DIFFERENCES IN CLINICAL CHARACTERISTICS, QUALITY OF LIFE, DISABILITY, AND WORK PRODUCTIVITY IN PSORIATIC ARTHRITIS PATIENTS BY GENDER: FINDINGS FROM A CROSS-SECTIONAL SURVEY IN THE US AND EUROPE

Laure Gossec1, Jessica A. Walsh2, Kaleb Michaud3, Steve Peterson4, Elizabeth Holdsworth5, Chetan Karyekar4, Nicola Booth5, Jessalyn Kemp5, 4Janssen Global Services, LLC, Horsham, PA, United States of America, 3University of Nebraska Medical Center, Omaha, NE, United States of America, 2University of Nebraska Medical Center, Omaha, NE, United States of America, 1Janssen Global Services, LLC, Horsham, PA, United States of America, 5Adelphi Real World, Manchester, United Kingdom, 6Janssen Scientific Affairs, LLC, Horsham, PA, United States of America, 7Drexel University College of Medicine, Philadelphia, PA, United States of America, 8Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA, United States of America

Background: Psoriatic arthritis (PsA) prevalence is equal in men and women, though gender may play a role in driving mechanisms of PsA leading to differences in manifestations of clinical disease (1).

Objectives: Assess key differences in clinical characteristics, disability, quality of life, and work productivity by gender in real-world practice.

Methods: Cross-sectional survey of rheumatologists and dermatologists and their patients in France, Germany, Italy, Spain, UK, and US. Data were collected from Jun-Aug 2018 via physician-completed patient record forms and patient self-completed forms. Data were analyzed by gender. Demographic characteristics, treatment use (biologic treatment), clinical characteristics (Tender Joint Count [TJC], Swollen Joint Count [SJC], Body Surface Area [BSA] psoriasis) were reported by physicians, while quality of life (EQ5D and PsAID12), disability (HAQ-DI), and work productivity (WPAI) were reported by patients. Men and women were compared using parametric tests and non-parametric tests where appropriate.

Results: Data were collected from 2270 patients (596 US, 1675 Europe). Demographic characteristics, time from first symptoms to diagnosis, biologic treatment, and clinical characteristics were comparable between women and men (Table 1). More women reported worse quality of life, disability, and work activity impairment than men (Table 2).

Table 1. Demographic and clinical characteristics in women and men [mean (SD) or n (%)]

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Women</th>
<th>Men</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>48.3 (13.7)</td>
<td>48.8 (12.8)</td>
<td>0.42</td>
</tr>
<tr>
<td>Working full time*, n (%)</td>
<td>206 (49.4)</td>
<td>350 (68.6)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Charlson Comorbidity Index score</td>
<td>1.10 (0.51)</td>
<td>1.15 (0.58)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Time from first symptoms to diagnosis, years</td>
<td>1.48 (3.53)</td>
<td>1.14 (2.48)</td>
<td>0.76</td>
</tr>
<tr>
<td>PsA duration, years</td>
<td>557 (53.2)</td>
<td>674 (55.1)</td>
<td>0.38</td>
</tr>
<tr>
<td>BSA psoriasis involvement, n (%)</td>
<td>5.5 (8.4)</td>
<td>5.5 (8.1)</td>
<td>0.87</td>
</tr>
<tr>
<td>Swollen Joint Count</td>
<td>3.2 (7.0)</td>
<td>3.5 (6.9)</td>
<td>0.39</td>
</tr>
<tr>
<td>Tender Joint Count</td>
<td>4.1 (5.2)</td>
<td>4.5 (8.0)</td>
<td>0.03</td>
</tr>
<tr>
<td>Enthesitis, n (%)</td>
<td>59 (5.6)</td>
<td>72 (5.9)</td>
<td>0.86</td>
</tr>
<tr>
<td>Dactylitis, n (%)</td>
<td>79 (7.5)</td>
<td>75 (6.1)</td>
<td>0.21</td>
</tr>
</tbody>
</table>

*Outside the home

Conclusion: In women and men with similar PsA disease activity and treatment rates, women experienced worse quality of life, greater disability, and greater work impairment, despite a lower burden of comorbidities.

Disclosure of Interests: Laure Gossec Grant/research support from: Abbvie, BMS, Celgene, Janssen, Lilly, MSD, Novartis-Sandoz, Pfizer, Sanofi, and UCB, Consultant for: Abbvie, Biogen, BMS, Celgene, Janssen, Lilly, MSD, Nordic Pharma, Novartis-Sandoz, Pfizer, Roche, Sanofi, and UCB, Consultant for: L Gossec has received honoraria from Celgene as investigator for this study, Jessica A. Walsh Grant/research support from: Abbvie, Pfizer, Consultant for: Abbvie, Celgene, Lilly, Novartis, Kaleb Michaud Grant/research support from: Pfizer (within past 2 years), Steve Peterson Shareholder of: Janssen, Employee of: BMS (2000-2002), Janssen (2002-present), Elizabeth Holdsworth Employee of: Adelphi Real World, Chetan Karyekar Shareholder of: J&J, Employee of: Janssen Scientific Affairs, LLC, Abbott, BMS, Novartis, Nicola Booth Employee of: Adelphi Real World, Jessalyn Kemp Employee of: Adelphi Real World, Soumya D Chakravarty Employee of: Johnson & Johnson, Employee of: Johnson & Johnson, Shelly Kafka Shareholder of: J&J, Employee of: J&J, Alexis Ogdie Grant/research support from: (To my university) Novartis, Pfizer, Grant/research support from: Novartis, Pfizer, Grant/research support from: Novartis, Pfizer, Consultant for: Abbvie, Bristol-Myers Squibb, Celgene, Corrona, Eli Lilly and Company, Novartis, Pfizer, and Takeda, Consultant for: Abbvie, Amgen, Bristol-Myers Squibb, Celgene, Corrona, Eli Lilly, Novartis, Pfizer Inc, Takeda, Consultant for: Abbvie, Amgen, BMS, Celgene, Corrona, Lilly, Novartis, Pfizer, Takeda, Consultant for: Abbvie, Amgen, BMS, Celgene, Corrona, Lilly, Novartis, Pfizer, Takeda


SAT0378

DRIVERS OF DISCORDANCE IN PSORIATIC ARTHRITIS WHEN ANALYZING THE LINK BETWEEN PATIENT-PERCEIVED GOOD STATUS AND THE DISEASE ACTIVITY IN PSORIATIC ARTHRITIS (DAPSA) COMPOSITE SCORE: AN ANALYSIS OF 436 PATIENTS FROM THE INTERNATIONAL REFLAP OBSERVATIONAL STUDY

Laure Gossec, Maarten de Wit, Laura C. Coates, Umut Kalyoncu, Emmanuelle Denis, Adeline Ruysseveld-Witrand, Ying Ying Leung, Rossana Scrivo, Juan D. Cañete, Penelope Palominos, Sandra Táll, Lita Kitz, Martin Soubrier, Lilli Eder, Ana-Maria Orbai, Josef S. Smolen, RFIP study group, PARIS, France

Background: In Psoriatic arthritis (PsA), the objective of treatment is remission or low disease which can be defined using the Disease Activity in Psoriatic Arthritis (DAPSA) (ref1). We previously showed DAPSA was associated to patient-perceived good status (i.e., self-assessed remission or low disease, yes/no) (ref2). However, some discordance was noted between patient-perceived status and the composite score. This discordance may be linked to demographic factors (such as age, gender or country of origin), disease-related factors (such as skin involvement which is not assessed in DAPSA) or patient-reported outcomes (such as fatigue or depressive affects). A better understanding of this discordance would be helpful in the context of shared decision-making.

Objectives: To explore the drivers of discordance between patient-perceived remission or low disease and DAPSA-defined remission or low disease.

Methods: This is an analysis of the first visit of ReFlap (NCT03119805, ref2), an observational study in 14 countries of consecutive adult patients with definite PsA >2 years of disease duration. Discordance in assessment of remission/low disease status was defined as a disagreement between a specific patient question (are you in remission or low disease, yes/no) and DAPSA-defined remission/low disease (i.e., score <=14, yes/ no). Potential drivers of this discordance were analysed through univari- able then stepwise multivariable logistic regression. Variables analysed were demographic (age, gender, disease duration, gross domestic product of country of origin), disease-related (joint counts, psoriasis BSA, enthesitis, CRP) and patient-reported outcomes (pain, fatigue, depressive affect and anxiety). There was no imputation of missing data.

Results: Among 436 patients, mean age 52.3 (SD 12.5) years, mean disease duration 10.1 (8.1) years, 218 (50.8%) male; 259 (63.5%) were taking a conventional DMARD and 247 (60.5%) a biologic. Disease activity was moderate: 36.1% had no current psoriasis skin lesions and mean swollen joint count was 2.2 (7.1). Remission of low disease was frequent both using the patient question (N=286, 65.6%) and using DAPSA (N=246, 56.4%). Discordance between patient-reported status and DAPSA

Reference
SUBCUTANEOUS VERSUS ORAL METHOTREXATE IN ACHIEVING MINIMAL DISEASE ACTIVITY IN PSORIATIC ARTHRITIS. CLINICAL PRACTICE: RUSSIAN PSORIATIC ARTHRITIS REGISTRY (RU-PSART) DATA

Elena Gubac1, Elena Loginova1, Anastasia Koltakova1, Yulia Korsakova1, Tatiana Korotaeva1, Evgeny Nasonov1, Alexander Lita1, Maria Sedunova2, Igor Pritstavyk3, Irina Ummova4, Irina Bondareva4, Snejza Kudishina4

1Nasonova Research Institute of Rheumatology, Moscow, Russian Federation; 2St. Petersburg Clinical Rheumatology Hospital No.25, Rheumatology, St. Petersburg, Russian Federation; 3Kemerovo Regional Hospital, Rheumatology, Kemerovo, Russian Federation; 4Vladivostok Clinical Hospital No.2, Rheumatology, Vladivostok, Russian Federation

Background: The aim of psoriatic arthritis (PsA) therapy is to achieve minimal disease activity (MDA) or clinical remission. Methotrexate (MTX) is the first-line treatment; however, the extent of the disease-modifying effect of MTX on PsA is a matter of debate. It has been shown that the MTX treatment achieves MDA in 6 months in <20% of patients (pts) (1). It has been demonstrated that parenterally administered MTX results in rapid and complete absorption, higher serum levels, and less variable exposure than the oral dosing (2). Clinical practice data on the use of MTX for treating PsA are contradictory.

Objectives: To show the efficacy of MTX in PsA pts in clinical practice and to compare the effectiveness of oral and subcutaneous (SC) MTX treatments.

Methods: 256 pts out of RU-PSART received synthetic disease-modifying antirheumatic drugs (sDMARDs), of whom 182 (71.1%) pts (M/F =68/114) received MTX, and were included in the study according to CASPAR criteria. Their median age 42 [Min 19-Max 73] years (yrs). Pts underwent standard clinical examination of PsA activity at the baseline and the follow-up visits. All pts were biological-naive. They all were treated with MTX monotherapy: 80 received SC and 102 oral MTX. The main purpose was to determine the cumulative frequency of achieving MDA after the MTX therapy onset. MDA is defined as the presence of 5 out of the following 7 domains: tender joint count ≤2, swollen joint count ≤2, patient global pain ≤3, tender entheseal points ≤1, Health Assessment Questionnaire score ≤0.5, patient global disease activity measured by Visual Analogue Scale (VAS) score ≤20, and patient pain VAS ≤15. Medians and quartiles [Me; Min-Max] were used. ORs with 95% CI were used to assess statistical significance. Results: Only 16.5% of all 182 pts treated with MTX, both orally and SC, achieved MDA. In the SC MTX group 25 pts (31%) achieved MDA, while 55 (69%) did not achieve it. In the oral MTX group 5 pts (5%) achieved MDA, while 97 (95%) did not achieve it. SC MTX treated significantly more often achieved MDA compared with those orally treated OR 8.8 [3.2-24.3]. Cumulative frequency of achieving MDA in 27 months from the treatment onset was 48% for SC administration, and 7% for the oral one (p<0.05). MTX median dose in SC administered pts who achieved MDA was 17 mg/week (wk), and 15 mg/wk in the group of pts who did not achieve MDA. Among orally administered pts who both achieved and did not achieve MDA the MTX dose was 15 mg/wk.

Disclosure of Interests: All authors have declared no conflicts of interest.

REFERENCES


Acknowledgement: This study was funded by Pfizer through an investigator-initiated grant.