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

Conclusion: In clinical practice, the sDMARD given to the majority of pts is MTX, but its use achieves the recommended treatment target of MDA only in 16.5% of pts. The SC MTX treatment significantly, up to 30%, improves the achievement of MDA. The use of SC MTX could be a therapy optimized option in clinical practice.

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SAT0380

FIBROMYALGIA IS THE STRONGEST NEGATIVE PREDICTOR FOR THE ACHIEVEMENT OF EITHER REMISSION AND MINIMAL DISEASE ACTIVITY IN NAIVE PSORIATIC ARTHRITIS PATIENTS STARTING BIOLOGIC DRUGS

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Background: There is evidence that fibromyalgia (FM) can increase the burden of disease in patients affected with psoriatic arthritis (PsA) and interfere with the assessment of clinical disease activity, but studies focusing the impact of FM on long-term clinical outcomes are lacking.

Objectives: We aimed at evaluating the impact of FM on the achievement of clinical remission or minimal disease activity (MDA) in naïve PsA patients on treatment with a first biologic drug in real life settings.

Methods: We retrospectively assessed PsA patients, fulfilling CASPAR criteria, from 1st January 2010 through 30th June 2017, starting a first biologic drug or apremilast. At baseline and at each visit thereafter, DAPSA, PASI, MDA, ASDAS-CRP, and HAQ were evaluated. Rate of patients achieving DAPSA based low disease activity (LDA) was assessed at 3 months, and MDA or DAPSA-remission at 12 months. LOCF method was carried out for those patients who did not reach 12 months follow-up or discontinue the treatment before 12 months. The persistence on the first treatment was evaluated by Kaplan-Meier survival curves. Estimated hazard ratios (HRs) of discontinuing therapy or achieving remission or MDA at last observation were assessed by a multivariate stepwise backward Cox regression model, adjusting for patient demographics (gender, age, BMI, comorbidities) and disease characteristics (co-therapy with MTX or glucocorticoids, DAPSA).

Results: Upon excluding pure axial PsA without peripheral involvement, 238 patients (126 female) with mean age 51 years (95% CI, 40-59), BMI 26 (95% CI, 23-30), disease duration 24 (95% CI, 10-60) months were analyzed. At baseline, 120 had polyarticular involvement (≥ 5 joints), 118 had oligoarticular pattern, and 64 had concomitant spine involvement. One hundred-fifteen began a treatment with anti-TNF-receptor, n.106 with anti-TNF-mAb, n.9 with ustekinumab, n.6 with apremilast, and n.2 with secukinumab. FM was diagnosed, according to both 1990 and 2019 ACR classification criteria, in 58 (female 74%) patients. Crude drug survival rate was significantly lower in FM-PsA patients (50%) (mean survival time (MST, 95% CI) 32 (25-38) months) than in PsA patients without FM (74%) MST 42 (38-45) months (log rank=15.6, p=0.0001) (Figure 1a). This large difference was also seen estimating drug survival by ineffectiveness, FM-PsA 58.6% (MST 35 (28-42) months) vs PsA 82% (MST 45 (42-48) months) (log rank=18.5, p=0.0001) (Figure 1b), but not by adverse events (data not shown). LDA at 3 months was reached by 78% of PsA patients and by 21% of FM-PsA patients (p=0.0001). At 12 months, MDA was achieved by 62% of PsA and only by 2% (1 out of 58) of FM-PsA (p=0.0001), and likewise remission was seen in 47% of PsA and in 2% of FM-PsA p=0.0001) Figure 2. FM was the only independent factor associated to drug discontinuation (HR 2.5, 1.6-4.1 (95% CI), or to the achievement of either MDA (HR 0.23, 0.1-0.5 (95% CI) and clinical remission (HR 0.26, 0.1-0.6 (95% CI), with the first biologic drug within the time span of the study.

Conclusion: Our findings clearly demonstrate the FM has a striking negative impact on clinical outcomes in PsA, as early as 3 months of treatment. Clinicians should be aware that treating PsA patients with comorbid FM is demanding, and appropriate patient shared strategies should be adopted in these settings.

Figure 1. Kaplan-Meier curves of crude drug survival (left) and by ineffectiveness in PsA patients with or without fibromyalgia.

Figure 2. Percentage of PsA patients with or without fibromyalgia achieving LDA-DAPSA at 3 months, and MDA or DAPSA-remission at 12 months.

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SAT0381

MINIMAL DISEASE ACTIVITY IN PSORIATIC ARTHRITIS PREDICTS LOW IMPACT OF DISEASE

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Background: Psoriatic arthritis (PsA) is the commonest form of inflammatory spondyloarthropathy with prevalence of 0.19% in UK. Patients suffering from PsA often have significant impact on daily life due to articular, non-articular and psychological symptoms. Minimal disease activity is an increasingly used target of therapy in both clinical trials and clinical practice.

Objectives: We aimed to assess relationships between physician and patient reported outcomes in routine clinical practice.

Methods: We performed a retrospective analysis of routinely collected patient reported and physician reported outcomes. We obtained clinical information of patients with PsA attending clinic from March 2018 to December 2018. Data was gathered from clinical letters (swollen and tender joint count, Leeds enthesitis index, Body surface area psoriasis), laboratory results (ESR, CRP) and questionnaire responses (HAQ, global assessments and PSAID12). Data were analysed using SPSS25. Logistic regression was used to assess patient reported outcomes which were associated with achieving MDA.

Results: Data were available for 205 patient visits. Presence of MDA could be evaluated at 187 patient visits (MDA n=60, Not MDA n=127).