- [2] Eder L, Thavaneswaran A, Chandran V, Cook R, Gladman DD. Increased burden of inflammation over time is associated with the extent of atherosclerotic plaques in patients with psoriatic arthritis. *Ann Rheum Dis*. 2015 Oct;74(10):1830-5.
- [3] Shang Q, Tam LS, Sanderson JE, Lee AP, Li EK, Yu CM. Impaired left ventricular apical rotation is associated with disease activity of psoriatic arthritis. *J Rheumatol*. 2014 Apr;41(4):706-13.
- [4] Blessberger H, Binder T. NON-invasive imaging: Two dimensional speckle tracking echocardiography: basic principles. *Heart*. 2010 May;96(9):716-22.

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SAT0386

PREVALENCE OF SUBCLINICAL CARDIOVASCULAR DISEASE IN PSORIATIC ARTHRITIS: A MULTICENTRIC STUDY

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Background: There are scarce data regarding subclinical vascular disease in psoriatic arthritis (PsA)(1). Similarly to rheumatoid arthritis, the real CVR could also be underestimated by clinical risk charts (2).

Objectives: To study the prevalence of subclinical vascular atheromatosis in patients with PsA; to analyze the association of carotid plaques with PsA characteristics; to identify which patients with intermediate or high clinical risk would be worthwhile to undergo carotid ultrasound to detect plaque.

Methods: Descriptive, transversal and multicentric study, of patients with clinical diagnose of PsA followed in 4 Spanish hospitals. Demographic data, classic CVR factors and clinical characteristics were recorded. The probability of a 10 years fatal cardiovascular event was calculated by SCORE charts adapted for Spain (3), and afterwards a systematic bilateral common carotid ultrasound (4) was conducted. The intima-media thickness of the carotid wall and the presence of atheroma plaque were registered. Patient's characteristics were described using descriptive analysis techniques. For univariate comparisons we used Chi2 and Anova. Multivariate analyses were conducted by logistic regression. The probability of plaque according to the age and the presence of CVR factors was calculated for patients with clinical intermediate or high risk by means of logistic regression. The study was approved by the Hospital General Universitario de Elda Ethic Committee (RCV-PS-MC/26/02/2016).

Results: 309 patients were included. The characteristics of the sample and the prevalence of CVR factors are depicted in Table 1. Patients were stratified by SCORE as follows: low risk 41 patients (13.3%), intermediate 182 (58.9%), high 75 (24.3%) and very high 11 (3.6%)

Table 1.. Clinical characteristics

Sex	Women 149 (48.2%), Men 160 (51.8%)
Age	54.8 (SD 12.5), median 55
Type of PsA	Axial: 94 (30.4%) Only axial: 18 (5.8%) Peripheral: 290 (93.9%) Only peripheral: 215 (69.6%) Axial and peripheral: 76 (24.6%)
Treatment	NSAIDs 31 (10%) cDIMARDs 124 (40.1%) bDIMARDs 151 (48.8%) Others (Aza, cyclosporin) 2 (0.6%)
PsA duration	125.1 months (SD 110.5)
Hypertension	89 (28.8%)
DM	45 (14.6%)
Dyslipidaemia	82 (26.5%)
Previous CV events	12 (3.9%)
BMI ≥30	110 (35.6%)
Tobacco	73 (23.6%)
Hyperuricemia	50 (16.2%)
Presence of CVR factors	
0 factors	107 (34.6%)
1 factor	108 (35%)
2 factors	60 (19.4%)
≥3 factors	34 (11%)

patients. Plaque criteria by ultrasound was found in 95 patients (30.7%), who were reclassified as very high risk. Final distribution after carotid ultrasound showed a decrease in all groups (12%, 43.7% and 14.2% in low, intermediate and high risk, respectively) with a consequent increase in the very high risk group (30.1%). In the univariate study, plaque was associated with age ($p<0.001$), diabetes ($p=0.004$), hypertension ($p=0.001$), hyperuricemia ($p=0.01$) and dyslipidaemia ($p<0.001$); any association with PsA characteristics wasn't found. In the multivariate analyses, plaque was associated with age >55 years (OR 2.84; IC 1.54-5.55), and with the number of classical CVR factors (OR 1.49; IC 1.13-1.97). In the presence of 3 or more risk factors, the probability of having plaque was 57.2% in patients with clinical intermediate risk and 61.8% in patients with high risk, and raised with increasing presence of CVR factors (Table 2).

Conclusion: Subclinical vascular disease is present in almost a third of the patients with PsA. SCORE tables may prove inaccurate for estimating the real CVR, and carotid ultrasound would be advisable in patients with intermediate or high risk who present any classical CVR factor.

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SAT0387

CONSISTENT EFFICACY IN PATIENT SUBGROUPS ACROSS BASELINE DEMOGRAPHICS AND DISEASE CHARACTERISTICS: RESULTS FROM A PHASE 2 STUDY OF GUSELKUMAB IN PATIENTS WITH ACTIVE PSORIATIC ARTHRITIS

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Background: Guselkumab (GUS) is a monoclonal antibody targeting interleukin-23 that has demonstrated efficacy in a phase 2 trial of psoriatic arthritis (PsA).¹

Objectives: Here subgroup analyses were conducted to evaluate the consistency of efficacy on the primary endpoint, ACR20 response.

Methods: In this randomized, double-blind, placebo-controlled, Phase-2 trial, pts with active PsA (≥ 3 tender, ≥ 3 swollen joints, C-reactive protein ≥ 3 mg/L, $\geq 3\%$ body surface area [BSA] of plaque psoriasis) despite current or previous treatment with standard-of-care therapies were randomized 2:1 to subcutaneous GUS 100 mg (n=100) or placebo (PBO, n=49) at Wk0, Wk4, and every 8 wks (q8w) through Wk44. At Wk16, pts with $<5\%$ improvement in both swollen and tender joints could escape early to open-label ustekinumab. Pts continuing PBO crossed-over to receive GUS 100mg at Wk 24, 28 then q8w through Wk44. The primary analysis was performed in a modified Intent-to-Treat (mITT) population which include all randomized subjects who received at least 1 administration of study agent based on their assigned treatment regardless actual treatment received. Pts who met treatment failure criteria, escaped early, or had missing data at Wk24 were considered non-responders for ACR20 at Wk24. Pre-planned subgroup analyses by demographic and disease characteristics at baseline and PsA medication use were performed, using the same data handling rules as in the primary analysis.

Results: At Wk24, 58/100 (58.0%) of pts in the GUS vs 9/49 (18.4%) in the PBO group achieved an ACR20 response ($p<0.001$). Efficacy was consistently observed in subgroups defined by demographics (gender, age, weight, region), disease characteristics at baseline (disease duration, PsA subtypes, tender/swollen joint counts, HAQ-DI, CRP, presence of dactylitis or enthesitis, PASI, and BSA) or PsA medication use (prior use of DMARDs or anti-TNFs, concomitant use of MTX, oral corticosteroids, or NSAIDs) (Table). The treatment effect was statistically significant in the majority of subgroups with the lower bound of the 95% confidence interval of the difference between GUS and PBO exceeding 0 in favor of GUS. There are a few exceptions where small sample sizes of the subgroups limited the interpretation. All enrolled subjects were white; therefore, the effect of guselkumab in other racial groups could not be assessed. Among GUS-treated pts, pts with enthesitis, dactylitis, PASI ≥ 12 , BSA $>10\%$, tender joint count ≤ 10 or swollen joint count ≤ 10 appeared to have numerically higher ACR20 response rate than those corresponding subgroups defined otherwise, although the sample size is small and the data should be interpreted with caution.