SAT0377

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

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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, and 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 for 2270 patients (595 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,

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

	Women	Men	P value
n (%)	1047 (46.1)	1223 (53.9)	-
Age, years	48.3 (13.7)	48.8 (12.8)	0.42
Working full time*, n (%)	206 (49.4)	350 (68.6)	<0.01
Charlson Comorbidity Index score	1.10 (0.51)	1.15 (0.58)	<0.01
Time from first symptoms to diagnosis, years	1.48 (3.53) 4.87 (6.15)	1.14 (2.48) 4.95 (5.79)	0.76
PsA duration, years			0.42
Currently receiving biologic treatment, n (%)	557 (53.2)	674 (55.1)	0.38
BSA psoriasis involvement, mean%	5.5 (8.4)	5.5 (8.1)	0.87
Swollen Joint Count	3.2 (7.0)	3.5 (6.9)	0.39
Tender Joint Count	4.1 (5.2)	4.5 (8.0)	0.03
Enthesitis, n (%)	59 (5.6)	72 (5.9)	0.86
Dactylitis, n (%)	79 (7.5)	75 (6.1)	0.21

*Outside the home

disability, and work activity impairment than men (Table 2).

Table 2. Quality of life, disability, and work productivity in women and men [mean (SD)]

	Women	Men	P value
EQ5D utility score	0.80 (0.18)	0.82 (0.17)	0.02
HAQ-DI score	0.56 (0.60)	0.41 (0.52)	<0.01
PsAID12 score	2.66 (2.07)	2.27 (1.98)	<0.01
WPAI percentage of activity impairment	27.9 (22.0) 4.0 (14.0)	24.6 (22.4) 5.8 (19.2)	<0.01
WPAI percentage of work time missed			0.62

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.

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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

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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 elements (such as age, gender or country), disease activity components (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 univariable 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 or 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

concerned 112 (25.7%) patients, of whom 76 (17.4% of 436) self-reporting REM/LDA, and 36 (8.3% of 436) reporting not being in REM/LDA. When exploring drivers of this discordance in univariate analyses, tender joint count, CRP, pain, fatigue and depression were significant. The multivariate analysis found CRP, pain and depression to be independent drivers of discordance (Table).

Table. Factors associated to discordance between DAPSA-defined remission or low disease, and patient-defined remission or low disease, in multivariable regression.

Characteristic	Value in discordant patients, mean (SD)	Value in concordant patients, mean (SD)	Odds ratio (95% CI)
Model 1			
CRP, mg/l	2.8 (9.1)	1.1 (3.1)	1.06 (1.01, 1.12)
Pain (0-10)	4.9 (2.3)	3.9 (2.9)	1.14 (1.05, 1.23)
Model 2 without pain			
CRP, mg/l	2.8 (9.1)	1.1 (3.1)	1.06 (1.01, 1.12)
Depression (0-10)	2.8 (3.2)	2.1 (2.8)	1.08 (1.01, 1.16)

Conclusion: Remission or low disease appears to be an attainable outcome in PsA. Patients widely self-reported themselves as being in a similar status as the status indicated by the DAPSA score. Discordance in assessment concerned 25.7% patients and was mainly related to CRP (driving higher DAPSA), pain and fatigue (driving patient assessments). When faced with discordance in assessment, the health professional should assess these elements carefully.

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SAT0379

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

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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 results of 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-naïve. 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 at least 5 out of the following 7 domains: tender joint count ≤1, swollen joint count (SJC) ≤1, Psoriasis Area Severity Index (PASI) ≤1 or body surface area ≤3%, tender entheses 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 (Q25; Q75)], [Min; Max], ORs with 95% CI, Breslow, Long Rank, Tarone-Ware tests were performed. Cumulative frequency was computed using the Kaplan-Meier method. All CI >1, p <0.05 were considered to indicate 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 pts 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/weekly (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.

Cumulative frequency of achieving MDA after the SC and oral MTX treatment onset