previous research (1,2) but the impact of other major clinical manifestations has not been similarly characterized.

Objectives: To quantify the impact of the major clinical manifestations of PsA on patient reported health related quality of life, as estimated by disease state preference (utility) derived from the EQ-5D index in a randomized clinical trial.

Methods: This analysis used data from a multicenter, randomized, double-blind, placebo-controlled trial of intravenous (IV) Golimumab in biologic naïve patients with active psoriatic arthritis (GO-VIBRANT study). Patient baseline characteristics of the GO-VIBRANT study population have been previously described (3). Core outcome measures recommended by OMERACT (Outcome Measures in Rheumatology Clinical Trials) and guideline on utility mapping by ISPOR (International Society for Pharmacoeconomics and Outcome Research) were used to guide initial attribute selection. Utility was derived from patient responses to the EQ-5D index, which assesses mobility, self-care, usual activities, pain/discomfort, and anxiety/depression, and was completed at weeks 0, 8, 14, and 24 in the trial (placebo-controlled period). EQ-5D index is used as a measure of overall health and is an outcome commonly used in health economic analyses. Multivariate analysis was performed using a Mixed-Effect Repeated Measures model based on observed data until week 24 in pooled patient population.

Results: Based on univariate analyses and evaluation of collinearity between variables, the following attributes were included in the multivariate models: age, gender, region, PsA disease duration, PASI score, enthesitis, dactylitis, tender joint count (TJC), swollen joint count (SJC), C-reactive protein (CRP mg/L) and Health Assessment Questionnaire-Disability Index (HAQ-DI). In the final model, PASI score ($\beta = -0.00126$, $p = 0.0006$), enthesitis ($\beta = -0.01237$, $p = 0.03$), TJC ($\beta = -0.00112$, $p < 0.0001$), CRP ($\beta = -0.00079$, $p < 0.0001$) and HAQ-DI ($\beta = -0.1664$, $p < 0.0001$) were all statistically significantly associated with the EQ-5D index. A sensitivity analysis among a subgroup of patients who had spondylitis with peripheral joint arthritis as their primary arthritic presentation of PsA showed that spinal pain ($\beta = 0.0101$, $p < 0.0001$), as measured by question #2 of the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), was also statistically significantly associated with the EQ-5D index in the multivariate model.

Conclusion: Multiple PsA clinical manifestations including psoriasis, enthesitis, TJC, spinal pain, CRP, and physical function were statistically significantly associated with utility among PsA patients as derived from the EQ-5D index. These findings indicate that consideration of multiple clinical manifestations of PsA is warranted when evaluating the impact of PsA on patients.

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AB0768

BASILINE PAIN SEVERITY AS A PREDICTOR OF PAIN IMPROVEMENT FOLLOWING TREATMENT WITH TOFACITINIB IN PSORIATIC ARTHRITIS

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Background: Pain is a core domain of psoriatic arthritis (PsA).¹ Rapid, sustained pain reduction is a priority for patients (pts) and physicians when choosing treatment. Tofacitinib is an oral Janus kinase inhibitor for the treatment of PsA.

Objectives: This post hoc analysis aimed to estimate time to clinically meaningful pain improvement with tofacitinib.

Methods: Data were analysed from 2 Phase 3 studies of tofacitinib in pts with active PsA and an inadequate response to ≥ 1 conventional synthetic disease-modifying antirheumatic drug (csDMARD) (OPAL Broaden; NCT01877668; 12-month study), or to ≥ 1 tumour necrosis factor inhibitor (OPAL Beyond; NCT01882439; 6-month study). Pts treated with tofacitinib 5 mg twice daily (BID) and placebo (PBO) advanced to tofacitinib 5 mg BID at Month 3 (PBO-tofacitinib), in combination with csDMARDs, were included in this analysis. Current arthritis pain severity was reported by pts using a 100 mm visual analogue scale, where higher scores indicated greater severity of pain. Pain improvement was defined as the first post-baseline improvement of $\geq 30\%$ (meaningful change), $\geq 50\%$ (substantial change) or $\geq 70\%$ relative to baseline.² Time-to-event analyses were performed using a Kaplan-Meier (KM) method on pooled data. Descriptive analyses of the rate of improvements by study were performed.

Results: Overall, 354 pts were available for analysis. Rates of pain improvement over time with tofacitinib 5 mg BID were approximately the same in both studies (Figure). By Month 1, $\geq 40\%$ of pts experienced $\geq 30\%$ pain improvement, and by Month 2, approximately 55% of pts experienced $\geq 30\%$ pain improvement (Figure). KM analyses showed that pts receiving tofacitinib 5 mg BID achieved improvements in pain severity of 30–70% significantly faster compared with pts in the PBO-tofacitinib group (Table). The median time to $\geq 30\%$ pain improvement was 55 days in the tofacitinib 5 mg BID group and 106 days in the PBO-tofacitinib group (pts switched to tofacitinib 5 mg BID at Month 3; $p = 0.0132$). Similar trends between treatment groups were observed across other pain improvement thresholds.

Table. Median time (days) to clinically meaningful pain improvement by improvement threshold in pts with PsA

VAS pain improvement threshold	Median time (days) to pain improvement		Test of equality between groups Log-rank test, p value
	Tofacitinib 5 mg BID	PBO switching to tofacitinib 5 mg BID at Month 3	
$\geq 30\%$	55	106	0.0132
$\geq 50\%$	85	169	0.0068
$\geq 70\%$	184	337	0.0033

Derived using non-parametric KM (nonparametric) models for time to event
BID, twice daily; KM, Kaplan-Meier; PBO, placebo; PsA, psoriatic arthritis; pts, patients; VAS, visual analogue scale

Figure. Proportion of pts receiving tofacitinib 5 mg BID with $\geq 30\%$ improvement in pain, by study

BID, twice daily; pts, patients

Conclusion: In pts with active PsA, faster, clinically meaningful pain improvements were reported in pts receiving tofacitinib 5 mg BID vs pts receiving PBO who switched to tofacitinib 5 mg BID at Month 3. After switch from PBO to active treatment, pain improvement was observed in line with pts receiving active treatment from Day 0. To achieve pain improvement at greater thresholds, longer duration of active treatment was required.

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AB0769

PATIENT IDENTIFIED TREATMENT GOALS IN PSORIATIC ARTHRITIS: DECREASING PAIN AND INCREASING ACTIVITY LEVEL ARE HIGH PRIORITIES

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Background: Treatment goals for physicians are primarily focused on improving musculoskeletal and cutaneous signs and symptoms of psoriatic

disease. Studies have reported that perceptions of psoriatic arthritis (PsA) disease control are often divergent between patients and physicians. Moreover, specific patient goals are uncommonly discussed or elicited in routine clinical practice.

Objectives: To examine patient reported treatment goals through direct questioning on what they most want to improve about their disease and how an effective treatment would improve their lives.

Methods: Patients in the Psoriatic Arthritis Research Consortium (PARC) completed standardized assessments between 2017-2018. PARC is a longitudinal observational cohort study conducted at four institutions in the United States: University of Pennsylvania, Cleveland Clinic, New York University, and University of Utah that includes a range of patient and physician disease measures. Answers to two open-ended questions (questions included on figures) were qualitatively categorized into response categories and descriptively reported in this cross-sectional study. While patients were encouraged to provide the one best answer, many listed multiple themes. We also examined differences in responses by gender, self-identified race (Caucasian vs not Caucasian), and whether a change in disease modifying anti-rheumatic drug was recommended (yes/no) on the date the questionnaire was completed.

Results: Among 82 patients with PsA enrolled, mean age was 48.3 (SD 13.2), 38 (46%) were female, and 57 (70%) of patients were changing therapy. The mean swollen (0-66) and tender (0-68) joint counts were 4.3 (SD 6.0) and 8.5 (12.2) respectively, mean psoriasis body surface area was 3.2% (SD 10.0), and mean physician and patient global assessments were 4.6 (SD 2.0) and 4.7 (2.6) respectively. Patient answers to the two questions are shown in the Figures. Decreasing pain was the most commonly cited goal for improvement (56%) with skin improvement the second most commonly reported goal for improvement (12%). Goals for successful therapy were more diverse. Decreasing pain was still most common (24%) but general improvement in life (18%), the ability to be more active (15%), participate in recreational activities (9%), function at work (11%) and exercise (5%) were common responses. There were no significant differences in responses according to race, or therapy change. However, all patients reporting fatigue or enjoyment as important outcomes for improvement were women.

Conclusion: In order to inform goals of care for patients with PsA, both physician and patient treatment goals should be defined to achieve optimal treatment success. In this study, while the majority of patients reported pain and activity as the most important outcomes for improvement, patient goals were heterogeneous. This underscores the importance of eliciting patient treatment goals on a regular basis to best individualize management in PsA.

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