biologics and DMARDs [OBDs] only, corticosteroids only, OBDs + corticosteroids and anti-TNF- α biologics with OBDs and/or corticosteroids) after March 21, 2014, the date on which apremilast was approved. Patients were followed from cohort entry through censor date, defined as the first of the following: index date (date patient became a case), end of record or end of study period (December 31, 2016). MI and stroke cases required 1 inpatient diagnosis plus 2 additional diagnoses on separate days; revascularization required a procedure code for revascularization without MI or stroke; all ≥ 7 days after cohort entry. A patient was considered currently exposed from the prescription date through the prescription duration + 30 days. We calculated incidence rates (IRs) and 95% confidence intervals (CIs) for each outcome per 100 patient-years among the entire population and in the subgroup of patients with no history of serious cardiovascular disease (CVD).

Results: The study population included 51,971 patients (median age: 52 years, 52% female, 4.0% serious CVD history). IRs were low for all outcomes, and differences between treatments did not reach statistical significance (95% CIs for IRs were overlapping). Among the 187 MI cases, IRs (95% CIs) were as follows: for apremilast only, 0.10 (0.01, 0.35); anti-TNF- α biologics only, 0.13 (0.09, 0.19); anti-TNF- α biologics with OBDs and/or corticosteroids, 0.31 (0.22, 0.43); OBDs only, 0.32 (0.23, 0.44); corticosteroids only, 0.44 (0.27, 0.68); OBDs + corticosteroids, 0.45 (0.24, 0.76); and apremilast in combination, 0.49 (0.20, 1.02). Among the 79 stroke cases, IRs (95% CIs) were as follows: for corticosteroids only, 0.08 (0.02, 0.22); anti-TNF- α biologics only, 0.09 (0.06, 0.13); for OBDs only, 0.10 (0.05, 0.17); anti-TNF- α biologics with OBDs and/or corticosteroids, 0.12 (0.06, 0.20); apremilast only, 0.15 (0.03, 0.43), or in combination, 0.14 (0.02, 0.51); and OBDs + corticosteroids, 0.21 (0.08, 0.45). Among the 292 revascularization cases, IRs (95% CIs) were as follows: for apremilast only, 0.25 (0.08, 0.57), anti-TNF- α biologics only, 0.36 (0.29, 0.44); anti-TNF- α biologics with OBDs and/or corticosteroids, 0.37 (0.27, 0.50); OBDs + corticosteroids, 0.38 (0.19, 0.68); apremilast in combination, 0.42 (0.15, 0.92); OBDs only, 0.48 (0.36, 0.61); and corticosteroids only, 0.49 (0.31, 0.73). Among patients with no serious CVD history, IRs were generally lower but results were not materially different from the main analyses.

Conclusion: Rates of MI, stroke and revascularization were low for treated PsA patients and were similar across treatments.

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Disclosure of Interests: Rebecca Persson Grant/research support from: Celgene Corporation, Katrina Wilcox Hagberg Grant/research support from: Celgene Corporation, Ellen Qian Employee of: Boston Collaborative Drug Surveillance Program, Catherine Vasilakis-Scaramozza Grant/research support from: Celgene Corporation, Steve Niemcruk Employee of: Celgene Corporation, Michael Peng Employee of: Celgene Corporation, Maria Paris Employee of: Celgene Corporation, Anders Lindholm Employee of: Celgene Corporation, Susan Jick: None declared

DOI: 10.1136/annrheumdis-2019-eular.780

AB0777

PSA PATIENTS REACHING MINIMAL DISEASE ACTIVITY/7 IMPROVE IN ALL FIELDS OF PSAID

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Background: Patients with psoriatic arthritis (PsA) show impact on physical and psychological aspect of the disease and it can be measured with the PsA Impact of Disease (PsAID) questionnaire. Impact of disease should improve if patient reach a minimal disease activity (MDA).

Objectives: To assess the association between MDA and PsAID questionnaire in patients with PsA from daily clinical practice.

Methods: A cross-sectional study was carried out in consecutive patients who fulfilled CASPAR criteria and who were treated according to routine clinical practice (EULAR/GRAPPA recommendations). Patients were considered in MDA if they met at least 5/7 of the MDA criteria. PsAID was also recorded. Continuous variables were reported as median (Q1-Q3). Categorical variables were reported as percentages and frequencies. All analyses were performed using SPSS software. Differences were considered statistically significant if $p < 0.05$ (two tailed).

Results: Seventy-two patients were included, 40 males (55.6%), median of age 53.5 years old (47.0-62.7) and disease duration 5 years (3-10). Obesity was 29.6% and C-RP level was 0.31mgr/dl (0.10-0.97). Patient

treatments were: NSAID 22.2%, corticosteroids 31.9%, csDMARD 55.6% and biological therapy 20.8%. DAPSA was 9.0 (2.2-19.4) being in VLDA (0-4) 37.5%, LDA (5-14) 22.2%, MDA (15-28) 30.6% and HAD (>28) 9.7%. Patients in MDA 5/7 state were 36 (50%) and median of total score of PsAID was 4.70 (0.85-9.40). All fields of PsAID improved if they reached MDA 5/7 ($p < 0.01$). MDA 5/7 was also related to age, duration of the disease, CRP and DAPSA (see table).

	MDA5/7 n=36	No MDA5/7 n=36	p
Age, years	60.5 (49.2-70.0)	52.0 (45.2-57.0)	0.027
Gender, n% male	21 (58.3)	15 (41.7)	0.635
Years from diagnoses	7.0 (4.0-13.0)	4.0 (0.2-8.0)	0.02
Obesity, n (%)	8 (22.9)	13 (36.1)	0.221
scDMARD, n (%)	24 (66.7)	16 (44.4)	0.058
bDMARD, n (%)	10 (27.8)	5 (13.9%)	0.147
CRP, mgr/dl	0.16 (0.08-0.40)	0.49 (0.27-1.75)	0.001
DAPSA	3 (0.3-4.2)	19.3 (15.5-25.8)	<0.001
Total PsAID	1.20 (0.05-4.32)	8.75 (5.60-12.0)	<0.001

Conclusion: Fifty percent of PsA patients achieve MDA in daily clinical practice. MDA patients had a significantly lower impact of the disease according to PsAID.

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Acknowledgement: Sociedade Galega de Reumatoloxía

Disclosure of Interests: Jose Pinto-Tasende Speakers bureau: Janssen, Novartis, Celgene, BMS, Abbvie, Pfizer, Clara Ventin: None declared, María Caeiro: None declared, Alvaro Seijas: None declared, Rodrigo Aguirre: None declared, María Teresa Silva: None declared, Francisco Blanco Speakers bureau: Celgene, Pfizer, Abbvie

DOI: 10.1136/annrheumdis-2019-eular.7393

AB0778

IMPACT OF DISEASE IN A SPANISH POPULATION WITH PSORIATIC ARTHRITIS

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Background: Patients with psoriatic arthritis (PsA) experience significant disability and reduced quality of life, resulting from the emotional distress and functional impairment associated with psoriatic skin lesions, as well as joint disease. Patient reported outcomes are important to evaluate healthcare interventions and to reflect the impact of PsA on patients' lives.

Objectives: The aims of the present study were to describe disease characteristics of PsA patients with an acceptable symptoms state (PsAID score < 4) as well as to analyze predictive factors for PsAID < 4 .

Methods: Post-hoc analysis of data from a cross-sectional observational, multicenter study, aimed at evaluating the prevalence of MDA in a Spanish population with PsA, to describe their characteristics and to evaluate the association between MDA and the impact of the disease as assessed by the PsAID questionnaire. The original study included 227 adult patients of both genders diagnosed with PsA according to CASPAR criteria with at least one year of disease evolution and on treatment with biological and/or conventional synthetic disease modifying anti-rheumatic drugs (cDMARD). The PsAID questionnaire reflects the effect of PsA from the patient's perspective. It is composed of 12 physical and psychological domains. PsAID score < 4 identified patient-acceptable symptoms state.

Results: 122 patients with a PsAID score < 4 were included. Demographic and clinical characteristics of the study population are shown in Table 1. Overall, 53/102 (52.0%) and 83/122 (68.0%) patients presented articular or skin remission, respectively. 76/122 (62.3%) of patients were in MDA state; the majority presented a low disability state according to HAQ (85.2%).

A moderate relationship between HAQ < 0.5 and PsAID < 4 ($k = 0.5325$) and fair between MDA and PsAID < 4 ($k = 0.3594$) were observed. Multivariate logistic regression analysis showed that patients with distal interphalangeal joint (DIP) involvement (odds ratio (OR) [95%CI], 0.402 [0.203-0.799]; $p = 0.009$), family history of PsA (OR: 0.252 [0.089-0.716]; $p = 0.010$) and