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Table. Fingernail (f)-PGA score of clear (0) or minimal (1) in Psoriasis Patients with Self-Reported PsA at Wk 48*

	Guselkumab	Adalimumab
PsO Patients randomized at Week 0, n	329	334
PsO Patients with Self-reported PsA, n	64	62
Patients with f-PGA score >2 at baseline	40	40
f-PGA score of clear (0)	20 (50.0%)	16 (40.0%)
f-PGA score of clear (0) or minimal (1)	33 (82.5%)	23 (57.5%)
Percent improvement from baseline in NPSI Scores in Psoriasis Patients with Self-Reported PsA at Wk 48*		
	Guselkumab	Adalimumab
PsO Patients randomized at Week 0, n	825	582
PsO Patients with Self-reported PsA, n	153	106
NPSI (N)	111	74
Mean (SD)	70.84 (40.49)	61.25 (42.43)
Median	100.00	70.85
Range	(-100.0; 100.0)	(-50.0; 100.0)
IQ range	50.00; 100.00)	(33.30; 100.00)

*-Post-hoc analyses based on Voyage 1 only

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AB0773

PSORIATIC ARTHRITIS IMPACT OF DISEASE QUESTIONNAIRE SCORES ARE CORRELATED WITH DISEASE ACTIVITY, AS MEASURED BY CDAPSA, IN PATIENTS WITH PSORIATIC ARTHRITIS

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Background: LAPIs-PsA is an ongoing, national, 52-week, multicenter, prospective, non-interventional study assessing long-term treatment with apremilast (APR) in adult patients with active psoriatic arthritis (PsA) in routine clinical practice in Germany.

Objectives: The current interim analysis assesses the clinical effectiveness of APR, as measured with the Clinical Disease Activity Index for PsA (cDAPSA) and its core components, as well as PsA health-related quality of life (HRQoL), measured with the 9-domain PsA Impact of Disease Questionnaire (PsAID9). In addition, correlations between cDAPSA and PsAID9 were assessed.

Methods: The interim analysis included data obtained at baseline (BL), Visit 1 (V1; ≥1 month), Visit 2 (V2; ≥4 months) and Visit 3 (V3; ≥7 months); all available data for patients treated with APR 30 mg twice daily were included in the analysis. A subgroup analysis was performed among patients categorized by cDAPSA disease activity scores at BL. Clinical characteristics and disease assessments at BL and V1-3 were assessed. Mean PsAID9 scores and proportions of patients meeting the PsAID Patient-Acceptable Symptom State (PASS), defined as a PsAID9 score of 4, were assessed by cDAPSA category at BL. Analyses are based on data as observed at each visit. Pearson's correlations were calculated between cDAPSA and PsAID9 at BL, V1, V2 and V3.

Results: A total of 394 patients were included in the analysis population (mean age: 55.1 years; female: 55.1%; previous biologic use: 25.4%). At BL, patients had a mean PsAID9 score of 5.3 and a mean cDAPSA score of 26.6. Continuous improvements in swollen/tender joint counts and patient-reported pain and disease activity were observed with continued APR treatment (Table). Patients reported incrementally reduced mean cDAPSA scores and consistent improvements in PsAID9 scores from BL to V3. Patients with low disease activity (cDAPSA >4 to ≤13) at BL had

a mean (SD) PsAID9 score of 3.4 (1.7) with 71.1% in PsAID PASS (Figure). Those with moderate (cDAPSA >13 to ≤27) and high (cDAPSA >27) disease activity had mean (SD) PsAID9 scores of 5.3 (1.9) and 6.1 (1.8), with 26.6% and 11% showing PsAID PASS, respectively. At follow-up visits, greater proportions of patients achieving cDAPSA low disease activity or remission also achieved PsAID PASS (Figure). Significant moderate to high correlations were observed between cDAPSA and PsAID9 at BL (Pearson's coefficient $r=0.43$), V1 ($r=0.51$; $P<0.0001$), V2 ($r=0.64$; $P<0.0001$) and V3 ($r=0.64$; $P<0.0001$).

Conclusion: Results from this observational PsA study of APR demonstrate a significant correlation between disease activity, as assessed by cDAPSA, and PsA-specific life impact/HRQoL, as measured by PsAID9. More patients met the PsAID PASS cutoff while achieving remission or lower disease activity, and improvements in PsA disease activity are associated with the PsAID PASS from a life impact perspective.

Clinical Characteristics and Disease Assessments at Visits								
	V0 (BL) N=394*		V1 (≥1 Month) N=313*		V2 (≥4 Months) N=359*		V3 (≥7 Months) N=265*	
	n [†]	Mean (SD)	n [†]	Mean (SD)	n [†]	Mean (SD)	n [†]	Mean (SD)
SJC (0-66)	337	4.7 (4.5)	249	2.9 (3.7)	262	2.7 (4.8)	184	1.2 (2.2)
TJC (0-68)	363	10.4 (10.6)	274	7.0 (9.8)	289	5.8 (9.0)	203	4.3 (8.1)
Pain (VAS 0-100 mm)	389	52.7 (22.9)	295	46.2 (23.3)	320	40.2 (25.1)	222	37.2 (25.8)
PIGA (VAS 0-100 mm)	387	55.7 (22.5)	287	45.0 (24.0)	317	38.2 (26.5)	223	36.1 (26.0)
cDAPSA (0-154)	323	26.6 (14.8)	230	19.2 (13.8)	232	15.7 (13.3)	157	12.2 (10.7)
PsAID9 (0-9)	378	5.3 (2.0)	278	4.7 (2.1)	299	4.0 (2.2)	212	3.7 (2.2)

Data as observed. *Number of patients evaluated at each visit. †Number of patients with data for the given assessment at both BL and post-BL (V1, V2 and V3). SJC=swollen joint count; TJC=tender joint count; VAS=visual analog scale; PIGA Patient's Global Assessment of Disease Activity.

Visit 1: ≥1 month; Visit 2: ≥4 months; Visit 3: ≥7 months. Data as observed. Includes patients with both cDAPSA and PsAID values available at each visit. Mod=moderate disease activity.

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AB0774

PREDICTORS OF SWITCHING IN A RETROSPECTIVE ITALIAN COHORT OF PSORIATIC ARTHRITIS PATIENTS RECEIVING BIOTECHNOLOGICAL DRUGS FOR AT LEAST 3 YEARS

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Background: Psoriatic Arthritis (PsA) is a chronic inflammatory disease typically treated, in its moderate-severe form, with biologic disease-modifying antirheumatic drugs (bDMARDs). However, refractory patients are not infrequent, and they are commonly managed by switching from one bDMARD to another. Since the chance of observing a good clinical response decreases according to line of treatment, it would be important