(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 ≥	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.

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AB0738

DUAL NEUTRALISATION OF INTERLEUKIN (IL)-17A AND IL-17F WITH BIMEKIZUMAB IN MODERATE-TO-SEVERE PLAQUE PSORIASIS: 60-WEEK RESULTS FROM A RANDOMISED, DOUBLE-BLINDED, PHASE 2B EXTENSION STUDY

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Background: Psoriasis is a chronic, systemic, immune-mediated inflammatory disease associated with prominent skin manifestations. One in four patients with psoriasis also has psoriatic arthritis,¹ with skin disease preceding joint manifestations in most patients.² Interleukin (IL)-17F shares structural homology and pro-inflammatory function with IL-17A. Preclinical and early clinical data support dual neutralisation of IL-17F, together with IL-17A, as a novel targeting approach for the treatment of immune-mediated inflammatory diseases. Bimekizumab, a monoclonal antibody that potently and selectively neutralises both IL-17A and IL-17F, is in development for the treatment of psoriasis, psoriatic arthritis and ankylosing spondylitis.³⁻⁵ In the 12-week BE ABLE 1 study (NCT02905006), bimekizumab provided rapid and substantial clinical improvements in patients with moderate-to-severe plaque psoriasis, with a safety profile consistent with previous bimekizumab studies.³

Objectives: The objectives of this Phase 2b extension study (BE ABLE 2; NCT03010527) were to assess the long-term safety and efficacy of subcutaneous bimekizumab every four weeks for an additional 48 weeks (60 weeks' total exposure).

Methods: BE ABLE 1 responders ($\geq 90\%$ reduction in Psoriasis Area Severity Index [PASI90] at Week 12) receiving placebo or bimekizumab 64mg, 160mg, 160mg (320mg loading dose [LD]) remained on the same dose; non-responders ($< \text{PASI90}$ at Week 12) were re-assigned from placebo/bimekizumab 64mg to 160mg or from 160mg/160mg (LD) to 320mg. Patients previously receiving bimekizumab 320mg/480mg received 320mg. The primary variable was the exposure-adjusted incidence rate (EAIR) of treatment-emergent adverse events (TEAEs); efficacy assessments were secondary.

Results: 217 patients were enrolled. Across all doses, BE ABLE 1 responders generally maintained complete or almost complete skin clearance for up to an additional 48 weeks: PASI90: 80–100%, non-responder imputation (93–100%, observed); PASI100: 70–83% (80–96%); Investigator's Global Assessment: 78–100% (98–100%). PASI100 was achieved by 33–76% (40–82%) of non-responders (Week 48). EAIR of TEAEs was 206.1/100 patient-years ($n=184/217$ [85%]). EAIR of serious TEAEs was 6.2/100 patient-years ($n=15/217$ [7%]); no serious TEAE was reported by >1 patient. The most frequent TEAEs were oral candidiasis and nasopharyngitis. No cases of suicidal ideation/behaviour, major adverse cardiac events, or inflammatory bowel disease were reported. No new safety findings were observed.

Conclusion: Nearly all BE ABLE 1 responders completing 60 weeks of bimekizumab treatment maintained complete or almost complete skin clearance, with a safety profile consistent with previous studies.³

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AB0739

THE PREVALENCE OF PSYCHOLOGICAL DISORDERS IN PATIENTS WITH SEVERE PSORIASIS WITH/WITHOUT PSORIATIC ARTHRITIS IN CLINICAL PRACTICE: DATA FROM A SINGLE DERMATOLOGICAL SETTING

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Background: Psoriatic arthritis (PsA) and Psoriasis (PsO) are associated with different psychological disorders. Depression is a risk factor for development of PsA among PsO patients (pts). Diagnosis of PsA in dermatological practice is still problematic. The prevalence of psychological disorders in patients with severe PsO with/without PsA are limited in the Russian Federation.

Objectives: To study the prevalence of anxiety, depression and fatigue in pts with severe PsO with/without PsA in a single dermatological setting.

Methods: 99 unselected pts (male-23/female-76) with severe plaque PsO, mean age 45.82 ± 14.04 years, BSA $56.35 \pm 9.11\%$, PASI 22.50 ± 5.13 were included. PsA was diagnosed by the CASPAR criteria. Anxiety, depression and fatigue were identified by the Hospital Anxiety Scale (HADS-A), HADS-Depression (HADS-D) and Functional Assessment of Chronic Illness Therapy (FACIT) (points) accordingly. The HADS-A/HADS-D was defined as normal - 0-7; presence of disorders - 8-10; psychiatric morbidity >11 points accordingly. FACIT 43.6 ± 9.4 matched with healthy control. The lower the level of FACIT corresponded to higher fatigue. The number of pts with FACIT ≤ 30 were calculated. All pts were treated with different synthetic DMARDs, mostly Methotrexate (subcutaneous 15-20 mg every week), biological DMARDs according local therapy according