included in the definition of remission; general recommendations for out-patient visits and the use of disease activity scores.

Results: Agreement was reached for 56 of the 80 proposed items (70%). The panelists concluded that although a definition of remission in axSpA is not currently available, there is consensus that it is possible to achieve remission in this disorder. There was agreement that the definition of remission in axSpA should include: pain, fatigue, functional impairment, mobility, extra-articular manifestations, peripheral involvement, joint inflammation, disease activity, laboratory tests, quality of life, need for treatment, progression of the disease, and both physician and patient global assessments. It is recommended to set a therapeutic goal when starting treatment in patients with axSpA, the ideal objective being remission, but low disease activity (LDA) may also be acceptable as an alternative objective, being ASDAS the preferred tool to assess disease activity with cut-off values of < 1.3 for remission and ≥ 1.3 to < 2.1 for LDA. A proposal for clinical remission in axSpA based on the ASDAS cut-off value associated to the absence of extra-articular (psoriasis, uveitis, inflammatory bowel disease) and peripheral (arthritis, enthesitis, dactylitis) activity, as well as the absence of inflammation assessed by the normalization of CRP levels and absence of radiographic progression.

Conclusion: This work offers consensus recommendations and a proposal of clinical remission that may be useful in the management of patients with axSpA.

Disclosure of Interests: Xavier Juanola-Roura: None declared, Eduardo Collantes-Estevez: None declared, Jordi Gratacos-Masmitja Grant/research support from: Pfizer Inc, Consultant for: Pfizer Inc, Speakers bureau: Pfizer Inc, Cristina Fernández-Carballido: None declared, Pedro Zarco-Montejo: None declared

DOI: 10.1136/annrheumdis-2019-eular.2361

Psoriatic arthritis

AB0735

SAFETY AND EFFECTIVENESS OF USTEKINUMAB IN PSORIATIC ARTHRITIS. A MULTICENTRIC STUDY

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Background: Ustekinumab (UST) is an anti-interleukin (IL) 12/23 monoclonal antibody that has been shown to be effective and safe in psoriatic arthritis (PsA) in two phases III clinical trials. However, we have very few UST data in a real-life setting.

Objectives: To assess the effectiveness, safety and survival of UST among patients with PsA treated under routine clinical care.

Methods: Retrospective and multicentric study. Epidemiological and clinical data were collected through the electronic medical record of all patients with PsA who started UST due to rheumatological indication in 14 hospitals of Catalonia and the Balearic Islands (Spain).

Results: 152 patients were included, 116 (76.3%) with 45mg and 36 (23.8%) with 90mg. 55.9% were women, mean age 54.79 (12.5) years, and mean disease duration 209 months. 132 patients (87%) had oligo (30.3%) or polyarticular involvement (56.6%). 26.8% had enthesitis and 36.2% dactylitis. 48p(35.6%) had erosions. 94p (61.8%) had previously received another biological therapy, and 39 of them (38.8%) had received 2 or more. 54.6% of the patients were taking DMARDs and 39.5% glucocorticoids. The baseline DAS 28 was 3.97 (1.45), C reactive protein (CRP) was 2 mg/dl (2), SJC was 4.0 (5.4), and PASI was 6.5 (8.4). There were no significant differences in clinical and epidemiological data between patients at 45 or 90 mg except in obese patients (58.4% in

90mg vs 40% in 45mg, $p = 0.038$). Overall, there was a significant decrease in DAS28, SJC, TJC and PASI in the first month of treatment, with more pronounced improvement in skin (PASI and BSA) than in joints outcomes, where the curves reached a plateau at 6 months. There were no significant differences between joint and/or skin outcomes between 45 and 90 mg doses.

Patients naive to biological therapy had an earlier skin improvement than patients with previous biological failure. Likewise, the improvement in joint outcomes was also faster in naive vs biological experienced patients (DAS28 and SJC 4m, $p = 0.01$ and 0.01 , respectively).

After an average of 19m of follow-up, 94 out of 152p (61.8%) continued with UST, 54.4% started at 45mg and 72.2% at 90mg ($p = 0.04$). 42p (28.2%) stopped UST due to joint inefficacy, 8p (5.4%) for skin inefficacy and 4 (2.7%) for adverse effect. Although survival was better in patients with fewer previous biological agents, no significant differences were achieved ($p = 0.233$ for naive and $p = 0.072$ for patients with 1 biological failure).

Conclusion: This analysis demonstrates that UST, administered to PsA patients in a routine clinical care setting, is safe and effective in improving skin and joint outcomes. 61.2% of the patients continued with the treatment after an average of 19m of follow-up. Joint and skin outcomes reached significant differences from the first month. The efficacy seems faster in those patients with fewer lines of previous biological therapies. One third of the patients interrupted the therapy due to joint inefficacy.

Acknowledgement: JANSSEN

Disclosure of Interests: Ana Belén Azuaga-Piñango: None declared, Beatriz Frade-Sosa: None declared, Ana Laiz Consultant for: Lilly, Novartis, AbbVie, MSD, UCB and Janssen, Speakers bureau: Lilly, Novartis, AbbVie, MSD, UCB and Janssen, Paula Estrada: None declared, Luciano Polino: None declared, Emma Beltrán: None declared, Águeda Prior-Español: None declared, Lourdes Mateo Soria: None declared, Carme Moragues Pastor: None declared, Agustí Sellas-Fernández: None declared, ANA URRUTICOECHEA-ARANA: None declared, Mireia Moreno: None declared, Javier García Miguel: None declared, José L. Tandaipan: None declared, Manel Pujol: None declared, Vicenç Torrente Segarra: None declared, Inmaculada Ros Vilamajo: None declared, Sergi Ordoñez: None declared, Delia Reina-Sanz: None declared, Andrea Cuervo: None declared, Juan D. Cañete: None declared, Julio Ramirez: None declared

DOI: 10.1136/annrheumdis-2019-eular.4877

AB0736

GENDER INFLUENCE ON TREATMENT EFFECTIVENESS IN PSORIATIC ARTHRITIS

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Background: Gender has been lately suggested as influential in the response to treatment with biological drugs in spondyloarthritis, such as psoriatic arthritis (PsA). However, data about the association between gender and treatment response in axial PsA (axPsA) or peripheral PsA (pPsA) are scarce.

Objectives: To analyze the association between gender and clinical response to biological therapy in patients with axPsA and pPsA.

Methods: An observational cohort study was conducted, prospectively collecting data from 108 patients treated with biological therapy (93% TNFi and 7% IL-17i) from 2002-2018. Patients were divided into two groups according to their clinical predominant manifestation: axPsA or pPsA. Disease activity indexes (ASDAS and BASDAI for axPsA and DAPSA and DAS28 for PsA) were collected before starting drug and 6 months later (baseline and 6m visit, respectively). Low disease activity (LDA) was defined as ASDAS < 2.1 or BASDAI < 4 (axPsA) and DAPSA ≤ 14 or DAS28 ≤ 3.2 (pPsA). Clinical improvement was defined as an improvement ≥ 1.1 points in ASDAS (dASDAS) or 50% in BASDAI (BASDAI50) for axPsA, and an improvement of 50% in DAPSA (DAPSA50) or dDAS28 ≥ 1.2 . First, the frequency of male- and female-patients achieving LDA and clinical improvement at 6m were compared using Fisher test, separately for axPsA and pPsA. Second, the association between gender and each of the clinical outcomes was analyzed using logistic regression models adjusted for confounders (age, disease duration, previous biologics, smoking habit, body mass index (BMI), baseline DMARDs and baseline disease activity (ASDAS or BASDAI for axPsA and DAPSA or DAS28 for pPsA).

Results: Out of 108 included patients, 55 (51%) had predominant axPsA and 54 (49%) pPsA. In the group of axPsA, 35 (64%) were males, 33