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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

¹Ana-Maria Orbai¹, Klaus Krueger², Frank Behrens³, Uta Kiltz⁴, Benoit Guerette⁵, Lillian Mellars⁵, Michele Brunoni⁵, Jurgen Wollenhaupt⁶. ¹Johns Hopkins Arthritis Center and Johns Hopkins University School of Medicine, Baltimore, United States of America; ²Rheumatologische Praxis München, München, Germany; ³Division of Rheumatology, Goethe University and Fraunhofer IME-TMP, Frankfurt, Germany; ⁴Rheumazentrum Ruhrgebiet, Herne and Ruhr-University of Bochum, Bochum, Germany; ⁵Celgene Corporation, Summit, United States of America; ⁶Schön Klinik Hamburg Eilbek, Klinik für Rheumatologie, Hamburg, Germany

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

Augusta Ortolan, Pamela Polito, Federico Benetti, Mara Felicetti, Mariagrazia Lorenzin, Roberta Ramonda. *Rheumatology Unit, Department of Medicine DIMED, University of Padova, Padova, Italy*

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

to recognize from the beginning patient prone to switching, in order to adopt tight-control strategies to optimize treatment.

Objectives: Our aim was to compare characteristics of patients who could maintain the same bDMARD over time (non-switchers) with those of refractory patients in whom bDMARD switch was necessary (switchers), and to evaluate predictors of switching.

Methods: PsA patients attending the Rheumatology Unit of University of Padova, classified according to CASPAR criteria and starting a first line bDMARD, were enrolled in the present retrospective study. We only included patients who maintained a bDMARD regimen (with or without switching) for at least 3 years, to ensure more complete follow-up data. Demographic data, comorbidities, clinimetric and anthropometric indexes, collected at baseline and once a year for every follow-up year and registered in the patient's records, were used. Disease activity was evaluated through Disease Activity in Psoriatic Arthritis (DAPSA), Leeds Enthesitis Index (LEI), Psoriasis Area and Severity Index (PASI). An overall Body Mass Index (BMI) category, summarizing data from the whole follow-up, was assigned to each patient, according to the BMI category which recurred more frequently in the patient's record. Then the variable was treated as categorical grouping underweight and normal-weight patients (base category), overweight and class I obesity (2° category), and class II and III obesity (3° category). Baseline characteristics for switchers and non-switchers were compared through chi-square or Fisher exact test, for categorical variable and t-test or Mann-Whitney test, for continuous variable, as appropriate. Logistic regression analysis was conducted to assess predictors of therapeutic switch. All variables associated to the outcome with a $p < 0.2$ at univariate analysis were included in the initial multivariable model. Backward selection was applied to select the most significant predictors.

Results: One-hundred-eighty-nine PsA patients were enrolled with a mean follow-up time of 7.0 ± 3.5 years. Their characteristics at the beginning of bDMARDs therapy are outlined in Table 1. Among the patients, 51 became switchers and 138 remained non-switchers. Their baseline features did not differ significantly, with the only exception of LEI, higher in switchers (0.5 ± 1.0 vs 0.2 ± 0.6 , $p = 0.05$). When predictors of switch were evaluated, the independent variables positively associated to the outcome at univariate analysis with $p < 0.2$ were: male sex (OR 1.57; 95% CI 0.82, 2.99), BMI (OR 1.58; 95% CI 0.08, 3.08 for the II and III class obesity together with respect to normal-weight patients), inflammatory bowel disease (OR 5.59; 95% CI 0.49, 63.04), baseline PASI (OR 1.10; 95% CI 0.96, 1.26), baseline LEI (OR 1.45; 95% CI 0.98, 2.14), baseline DAPSA (OR 1.01; 95% CI 0.99, 1.03). In the multivariable model, only BMI (5.03; 95% CI 1.10, 22.89 for the II and III class obesity together with respect to normal-weight patients) and LEI (OR 1.46; 95% CI 1.00, 2.18) were able to independently predict the odds of switching.

Conclusion: Obesity and enthesal involvement, as expressed by LEI, seem to be the most useful predictor in order to identify patients who are more likely to switch, in line with data from literature that highlight a lower response of bDMARDs in obese patients.

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AB0775

EFFECTIVENESS AND SAFETY OF USTEKINUMAB 90 IN PATIENTS WITH PSORIATIC ARTHRITIS. REAL WORLD EVIDENCE STUDY

¹Estefanía Pardo Campo^{*}, José Andrés Lorenzo Martín¹, Liliyan Consuelo Charca Benavente², Sara Alonso Castro², Mercedes Alperi-López², Luis Marcelino Arboleya Rodríguez², Francisco Javier Ballina-García², Rubén Queiró Silva². ¹Hospital Universitario Central de Asturias, Oviedo, Spain; ²Hospital Universitario Central De Asturias, Oviedo, Spain

Background: Ustekinumab (UST) is a drug with proven efficacy in two randomized clinical trials in psoriatic arthritis -PsA- (PSUMMIT I and II). The data from these trials suggest that the 90 mg dose may be better than the 45 mg dose. Studies real world evidence (RWE) show that UST is effective and safe, nevertheless most of the evidence is base on the 45mg dose.¹

Objectives: Our objective has been to check the effectiveness and safety of UST 90 mg in patients with PsA in RWE conditions.

Methods: An observational study in RWE conditions was driven. We included 58 patients (37 women, 21 men, age 55 ± 8.7 years) with PsA from a single university hospital. All patients met CASPAR criteria. The observation period was from July 2017 to the present. All patients

received the 90 mg dose from the beginning. The average BMI was 29.9 ± 4.41 . 50% of patients were obese. To measure the disease activity, the DAPSA index was used. A descriptive statistic was performed and the McNemar test was used to analyse the mean change of the DAPSA (final-basal). A bivariate analysis was performed to identify associated factors with a DAPSA remission/low activity.

Results: The duration of psoriasis was 14.8 ± 12.8 years, and 6.3 ± 6.5 years for the arthritis. 34.5% were oligoarticular forms, 13.8% polyarticular forms, and the remaining 51.7% were mixed forms. The distal interphalangeal joints synovitis was present in 38% of the patients and dactylitis in 24%. 17 patients were naive to biologic drugs (29.3%), UST was second line in 25.9%, third in 32.8%, fourth in 10.3% and fifth in 1.7% of patients. Half of the patients were treated with MTX. In the baseline situation, 9.4% had low activity, 75% had moderate activity, and 15.6% had high activity by DAPSA index. At the end of the analysis, 12.5% were in remission, 59.4% in low activity, and 28.1% in moderate activity, according to the DAPSA index. There were no patients in high activity. That is, 72% were in DAPSA remission/low activity. The average reduction of DAPSA was 9.53 ± 5.52 (McNemar's $p < 0.0005$). The only factor associated with remission/low DAPSA activity was baseline DAPSA, OR 1.51 (1.02-2.22), $p = 0.044$. In 6 patients, the drug was discontinued (4 due to lack of efficacy and 2 due to poor tolerance or adverse effects).

Table 1. Baseline demographic and clinical characteristics of patients

Age (years), mean $\pm$ SD	54.6 $\pm$ 11.8
Male sex, n (%)	108 (57.1)
Disease duration (years), mean $\pm$ SD	16.2 $\pm$ 8.8
Family history of psoriasis, n (%)	168 (88.9)
Family history of arthritis, n (%)	181 (95.8)
IBD, n (%)	3 (1.6)
Uveitis, n (%)	3 (1.6)
Dactylitis, n (%)	15 (8.0)
LEI (0-6), mean $\pm$ SD	0.4 $\pm$ 0.8
PASI (0-72), mean $\pm$ SD	1.9 $\pm$ 2.2
HAQ (0-3), mean $\pm$ SD	0.8 $\pm$ 0.7
PCR (mg/L), mean $\pm$ SD	8.8 $\pm$ 11
DAPSA, mean $\pm$ SD	28.6 $\pm$ 18.2
BMI, mean $\pm$ SD	25.6 $\pm$ 4.6
CCI, mean $\pm$ SD	1.5 $\pm$ 1.4

IBD, Inflammatory Bowel Disease; LEI, Leeds Enthesitis Index; PASI, Psoriasis Area and Severity Index; HAQ, Health Assessment Questionnaire; CRP, C Reactive Protein; DAPSA, Disease Activity in Psoriatic Arthritis; BMI, Body Mass Index; Charlson Comorbidity Index

Conclusion: In this RWE series, UST 90 mg was effective and safe in 75% of our patients probability of achieving a remission/low activity state by DAPSA.

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AB0776

RATES OF MYOCARDIAL INFARCTION, STROKE AND REVASCULARIZATION AMONG PATIENTS WITH PSORIATIC ARTHRITIS TREATED WITH APREMILAST, BIOLOGICS, DMARDS AND CORTICOSTEROIDS IN THE US MARKETSCAN DATABASE

¹Rebecca Persson^{*}, Katrina Wilcox Hagberg¹, Ellen Qian¹, Catherine Vasilakis-Scaramozza¹, Steve Niemcryk², Michael Peng², Maria Paris², Anders Lindholm², Susan Jick³. ¹Boston Collaborative Drug Surveillance Program, Lexington, United States of America; ²Celgene Corporation, Summit, United States of America; ³Boston University School of Public Health, Boston, United States of America

Background: Patients with psoriatic arthritis (PsA) are at increased risk for cardiovascular events, but different treatment options may not have the same rates of cardiovascular events.^{1,2}

Objectives: To compare rates of myocardial infarction (MI), stroke and revascularization by treatment type in patients with PsA.

Methods: We conducted a population-based cohort study of treated PsA patients in the MarketScan database in 2014-2016. The cohort entry was the date of the first prescription for a study drug (apremilast only or in combination with ≥ 1 other study drugs, anti-TNF- α biologics only, other