	-0.36 (187)	-0.32 (184)
	No	50.0 (25/50)	50.0 (25/50)	43.8 (24/55)	-0.37 (49)	-0.40 (50)	-0.33 (47)
Concomitant csDMARD ^b							
	MTX only	48.9 (91/186)	51.6 (106/185)	34.9 (52/189)	-0.37 (187)	-0.40 (185)	-0.37 (181)
	Other	53.9 (23/43)	47.2 (22/47)	33.3 (16/42)	-0.40 (43)	-0.38 (47)	-0.32 (42)
Concomitant use (yes)							
	Yes	46.3 (31/67)	51.4 (39/77)	39.6 (31/78)	-0.33 (66)	-0.41 (77)	-0.18 (69)
	No	51.5 (88/171)	53.3 (106/199)	27.3 (51/187)	-0.40 (170)	-0.38 (199)	-0.34 (184)

^aAnalysis was not conducted due to small sample size; ^bAt screening; ^cIn pts with baseline PASI >0 and baseline BSA $\geq 3\%$

Statistical methods: ACR20 response was defined as achieving a $\geq 20\%$ improvement in ACR criteria components Missing ACR20 response was considered a non-response to treatment

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

ACR, American College of Rheumatology; BID, twice daily; BMI, body mass index; BSA, body surface area; CRP, C-reactive protein; csDMARD, conventional synthetic disease-modifying antirheumatic drug; DSS, Dactylitis Severity Score; HAQ-DI, Health Assessment Questionnaire-Disability Index; LEI, Leeds Enthesitis Index; LSM, least squares mean; MTX, methotrexate; N, number of patients in full analysis set (randomised and received ≥ 1 treatment dose); n, number of responders; N1, number of patients in the full analysis set by category of subgroup and treatment; N2, number of patients included in the repeated measures model by category of subgroup and treatment; NC, analysis not conducted; PASDAS, Psoriatic Arthritis Disease Activity Score; PASI, Psoriasis Area and Severity Index; PsA, psoriatic arthritis; pts, patients; ROW, rest of world (Brazil, Mexico and Taiwan); SPARCC, Spondyloarthritis Research Consortium of Canada (enthesitis index)

Conclusions: In this analysis of pooled data from 2 Phase 3 studies in pts with active PsA, tofacitinib 5 and 10 mg BID consistently improved efficacy at Month 3 compared with PBO across all predefined subgroups evaluated, with the exception of current smokers; however, as this was not a pre-specified analysis and some subgroups (including smoking status) were small, interpretation should be made with caution.

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[1] Nash P, et al. Arthritis Rheumatol 2017;69(suppl 10):619.

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AB0922 METABOLIC SYNDROME IS ASSOCIATED WITH ACTIVE DISEASE IN PSORIATIC ARTHRITIS AND MAY CONTRIBUTE TO DEVELOPMENT OF SYNDESMOPHYTES

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Background: An increased prevalence of metabolic syndrome (MetS) has been reported in psoriatic arthritis (PsA) suggesting an association between the inflammation and MetS.

Objectives: The aim of this study is to investigate its relationship with disease activity in patients with PsA. We also evaluated whether an association exists between MetS and axial involvement in PsA.

Methods: This study included patients with PsA followed in the Rheumatology outpatient clinic at Dokuz Eylul University. Age-matched patients with Takayasu arteritis (TA), an inflammatory systemic disease, were enrolled as diseased controls. The NCEP-ACT III criteria were used to identify subjects with MetS. Disease activity was assessed in patients with PsA by using several parameters including BASDAI, ASDAS, VAS patients' and physician' global, Tender and Swollen joint assessment (28/68), DAS28, DAPSA, CPDAI and SPARCC Enthesitis Index. ESR and serum CRP levels were measured. BASFI and BASMI were used to evaluate functional status and HAQ, ASQoL and DLQI to evaluate health and PASI to measure the severity of psoriasis. Hand and pelvis X-rays and sacroiliac joint MRIs were performed when indicated.

Results: There were 104 PsA patients (63.5% F; mean age: 50.9±13.0 years) who fulfilled the CASPAR criteria and 28 TA patients (89% F, mean age: 46.3±9.1) who fulfilled the ^{ACR 1990} criteria. The prevalence of MetS was found to be considerably higher in PsA patients compared to TA patients (45.2% and 21.4% respectively, p<0.001). In the comparison of PsA patients with and without MetS, no differences were found regarding treatment frequencies of NSAIDs, glucocorticoids, DMARDs and anti-TNFs and also mean glucocorticoid dosages. PsA patients with MetS had higher BASDAI, BASFI, BASMI, VAS, ASQoL, CPDAI, ASDAS and HAQ scores compared to PsA patients without MetS (table 1). More patients with syndesmophytes were found among PsA patients with MetS compared to those without MetS (p=0.027). There were no differences in indexes related predominantly peripheral involvement, such as tender and swollen joint counts, enthesitis score and presence of dactylitis. In multivariable regression analysis, presence of syndesmophytes had no relationship with MetS, but still related with ESR and BASMI.

Abstract AB0922 – Table 1. Clinical features and disease activity parameters in PsA patients with and without MetS.

	PsA Patients with MetS (n:47)	PsA Patients without MetS (n:57)	p value		PsA Patients with MetS (n:47)	PsA Patients without MetS (n:57)	p value
Age (mean, yrs)	55.49	47.28	0.001	TJC (med, IQR)	1 (2) min:0 max:9	0 (1) min:0 max:6	0.31
Smoking (%)			0.016	SJC (med, IQR)	0 (1) min:0 max:5	0 (1) min:0 max:4	0.83
None	25/47 (53%)	17/57 (29%)		ESR (med, IQR) (mm/h)	11 (13)	10 (15)	0.478
Ex-smoker	13/47 (27%)	14/57 (24%)		CRP (med, IQR) (mg/L)	5.5 (9.6)	3.8 (5.6)	0.280
Active smoker	9/47 (19%)	26/57 (45%)		Dactylitis (n, %)	2/47 (4.2%)	7/56 (12.5%)	0.140
BMI (med, IQR)	30.3 (6.6)	26.4 (5.9)	<0.001	Enthesitis (n, %)	3/46 (6.5%)	6/56 (10.7%)	0.458
Disease duration (yrs) (med, IQR)	7 (6)	9 (8)	0.386	Uveitis (n, %)	1/47 (2.1%)	2/56 (3.5%)	0.664
BASDAI (med, IQR)	22 (34)	11 (25)	0.042	Syndesmophytes	22/36 (61%)	16/44 (36%)	0.027
BASFI (med, IQR)	18 (36)	5 (14)	0.009	Sacroiliitis (radiographic) (n, %)	8/44 (18%)	13/53 (24%)	0.296
BASMI (med, IQR)	20 (20)	10 (20)	0.001	Hand X-ray erosions (n, %)	12/31 (38%)	14/37 (37%)	0.589
VAS (med, IQR)	31 (33)	20 (31)	0.030	Hand X-ray osteoproliferation (n, %)	9/31 (29%)	10/37 (27%)	0.589
DAS28 (med, IQR)	2.4 (1.2)	2.1 (1.4)	0.059	Obesity/ overweight (n, %)	44/47 (93%)	35/57 (61%)	<0.001
PASI (med, IQR)	0.1 (4.8)	1.5 (7.2)	0.164	Sij MRI positivity (active sacroiliitis) (n, %)	9/13 (69%)	10/18 (55%)	0.44
CPDAI (med, IQR)	6.3 (6.0)	3.6 (7.4)	0.049				
ASQoL (med, IQR)	7 (8)	3.0 (6)	0.017				
DLQI (med, IQR)	0 (4)	1 (2)	0.794				
ASDAS (med, IQR)	2.5 (1.8)	1.7 (1.2)	0.008				
HAQ (med, IQR)	0.375 (1.125)	0.125 (0.438)	0.011				
VAS physician (med, IQR)	16 (17)	13 (16)	0.151				
DAPSA (med, IQR)	15.8 (13.4)	10.6 (19.9)	0.190				

Conclusions: This study demonstrates a higher prevalence of MetS in PsA patients compared to TA. It also suggests that MetS might be associated with high disease activity and more severe disease especially in patients with axial involvement.

Disclosure of Interest: None declared
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AB0923 AUTONOMIC DYSFUNCTION IN PSORIATIC ARTHRITIS PATIENTS AND PSYCHO-EMOTIONAL DISORDERS FREQUENCY

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Background: Progressive autonomic dysfunction syndrome development is a characteristic for the most of immune inflammatory processes. Pain syndrome chronization in patients with psoriatic arthritis (PsA) is one of the leading factors contributing to the development of psycho-emotional disorders. They, in turn, exacerbate the disorders of the autonomic nervous system.

Objectives: to evaluate function of the autonomic in PsA patients and the presence of psycho-emotional disorders in them

Methods: 73 patients with PsA (≥5 SJC and ≥5 TJC; CRP≥0.3 mg/dL) were examined by psycho-emotional testing using the Spielberger anxiety and Hamilton depression scales. Autonomic disorders were detected by "Vein-Patient"-VP method's questionnaire, filled by the patient (when more than 15 points – autonomic dysfunction is possible (AD)) and "Vein-Doctor"-VD questionnaire, filled by the doctor (more than 25 points – confirmation of the presence of AD); studied the general indicators of heart rate variability (HRV) – mode (Mo), mode amplitude (AMo), autonomic equilibrium index (AEI), activity index of regulatory systems (AIRS); spectral characteristics – standard deviation of normal RR intervals (SDNN); square root of the mean of the sum of the squares of the differences between consecutive RR-intervals (RMSSD) and the ratio of balance between sympathetic and parasympathetic activities (LF/HF) of autonomic nervous system (ANS). All the patients received MTX in a stable dose for 6 months at least, prior the time of the study.

Results: in 39 PsA patients (53,4%) increased reactive anxiety (37,0±1,5 points) and personal anxiety (45,4±1,5 points) levels were determined as results of testing. They made up the 1st observation group, and the remaining 34 patients – the 2nd observation group. In the first group, according to the questionnaire VP and VD more significant excess of the norm was defined (19,79±0,54 points and 29,8±0,77 points respectively) than in the 2nd group (16,92±0,62 and 27,1±0,8 points). The decrease of the SDNN и RMSSD in comparison with norm was revealed in the both groups, that evidences an inhibited sympathetic regulation. However, more significant LF/HF growth (4,15±0,64) and SDNN decrease (22,4±5,6 ms) in the 1st group, than in the 2-nd (3,0±0,86; 29,1±8,4 ms, respectively) occurred. It indicates a link between the increase in the sympathetic level of regulation and the presence of signs of psycho-emotional disorders. And also the growth of AMO in the 1st group (47,9±8,4%) shows the strength of sympathetic mobilising influence and evidences an increased medullary vasomotor centre activation and growth of sympathetic regulation in PsA patients with depression. In general, the severity of changes in HRV in PsA patients can be due to a high content of pro-inflammatory cytokines, which induce the synthesis of free acid radicals and worsen ANS maintenance of the organisms' activity.

Conclusions: Emotional disorders of the anxiety-depressive spectrum contribute to the regulatory mechanisms tension increase and adaptive capabilities