surface area involvement, with PASI-50 and PASI-75 response rates of 65.8% (98/149) and 43.6% (65/149), respectively. Results were similar for subjects receiving APR20 (data not shown). Consistent efficacy results were seen across the 3 individual trials. No new safety concerns were identified with APR up to 260 weeks. For APR30 subjects entering the 5th year of APR exposure, adverse events (AEs) occurring in $\geq 5\%$ were nasopharyngitis (6.6%) and upper respiratory tract infections (5.8%); most AEs were mild or moderate in severity. Among APR30-exposed subjects, serious AEs occurred in 5.8% in Weeks >208 to ≤ 260 ; 5 subjects discontinued due to an AE.

Table 1:

	Outcomes at Week 260	
	APR30 n=329*	
ACR20, n/m [†] (%)	215/320 (67.2)	
ACR50, n/m [†] (%)	144/324 (44.4)	
ACR70, n/m [†] (%)	89/325 (27.4)	
SJC (0-76), mean % change from BL	-82.3	
TJC (0-78), mean % change from BL	-72.7	
MASES=0, n/m [†] (%)	136/218 (62.4)	
Dactylitis count=0, n/m [†] (%)	114/141 (80.9)	
cDAPSA (0-154) ≤ 13 , n/m (%)	198/328 (60.4)	
HAQ-DI (0-3), mean change from BL	-0.42	
HAQ-DI MCID ≥ 0.35 , n/m (%)	173/329 (52.6)	
PASI-50, n/m [†] (%)	98/149 (65.8)	
PASI-75, n/m [†] (%)	65/149 (43.6)	

Data as observed.

*The n reflects the number of subjects with data available at Week 260, regardless of when subjects started taking APR30 (BL, Week 16, or Week 24); actual number of subjects having data available for each end point may vary. [†]Denominators vary slightly due to availability of sufficient data for each level of ACR response assessment. [‡]Examined among subjects with enthesitis at BL and having data at Week 260. [§]Examined among subjects with dactylitis at BL and having data at Week 260. ^{||}Examined among subjects with psoriasis involvement of the body surface area $\geq 3\%$ at BL and data at Week 260. ACR20/50/70= $\geq 20\%/ \geq 50\%/ \geq 70\%$ improvement in American College of Rheumatology response criteria; n/m=number of responders/number of subjects with sufficient data for evaluation; SJC=swollen joint count; TJC=tender joint count; MASES=Maastricht Ankylosing Spondylitis Enthesitis Score; cDAPSA=Clinical Disease Activity in Psoriatic Arthritis; HAQ-DI=Health Assessment Questionnaire-Disability Index; MCID=minimal clinically important difference; PASI-50/75= $\geq 50\%/ \geq 75\%$ reduction from BL Psoriasis Area and Severity Index score.

Conclusions: APR demonstrated sustained, clinically meaningful improvements in PsA signs and symptoms, physical function, and associated psoriasis in the population of subjects continuing treatment over 5 years. APR continued to demonstrate a favourable safety profile and was generally well tolerated at 5 years.

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THU0295

FACTORS ASSOCIATED WITH PATIENT-PHYSICIAN DISCORDANCE IN A PROSPECTIVE COHORT OF PATIENTS WITH PSORIATIC ARTHRITIS: AN ASIAN PERSPECTIVE

¹C. Wang, Y.H. Kwan^{1,2}, W. Fong^{1,2}, S.Q. Xiong¹, Y.Y. Leung^{1,2}. ¹Rheumatology and Immunology, Singapore General Hospital; ²Duke-NUS Medical School, Singapore, Singapore

Background: Psoriatic arthritis (PsA) is a chronic inflammatory articular disease with diverse clinical manifestations. Few biomarkers are available to assess disease activity in PsA. Hence, both the patient's and the physician's assessment of disease activity is vital in ensuring optimal treatment outcomes. Understanding factors associated with patient and physician discordance can facilitate shared decision making and treatment management between patient and physician. There is limited data on factors associated with patient and physician discordance in psoriatic arthritis; none of which exist in the Asian population.

Objectives: To identify the factors associated with patient-physician discordance in a multi-ethnic Asian cohort of Psoriatic arthritis (PsA) patients.

Methods: Data was obtained from a prospective cohort of consecutive patients with psoriatic arthritis, who fulfil the CASPAR criteria recruited from a single centre in Singapore. Sociodemographic, clinical data and patient reported outcomes

were collected using a standardised protocol at baseline, 4 months, 8 months, 1 year and 2 years. Patient-physician discordance was defined as patient global assessment minus physician global assessment (PGA - PhGA). We evaluated factors associated with patient-physician using generalised linear regression to control for within-subject effect.

Results: From 126 patients (50.4% male, 67.5% Chinese, age: 51 ± 13.8 years, duration of illness: 5.6 ± 6.1 years) recruited at baseline, paired data for patient and physician global assessments were available for 224 visits over a median follow up of 10 (range 0–15) months. In univariable analysis, gender, duration of illness, fatigue, pain score, number of tender joint/swollen joint/dactylitis, mental health subscale of SF36 and physical function by Health Assessment Questionnaire (HAQ) were significantly associated with patient-physician discordance. In multivariable analysis, higher level of fatigue, higher pain score, poorer mental health were associated with PGA-PhGA; while higher swollen joint and dactylitis count were negatively associated with PGA-PhGA (table 1).

Abstract THU0295 – Table 1. Multivariable analysis for factors associated with patient-physician discordance

Factors	β	95% Confidence Interval	p-value
Age	0.211	(-0.029, 0.452)	0.085
Gender	-3.687	(-8.830, 1.457)	0.160
Female	Ref	-	-
Male			
Ethnicity	-1.085	(-6.654, 4.484)	0.703
Chinese	Ref	-	-
Non-Chinese			
Education	-6.105	(-12.2, -0.012)	0.050
Secondary or below	Ref	-	-
Post-secondary (>10 years)			
Duration of illness (years)	0.252	(-0.187, 0.692)	0.261
Fatigue ^a	1.964	(0.577–3.350)	0.005
Pain ^a	0.456	(0.312–0.601)	<0.001
Tender joint count	-1.006	(-2.197, 0.184)	0.098
Swollen joint count	-3.312	(-5.095, -1.528)	<0.001
Dactylitis count	-3.059	(-5.594, -0.523)	0.018
HAQ ^a	-2.265	(-8.619, 4.090)	0.485
SF36-mental health domain ^a	0.958	(0.169–1.747)	0.017

REFERENCE:

[1] A Higher score represents poorer status

Abbreviations: HAQ: Physical function by Health Assessment Questionnaire; SF36: Medical Outcome Short Form 36

Conclusions: Higher pain score, higher level of fatigue and poorer mental health may explain underestimation of patient global assessment by physicians. Higher swollen joint and dactylitis count may explain overestimation of physician global assessment.

Disclosure of Interest: None declared

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THU0296

CLINICAL RESULTS OF PATIENTS WITH PERIPHERAL PSORIATIC ARTHRITIS NOT RECEIVING BIOLOGICAL THERAPY IN A MULTIDISCIPLINARY UNIT

¹C.E. Pérez-Velázquez, M.L. García-Vivar¹, S. Pérez-Barrio², E. Galindez-Agirregoikoa¹, E. Ruiz-Lucea¹, I. Torre-Salaberri¹, O. Fernandez-Berrizbeitia¹, J. M. Blanco-Madrigal¹, A.R. Intxaurre-Pellejero¹, E. Guerrero-Basterretxea¹, I. Calvo-Zorrilla¹, O. Ibarguengoitia-Barrena¹, D. Montero-Seisdedos¹, N. Rivera-García¹, M.J. Allande¹, I. Gorostiza-Hormaeche³. ¹Rheumatology; ²Dermatology; ³Research Unit, University Hospital of Basurto, Bilbao, Spain

Background: We consider multidisciplinary management necessary, especially in a subgroup of patients with Psoriatic Arthritis (PsA) for complexity, cutaneous and/or joint involvement. Despite the limited evidence of efficacy of methotrexate (MTX) and other classical synthetic DMARDs (csDMARDs) in these patients, they are commonly prescribed in our multidisciplinary unit (following the recommendations of experts, in peripheral PsA).

Objectives: To assess joint and cutaneous involvement in patients with peripheral psoriatic arthritis not receiving biologics in our multidisciplinary unit (visited for at least 6 months).

Methods: We review clinical records of 199 PsA patients visited in our multidisciplinary unit and select 74 patients with the above mentioned criteria; we collect epidemiological and clinical data, and joint and skin activity evaluation by DAPSA, PASI, BSA and PGA (in plaque psoriasis) and proportion of patients that achieve MDA (minimum disease activity) as a therapeutic goal. Data were analysed using SPSSv23.