Physicians and patients independently provided information on satisfaction with disease control on a 5-point scale (very satisfied/satisfied/neither/dissatisfied/very dissatisfied). Physician and patient reports of satisfaction were compared to assess levels of misalignment. Physicians also provided information on demographics and disease history/severity. Patients provided information on involvement in treatment decisions, EuroQol-5D Visual Analogue Scale (EQ-5D), Work Productivity and Activity Impairment (WPAI) and Health Assessment Questionnaire Disability Index (HAQ-DI). Factors associated with misalignment were analysed by a multivariate logistic regression modelled using predictors identified as significant in univariate logistic regression. Data entered in the analyses included demographics, time diagnosed, treatment history, disease severity, flaring, pain, patient-reported involvement in treatment decisions, EQ-5D, WPAI, HAQ-DI.

Results: 519 physicians (331 rheums, 188 derms) provided data for 2467 PsA patients, 656 meeting all inclusion criteria. Mean age was 49.9 (SD 12.1) years, mean disease duration 6.7 (6.2) years, 53.8% patients were male and 66.1% employed. Satisfaction with disease control was generally high amongst both patients (78.3%) and physicians (91.9%) with alignment in 79.4% of cases. In 16.8% of cases there was misalignment where patients were dissatisfied but physicians satisfied.

Multivariate logistic regression showed that worse HAQ-DI (OR [95% CI]: 0.54 [0.38–0.77], $p=0.001$), worse EQ-VAS (OR 1.03 [1.02–1.04], $p<0.001$), lack of involvement in treatment decisions (OR 1.26 [1.07–1.50], $p=0.007$) and physician-reported severe disease as opposed to mild (OR 0.20 [0.05–0.78], $p=0.020$) were all independently associated with misalignment.

Conclusions: Satisfaction with disease control was generally high for both patients and physicians; however, misalignment was not rare. Patients had higher levels of symptoms/increased impact on activities where there was misalignment. An independent factor associated with misalignment was patient-perceived involvement in condition management. Improving patient-physician engagement in overall disease management may lead to greater patient satisfaction and patient-physician alignment.

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THU0316

GENDER DIFFERENCES IN BIOLOGIC TREATMENT OUTCOMES – A STUDY OF 1750 PATIENTS WITH PSORIATIC ARTHRITIS USING DANISH HEALTH CARE REGISTERS

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Background: Previous studies have shown conflicting findings on the impact of gender on effectiveness of tumour necrosis factor alpha inhibitor (TNFi) treatment in patients with psoriatic arthritis (PsA).

Objectives: To investigate gender differences in disease manifestations, patient-reported outcomes, comorbidities and treatment effectiveness among patients with PsA treated with their first TNFi

Methods: In this observational cohort study, the nationwide DANBIO register provided prospectively collected data on disease activity and treatment outcomes for PsA patients who initiated their first TNFi in 2000–2015. Data on comorbidities, diagnosed in hospital departments, were obtained by cross-linkage to the Danish National Patient Register. Treatment response was evaluated according to EULAR and ACR criteria at 3- and 6 months. Cox- and logistic regression models analysed the impact of gender on TNFi persistence and response, respectively, while adjusting for a priori selected confounders including clinical-, laboratory- and patient-reported factors, comorbidities and lifestyle characteristics

Results: A total of 1750 PsA patients (53% females) were included. At baseline, women were older (49 years/47 years), more often smokers (32%/26%), had worse patient-reported scores (e.g. global score 71 mm/65 mm) and higher frequencies of hospital-diagnosed anxiety or depression (7%/4%) and chronic pulmonary disease (7%/3%), than men (all $p<0.01$). Median TNFi persistence was 3.8 years (95% CI 3.0–5.7) in men versus 1.4 (1.1–1.8) in women ($p<0.001$), figure 1. Men had higher odds of achieving response according to all response criteria, e.g. adjusted odds ratio=3.2 (1.6–6.1) for EULAR good/moderate response at 6 months (vs. women).

FIGURE: KAPLAN MEIER PLOTS

Abstract THU0316 – Figure 1. Kaplan meier plots

Conclusions: Male patients had better TNFi treatment outcomes. Adjustment for baseline risk factors including patient-reported outcomes, disease activity, comorbidities and lifestyle factors did not influence this relationship, which suggests a role of biological factors.

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THU0317

CREATING A EUROPEAN DATABASE OF PSORIATIC ARTHRITIS PATIENTS TREATED IN ROUTINE CARE – FIRST, PRELIMINARY RESULTS FROM THE EUROSPA RESEARCH NETWORK COLLABORATION

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Background: A research network collaboration of 15 European registries collecting data on patients with spondyloarthritis (SpA), "EuroSpA", has recently been created to strengthen research capabilities in the real world setting¹. Here we present initial findings from the collaboration.

Objectives: To investigate the feasibility of creating a common database within the EuroSpA collaboration and to conduct proof-of-concept analyses by investigation of baseline characteristics, disease activity at baseline and after 6 months and 12 months' TNFi retention rate in patients with psoriatic arthritis (PsA) initiating Tumour Necrosis Factor inhibitors (TNFi).

Methods: A common data model for PsA was agreed upon by the EuroSpA Scientific Committee. Virtual meetings between the EuroSpA and registry data managers clarified data availability and structure. This was followed by upload of anonymized data through the secure Virtual Private Network pipelines to the EuroSpA server. Baseline characteristics and disease activity at baseline and after 6 months were investigated with non-parametric descriptive statistics. Kaplan-Meier estimation was used to investigate TNFi retention rates.

Results: By January 8th 2018, four of the 15 registries participating in EuroSpA had completed data upload to the EuroSpA database resulting in 3172 patients with PsA in a pooled dataset. Baseline characteristics of the participating registry populations at initiation of first TNFi are shown in table 1. Crude 12 month TNFi retention rates varied from 65%–80% for 1st TNFi and 57%–82% for 2nd TNFi (see figure 1). For the pooled dataset crude 12 months TNFi retention rates were 68% and 60% for the 1st and 2nd TNFi, respectively.

Abstract THU0317 – Table 1. Baseline demographic and disease characteristics of patients with PsA registered in four EuroSpA registries

	DANISH (Denmark) N=2379	Brazil (Brazil) N=375	TURK-BRO (Turkey) N=93	ICEREN (Croatia) N=239		
Age, years	48 (9-56)	49 (13-77)	45 (30-55)	50 (18-59)		
Male (%)	1488 (63)	205 (55)	33 (35)	158 (66)		
cDAS28 (n°)	1.588 (0.3)	2.28 (1.3)	29 (0.8)	173 (0.7)		
Disease duration, years	7 (1-43)	6 (0-32)	2 (0-16)	7 (1-40)		
Smoking status, current, n (%)	184 (8)	34 (9)	21 (24)	18 (8)		
First TNF-inhib, n° (%)						
• INF	415 (18)	37 (10)	26 (28)	163 (67)		
• ETA	355 (15)	75 (20)	22 (24)	11 (5)		
• ADA	174 (7)	189 (51)	11 (12)	71 (30)		
• CCR	178 (8)	12 (3)	0 (0)	1 (0)		
• GOL	122 (5)	49 (13)	2 (2)	42 (18)		
First TNF-inhib, yr						
• Before 2009	423 (18)	28 (8)	18 (19)	97 (40)		
• 2009-2011	648 (27)	181 (48)	24 (26)	48 (20)		
• 2012-2017	1609 (68)	239 (64)	51 (55)	188 (79)		
Baseline	6 months	Baseline	6 months	Baseline	6 months	
DAS28-CRP	4.3 (3.4-5.3)	2.5 (1.3-4.1)	5.4 (3.3-8.1)	2.7 (1.3-5.9)	4.4 (3.3-5.8)	2.4 (1.6-3.3)
CRP (mg/L)	7.2 (3.9)	21 (6)	8.9 (3.9)	2.0 (0.7)	7.0 (3.9)	3.3 (1.5)
VAS (0-100) mm	36 (18-80)	18 (14-65)	30 (10-90)	30 (10-90)	37 (15-84)	37 (10-86)
VAS pain score	42 (18-77)	28 (13-52)	30 (10-90)	30 (10-90)	48 (15-79)	28 (11-77)

Data are n or, absolute, mean (SD) or percentage. cDAS28 = combined systemic Disease Modifying Anti Rheumatic Drug (DMARD) score. TNF-inhib: tumor necrosis factor inhibitor. TNF = infliximab, TNF-inhib = ADA, adalimumab; CRP = c-reactive protein; GOL: golimumab; CCR = certolizumab; ETA = etanercept; ADA = adalimumab.

Data are as observed, median (IQR) or percentage. cDAS28 = conventional synthetic Disease Activity Index; ADA = ACR/Leucocyte Count; CRP = C-reactive protein; DAS28 = Disease Activity Score in 28 joints; VAS = Visual Analogue Scale; point global.

Conclusions: Preliminary analyses showed differences across European registries regarding baseline characteristics and crude retention rates in PsA patients initiating TNFi. These initial, preliminary analyses demonstrate that the creation of a large European database of PsA patients treated in routine care based on a common data model is feasible, offering important opportunities for future research.

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THU0318

TREATING PSORIATIC ARTHRITIS TO TARGET: COMORBIDITIES, NON-ADHERENCE AND FACTORS RELATED TO THE HEALTH SYSTEM PREVENT ESCALATION OF THERAPY IN REAL LIFE

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Background: Although the treat-to-target (T2T) strategy in psoriatic arthritis (PsA) clinical trials resulted in better outcomes in domains such as joints, skin, function and quality of life compared to standard care, in real life several factors affect such a strategy¹.

Objectives: To determine the prevalence of patients achieving minimal disease activity (MDA) in our PsA clinic and the reasons why therapy in patients not achieving MDA was not optimised.

Methods: An observational, retrospective cross-sectional study nested in a cohort study was conducted; medical records of patients attending PsA clinic in a public university hospital were reviewed. Demographic data, current treatment and components of the MDA score were collected. When patients were not in MDA but the treatment was not optimised, the reasons for the non-escalation of therapy were recorded.

Results: MDA score was available in 113 visits, corresponding to 69 patients. Mean age of patients was 57.4±10.6, 53.6% (n=37) were females and 40.6% (n=28) were treated with biological drugs. MDA was reached in 31.0% (n=35) of visits; 36.2% (n=25) of the patients achieved MDA in at least one visit during the 8 months follow-up. There was no statistical difference in the proportion of patients achieving MDA according to treatment prescribed (biological DMARDs versus synthetic conventional DMARDs) (p=0.979). Although MDA was not achieved in 69.0% (n=78) of visits, optimisation of therapy was done in only 42.3% (n=33) of those visits. The main reasons which prevented treatment escalation were: physician impression of clinical remission and MDA overestimated by comorbidities and chronic deformities (57.7%, n=26), non-adherence to previous prescription (17.8%, n=8), delay to receive drugs from health insurance (17.8%, n=8), adverse events (11.1%, n=5), patient low cognitive level (6.7%, n=3) and patient refusal to escalate therapy (4.4%, n=2). In visits with impression of remission by rheumatologist, the skin and the swollen joint components of the MDA score were achieved in more than 80% of this visits (80.8%, n=21).

Conclusions: Rheumatologists are reluctant to escalate therapy in PsA even if patients are not in MDA if "objective" components of the MDA score such as skin and swollen joint counts are reached. Comorbid conditions, patients non-adherence to therapy and factors related to the health system influence a tight control strategy in the real life clinical practice.

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THU0319

OVERALL SAFETY OF 7-WEEK SECUKINUMAB EXPOSURE DURING PREGNANCY IN WOMEN WITH PSORIATIC ARTHRITIS

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Background: Psoriatic arthritis (PsA) often affects women of reproductive age. Secukinumab (SEC), a monoclonal antibody against interleukin-17A is effective in contrasting the progression of articular and cutaneous manifestations of PsA but has not been extensively studied in pregnancy, despite 84 cases of accidental exposure reported with reassuring safety outcomes.

Objectives: To evaluate the maternal and fetal outcomes in women with PsA exposed to SEC during pregnancy.

Methods: During a 10 months observational period, we enrolled 6 patients, treated by SEC 150 mg subcutaneously every month after weekly induction. All of them stopped the treatment by the time pregnancy test turned positive. All women had previously been counselled about contraceptive methods adoption and the potential risk of becoming pregnant during SEC administration, signing an informed consent. We collected demographic and clinical data of both patients