Results: Overall, 398 pts were included in the analysis of the cumulative ABA period (213 received ABA from study Day 1; 185 completed initial randomisation to PBO and received ABA thereafter). Of these, 322 pts entered the LTE (initial randomisation: ABA, n=162; PBO, n=160) and continued to receive OL ABA beyond the 28-week OL period. Of 162 and 160 pts initially randomised to ABA and PBO, respectively, 19 (11.7%) and 21 (13.1%) pts discontinued ABA in the LTE. Median (range) number of ABA injections in the cumulative ABA period to end of LTE was 80 (1–133). Safety during the cumulative ABA period over 2 years is shown (Table 1); 6-month interval safety data will be available at time of presentation. In the LTE, there were 3 SAEs of infection (osteomyelitis, intervertebral discitis and cellulitis) and 3 pts discontinued due to infection (hepatitis A, Epstein-Barr virus, intervertebral discitis). No malignancies or deaths were reported, and no autoimmune events were reported as serious or led to ABA discontinuation during the LTE. AEs, SAEs and AEs of special interest occurred with a similar frequency regardless of concomitant MTX or prior TNF inhibitor (TNFi) use. The proportion of pts with anti-ABA antibodies during the cumulative ABA period was higher during the post-treatment period (≥ 22 days after last dose; 37.1% [91/245]) than in the on-treatment period (first treatment dose date to ≤ 21 days after last dose; 7.1% [28/392]). No apparent relationship between anti-ABA antibodies and efficacy in the on-treatment period or AEs suggestive of systemic immune reactions was seen.

Conclusion: Abatacept was well tolerated up to 2 years with no new safety signals during the LTE in this Phase III study in PsA. There was no impact of concomitant MTX use or prior TNFi exposure on the safety profile of abatacept. The occurrence of anti-abatacept antibodies had no impact on abatacept efficacy or safety.

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AB0764 USE OF IXEKIZUMAB IN A THIRD LEVEL HOSPITAL

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Background: Psoriatic arthritis (PsA) is a chronic inflammatory disease mediated by the immune system, which affects the musculoskeletal system and the skin. It is a disease with increased expression of TNF-alpha

and IL23/IL17 cytokines, which are therapeutic targets whose neutralization has a great impact on the control of the disease.

Ixekizumab is a monoclonal antibody inhibitor of IL-17 indicated for the treatment of moderate-severe psoriasis and PsA. Ixekizumab is administered subcutaneously every 4 weeks, and according to the latest studies, it is a well-tolerated drug and an effective treatment option with significant improvement in the quality of life of patients with cutaneous psoriasis and PsA.

Objectives: -Describe the clinical characteristics, tolerance, safety and survival of a cohort of patients diagnosed with psoriasis or PsA, who have started treatment with Ixekizumab.

-Correlate skin involvement and joint with the quality of life of the patient through the life questionnaire (DLQI) in patients treated with Ixekizumab.

Methods: An observational, cross-sectional and retrospective study was conducted on a cohort of 29 patients who started treatment with Ixekizumab in our hospital in the last year (2018). The data were obtained through the review of patients' medical records and through telephone contact to carry out quality of life questionnaires (DLQI).

Results: Twenty-nine patients were included, of which 22 were males (79.5%). The mean age of the patients was 47 years. Of the cases included, 22 of the patients presented cutaneous Psoriasis (75.8%), 6 of the patients with PsA (20.7%) and 1 patient presented with Dermatomyositis antiMDA 5 (3.5%). Of the 29 patients included, 24 (82.2%) did not present adverse effects. Of the 5 patients who presented adverse effects, in 100% of the cases they were mild. All patients had received prior therapy with disease modifying drugs (DMARDs), and 31% were naive to biological therapy. A total of 4 patients required concomitant therapy with corticosteroid treatment, 3 of them with PAs and 1 with dermatomyositis anti MDA 5. The average of the DLQI of the patients analyzed was 4 and an average PASI of 1 after the start of the treatment, obtaining an Overall improvement of the skin.

A statistically significant Pearson correlation of 0.895 was found between DLQI and PASI (dependent variable), with a strong degree of association. In which patients with a lower score in the DLQI had a lower PASI.

Regarding the pain produced by the autoinjector, measured according to the EVA scale, it was 2 (mild pain), and none would abandon the treatment for this reason. Of all the patients, 9.1% abandoned the treatment due to inefficiency.

Conclusion: The treatment with Ixekizumab presents some promising results in the treatment of cutaneous psoriasis and PsA.

Treatment with Ixekizumab presents a significant improvement in the quality of life of patients.

Ixekizumab is a well-tolerated drug with good efficacy in the short-medium term. It has also been shown to be a safe drug among the patients included in the study.

However, long-term studies with a larger number of patients are required to evaluate the efficacy and safety of Ixekizumab.

Disclosure of Interests: None declared

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AB0765 THE IMPACT OF PSORIASIS SEVERITY ON OUTCOMES AMONG PSORIATIC ARTHRITIS PATIENTS RECEIVING ADALIMUMAB

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Background: Psoriatic arthritis (PsA) is a heterogeneous, chronic, immune mediated disease associated with psoriasis (PsO). The American College of Rheumatology (ACR) and National Psoriasis Foundation (NPF) recently released a guideline for treatment of PsA, in which TNF inhibitors are recommended over IL-17 or IL-12/23 inhibitors in pts with active PsA.¹ The ACR/NPF conditionally recommend that IL-17 or IL-12/23 inhibitors may be used instead of TNF inhibitors in pts with severe PsO (defined as a psoriasis activity and severity index [PASI] ≥ 12 or a body surface area [BSA] of $\geq 10\%$).

Objectives: Evaluate the impact of PsO severity on clinical, functional, and structural outcomes among PsA pts treated with adalimumab (ADA) or placebo (PBO).

Table. Clinical, Functional, and Structural Outcomes Through 24 Weeks Among Adalimumab- and Placebo-treated Patients Having Severe* or Mild-to-Moderate* Psoriasis at Baseline Relative to the Overall Study Population.

n (%)	ADA 40 mg eow				PBO eow			
	Severe Ps (N=17)	Mild-to-Moderate Ps (N=66)	Mild-to-Moderate Ps (N=83)	Total study population (N=151)	Severe Ps (N=20)	Mild-to-Moderate Ps (N=60)	Mild-to-Moderate Ps (N=80)	Total study population (N=162)
MDA	5 (29)	29 (44)	34 (41)	53 (35)	3 (15)	6 (10)	9 (11)	11 (7)
DAPSA <4	4 (24)	19 (29)	23 (28)	33 (22)	1 (5)	1 (2)	2 (3)	4 (2)
DAPSA ≤4, ≥14	4 (24)	19 (29)	14 (17)	33 (22)	3 (15)	5 (8)	8 (10)	14 (9)
HAQ-DI ≤0.25	6 (35)	29 (44)	35 (42)	70 (46)	4 (20)	12 (20)	16 (20)	33 (20)
ΔHAQ-DI ≥0.22	12 (75)	43 (80)	55 (79)	99 (79)	5 (31)	16 (38)	21 (36)	52 (42)
ΔmTSS ≤0*	14 (82)	46 (70)	60 (72)	120 (79)	11 (55)	33 (55)	44 (55)	93 (57)
ΔmTSS ≤0.5*	16 (94)	54 (82)	70 (84)	132 (87)	12 (60)	41 (68)	53 (66)	111 (69)
PASI50*	14 (82)	42 (64)	56 (68)	N/A	3 (15)	8 (13)	11 (14)	N/A
PASI75*	8 (47)	35 (53)	43 (52)	N/A	1 (5)	3 (5)	4 (5)	N/A
PASI90*	7 (41)	24 (36)	31 (37)	N/A	1 (5)	2 (3)	3 (4)	N/A

All analyses are non-responder imputation, unless otherwise noted.
 *Severe psoriasis defined as PASI ≥12 AND BSA ≥10%; Mild-to-Moderate psoriasis defined as PASI <12 AND BSA <10%; Imputation using ranks of total Sharp score and 75th percentile; *PASI responses were only collected for patients with psoriasis involving >3% BSA at baseline; ADA: adalimumab; eow: every other week; PBO: placebo; Psoriasis: Minimal disease activity; DAPSA: disease activity index for psoriatic arthritis; HAQ-DI: health assessment questionnaire disability index; ΔHAQ-DI: change from baseline in HAQ-DI; ΔmTSS: change from baseline in modified total Sharp score.

Methods: Pts with baseline PASI and BSA available from ADEPT, a phase 3, randomized, double-blind, PBO-controlled trial of ADA 40 mg every other week, were included in this post hoc analysis.² Pts were sub-grouped based on baseline PsO severity (severe PsO: PASI ≥12 OR BSA ≥10%; mild-to-moderate PsO: PASI <12 AND BSA <10%), relative to overall study population. Clinical outcomes at wk 24 were assessed by attainment of minimal disease activity (MDA), remission and low disease activity (LDA) by disease activity index for psoriatic arthritis (DAPSA), and PASI50/75/90; function and structural progression were assessed by the % of pts experiencing HAQ-DI normative values (≤0.25) and improvement from baseline ≥0.22 (MCID), and the % of pts having change from baseline in mTSS ≤0 and ≤0.5 in the modified total Sharp score (mTSS) respectively. A logistic model with treatment group baseline PASI/BSA and PASI/BSA by treatment interaction was fit for each outcome variable. *P*-values for interaction term and baseline BSA/PASI were calculated. Non-responder imputation was used for missing clinical and functional endpoints. 75th percentiles were imputed for missing radiographic data. Treatment-emergent adverse events (TEAEs) were monitored throughout.

Results: Of the 163 pts enrolled in the study with baseline PASI and BSA, only 23% (n=37; ADA: 17; PBO: 20) were classified as having severe PsO and had similar characteristics to those with mild-to-moderate PsO, except for numerically higher physician's global assessment, dactylitis, and enthesitis scores. Following 24 wks of treatment, 41% of ADA-treated pts achieved MDA and 45% achieved DAPSA LDA or better, a finding consistent irrespective of baseline PsO severity (Table). 72% of ADA-treated pts with baseline PsO did not exhibit any structural progression by mTSS (≤0) through 24 wks as compared to 55% receiving PBO. Logistic regression analyses confirmed limited role that PsO severity played across examined outcomes. DAPSA remission was more likely at wk 24 among pts with higher baseline PASI scores, and this effect was less apparent with ADA treatment. TEAEs appeared comparable between ADA and PBO groups; fewer infectious AEs occurred in the ADA severe PsO group vs the mild-to-moderate PsO group.

Conclusion: Prevalence of severe PsO in this population of PsA pts was consistent with previous observations.³ Treatment with ADA was associated with better PsA outcomes as compared to PBO irrespective of the degree of PsO severity at baseline.

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AB0766 EVOLUTION OF BONE MINERAL DENSITY IN PATIENTS WITH PSORIATIC ARTHROPATHY

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Background: Some studies indicate that psoriatic arthritis (PsA) patients have increased bone loss due to chronic inflammation, but data in the Spanish population is scarce.

Objectives: To study the evolution over time of bone mineral density (BMD) in patients with PsA and to investigate the factors related to these changes.

Methods: We included PsA patients with peripheral joint involvement. They were treated at the Doctor Peset University Hospital and a 3-year follow-up was carried out.

All patients underwent a bone densitometry and history of fracture was collected by conventional radiology at baseline and at 3 years. Phosphocalcic metabolism was also analyzed. We collected demographic and clinical variables [disease duration, DAS28, body mass index (BMI), smoking]. We considered 25OHD as deficient if <20 ng/ml, low bone mass as T or Z scale <-1 SD and osteoporosis as scale T <-2.5 DE or Z <-2 SD. Statistical analysis were performed with SPSS 22.0 program.

Results: We included 91 patients (67.2% women), with a mean age of 56.4 (SD 1.2) years. The mean of disease duration was 104.9 (SD 11.8) months. The BMI mean was 27.6 (SD 0.5) and 36.3% of patients were smokers. 25OHD mean was 27.7 (SD 1.3) ng/ml and 33.3% of patients had a deficient 25OHD. More than half of the patients (53.8%) had low bone mass and 14.3% had osteoporosis, measured by densitometry. Twelve patients had history of fractures [6 distal forearm, 5 vertebral fractures (VF) and 1 of femur]. Thirteen patients received antiresorptive treatment [9 bisphosphonates, 3 denosumab and 1 selective estrogen receptor modulator (SERM)], and 39.6% of patients received 25OHD supplements. We did not observe any significant correlation between the 25OHD values and the activity parameters of the PsA. However, we observed lower levels of 25OHD in obese patients. At 3 years, the BMD remained stable in the majority of patients (68.1%) receiving antiresorptive treatment, and it worsened in 2 patients despite treatment with bisphosphonates. We registered new fractures in 7 patients (4 VF, 1 femur fracture and two patients had more than one fracture). New fractures were not correlated with age, 25OHD deficiency or with previous osteoporotic treatment. We observed greater progression of BMD in patients exposed to tobacco.

Conclusion: More than half of patients with PsA have a low BMD (53.8%) and 33.3% deficient levels of 25OHD. Our study confirms results found in general population: classic risk factors, such as smoking, are related to BMI progression. It is important to evaluate BMD in these patients and intervene early.

Disclosure of Interests: None declared

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AB0767 MULTI-SYMPTOM IMPACT ON THE EQ-5D INDEX IN BIO-NAÏVE ACTIVE PSORIATIC ARTHRITIS PATIENTS: AN ANALYSIS THROUGH WEEK 24 OF THE GO-VIBRANT STUDY

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Background: Psoriatic arthritis (PsA) is a chronic inflammatory disease characterized by peripheral arthritis, axial inflammation, dactylitis, enthesitis and skin and nail psoriasis. The impact of skin and joint components of the disease on patient health-related quality of life has been described in