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.

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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.

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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

(60%) were non-smokers, 33 (60%) had a BMI ≥ 25 , with mean (SD) baseline disease activity of ASDAS: 3.3 (1.0) and BASDAI: 5.4 (2.0). The frequency of patients achieving clinical response was higher in males than females (LDA: 74% vs 37%; $p=0.02$, respectively) (Table 1). After adjusting for confounders, male gender was significantly associated with higher probability of achieving LDA (ASDAS OR=4.4; $p=0.03$ and BASDAI OR=6.0; $p=0.01$), and clinical improvement (dASDAS: OR=4.8; $p=0.04$ and BASDAI50: OR=5.19; $p=0.03$). In the group of pPsA, 20 (37%) were males, 37 (68%) were non-smokers, 34 (63%) had a BMI ≥ 25 , with mean (SD) baseline disease activity indexes of DAPSA: 26 (14.9) and DAS 28: 4.8 (1.2). The frequency of patients achieving LDA was higher in males than females (74% vs 39%; $p=0.02$, respectively). After adjusting for cofounders, male gender was independently associated with higher probability of achieving LDA by DAPSA (OR=4.0; $p=0.03$) and DAS28 (OR= 2.1; $p=0.3$). Finally, an association between male gender and clinical improvement was also observed but this was statistically significant only when using dAS28 as the outcome: OR=2.9; $p=0.1$ for DAPSA50 and OR=5.8; $p=0.02$ dAS28.

Conclusion: Male gender is associated with a higher rate of response to biological treatment (TNFi and IL-17i) in both predominant articular manifestations: axPsA and pPsA. This association is robust despite using the new recommended disease activity indices and cut-off points for clinical practice. Further investigations of these gender-related differences are important for a better management of PsA.

Abstract AB0736 Table 1. Response rates after 6 months of biological therapy, stratified for PsA subtype and gender.

axPsA (n= 55)				pPsA (n= 54)			
	Males (n= 35)	Females (n= 20)	p-value		Males (n= 20)	Females (n= 34)	p-value
LDA							
ASDAS ≤ 2.1	25 (74 %)	7 (37 %)	0.02	DAPSA ≤ 14	14 (74 %)	12 (39 %)	0.02
BASDAI ≤ 4	24 (72 %)	5 (26 %)	0.02	DAS28 ≤ 3.2	13 (68 %)	6 (31 %)	0.09
Clinical Improvement							
dASDAS ≥ 1.1	20 (59 %)	7 (37 %)	0.15	DAPSA50	10 (53 %)	11 (36 %)	0.25
BASDAI50	16 (48 %)	3 (16 %)	0.04	dDAS28 ≥ 1.2	11 (57 %)	8 (42 %)	0.15

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AB0737 ACHIEVEMENT OF RAPID3 NEAR REMISSION OR LOW SEVERITY IS ASSOCIATED WITH RESIDUAL LEVELS OF ARTICULAR AND EXTRA-ARTICULAR MANIFESTATIONS OF ACTIVE PSORIATIC ARTHRITIS IN SUBJECTS TREATED WITH APREMILAST

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Background: The Routine Assessment of Patient Index Data 3 (RAPID3) is an outcome measure of disease activity widely used in the USA as part of routine care¹ and is entirely derived from patient self-reported measures (Health Assessment Questionnaire-Disability Index [HAQ-DI] or multidimensional HAQ [MDHAQ], Pain visual analog scale [VAS] and Patient's Assessment of Disease Activity [PtGA] VAS). However, the lack of more objective, traditional physician assessments, such as joint counts, may lead to residual active disease that will be missed.

Objectives: To examine trajectories for improvement in RAPID3 score over time and PsA manifestations not measured specifically by RAPID3

in subjects achieving RAPID3 near remission (REM) or low disease severity at Week 52.

Methods: Pooled analyses of the phase III PALACE 1, 2 and 3 studies were performed for subjects assigned to receive APR 30 mg twice daily (BID) at baseline (BL). Subjects with available scores on RAPID3 components (HAQ-DI, Pain VAS and PtGA VAS) at Week 52 were included and grouped according to RAPID3 categories at Week 52 (near REM: ≤ 3 ; low: >3 to ≤ 6 ; moderate: >6 to ≤ 12 ; and high: >12 to 30). Mean RAPID3 scores were assessed from BL through Week 52. Other measures of PsA disease activity were reported longitudinally by RAPID3 category at Week 52.

Results: The analysis included 376 APR subjects, with 42 with near REM and 42 with low severity at Week 52. Overall, mean RAPID3 trajectories improved overtime with greater mean improvements observed for those achieving RAPID3 near REM and low disease severity by Week 52. At a mean level, subjects in moderate RAPID3 at baseline were associated with achievement of RAPID3 near REM or low disease severity by Week 52 with APR (Figure). Many subjects who achieved RAPID3 near REM or low disease severity at Week 52 showed improvements in articular and extra-articular disease activity, although not all manifestations were controlled at Week 52 (Table); mean TJC was higher than expected in subjects achieving RAPID3 targets at Week 52 and there was no association between low mean RAPID3 and mean Psoriasis Area and Severity Index (PASI) scores.

Conclusion: At a mean level, subjects in moderate RAPID3 at baseline were associated with achievement of RAPID3 near REM or low disease severity targets with APR by Week 52. Achievement of RAPID3 targets was associated with improvement, but not necessarily control, of all articular and extra-articular manifestations. Complementing the RAPID3 measure with joint and skin assessments may help to evaluate achievement of treatment goals in clinical practice.

Includes subjects randomized at baseline who had RAPID3 components available at Week 52; data are as observed. RAPID3 near remission: ≤ 3 ; low severity: >3 to ≤ 6 ; moderate severity: >6 to ≤ 12 ; and high severity: >12 to 30. REM=remission.

Articular and Extra-Articular Disease Activity in Subjects With Low Severity or Near Remission RAPID3 Scores at Week 52

Mean	Near Remission at Week 52 n=42				Low Severity at Week 52 n=42			
	BL	Week 16	Week 24	Week 52	BL	Week 16	Week 24	Week 52
SJC (0-66)	10.2	3.9	3.2	1.6	8.4	4.4	2.5	2.1
TJC (0-68)	14.6	4.7	4.3	2.5	14.8	7.6	5.9	6.3
Pain VAS (0-100 mm)	45.8	16.8	11.7	5.7	45.4	24.7	22.5	19.4
PtGA VAS (0-100 mm)	44.1	26.6	17.4	7.2	44.9	28.6	23.3	15.4
PhGA VAS (0-100 mm)	48.5	20.3	19.1	12.8	50.8	24.5	15.7	15.4
PASI* (0-72)	9.4	4.8	4.5	5.2	6.9	3.8	3.4	2.4
MASES [†] (0-13)	2.7	1.1	0.7	0.9	3.6	2.2	2.2	2.0
Dactylitis count [‡] (0-20)	3.1	1.0	0.8	0.6	2.6	1.5	0.9	0.6
HAQ-DI (0-3)	0.7	0.2	0.2	0.0	0.9	0.5	0.4	0.3

Data are as observed and n values vary by time point based on number of subjects with available data for a given time point.

*Assessed in subjects with $\geq 3\%$ psoriasis-involved body surface area at BL. [†]Assessed in subjects with enthesitis at BL. [‡]Assessed in subjects with dactylitis at BL. MASES=Maastricht Ankylosing Spondylitis Enthesitis Score; PhGA=Physician Global Assessment of Disease Activity.

REFERENCES

- Coates LC, et al. Arthritis Care Res. 2018;70:1198-1205.

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