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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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 0.31mg/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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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

increased CRP (OR: 0.922 [0.854–0.995; $P = 0.036$]) were significantly less likely to reach a PsAID score <4 .

Abstract AB0778 Table 1.. Demographic and clinical characteristics of PsA patients with PsAID <4

	Total N (122)
Male, n (%)	70 (57.4)
Age, mean (SD), yr	54.5 (12.7)
BMI, mean (SD) (kg/m ²)	27.1 (3.9)
CRP (mg/L), mean (SD)	2.8 (3.3)
Comorbidities, n (%)	
Dyslipidemia	40 (32.8)
HBP	33 (27.0)
Obesity	30 (24.6)
DM	12 (9.8)
PsA clinical patterns, n (%)	
Axial	3 (2.5)
Peripheral	107 (87.7)
Mixed	12 (9.8)
DIP disease	45 (36.9)
Familial history, n (%)	
Psoriasis	60 (49.2)
PsA	11 (9.0)
Ankylosing spondylitis	2 (1.6)
PsA duration, mean (SD), yrs.	9.6 (7.9)
Skin symptoms duration, mean (SD), yrs.	21.6 (14.5)
Articular symptoms duration, mean (SD), yrs.	11.9 (8.7)
Radiologic findings	
Erosions in hands, n (%)	40 (32.8)
Erosions in feet, n (%)	33 (27.0)
PASI, mean (SD)	1.2 (3.8)
HAQ, mean (SD)	0.2 (0.3)
HAQ ≤ 0.5 , n (%)	104 (85.2)
MDA, n (%)	76 (62.3)
Kappa [CI _{95%}] HAQ ≤ 0.5 vs. PsAID <4	0.5325 [0.4212–0.6438]
Kappa [CI _{95%}] MDA vs. PsAID <4	0.3594 [0.2393–0.4795]

MDA: Minimal disease activity; SD: Standard deviation; BMI: Body mass Index. CRP: C-Reactive Protein; HBP: High blood pressure; DIP: distal interphalangeal joint disease. DM: Diabetes mellitus; PASI: Psoriasis Area and Severity Index; HAQ: Health Assessment Questionnaire; PsAID: Psoriatic Arthritis Impact of Disease. CI: confidence intervals

Conclusion: There are discrepancies between the treatment goals (MDA) and the impact of disease as assessed by PsAID. Clinical characteristics such as DIP involvement, inflammatory load (PCR) and genetic factors (familial history) seem to be associated with a lower probability of being in an acceptable symptoms state in PsA patients.

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AB0779

TOWARDS A GLOBAL MANAGEMENT OF PSORIATIC ARTHRITIS: ESTIMATION OF THE CARDIOVASCULAR RISK AND THE ACTIVITY OF THE DISEASE IN CLINICAL PRACTICE

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Background: Psoriatic arthritis (PsA) patients usually have a high prevalence of cardiovascular risk factors (CVRF) and cardiovascular events, which makes the routine estimation of cardiovascular risk (CVR) highly advisable. Currently, this risk is estimated through classic risk scores (SCORE, Framingham), however, the values of these scores may underestimate the real CVR of these patients.

On the other hand, in clinical decision making and when evaluating the therapeutic response, it is advisable the use of some composite activity index. The heterogeneity of PsA makes it difficult to estimate the real activity and the remission state, so it is important to assess which of these composite index is more suitable for these purposes in clinical practice.

Objectives: We aimed to analyze whether carotid ultrasound is a useful tool for estimating CVR in patients with PsA, and if it is capable of correcting the estimated risk using classical tables. We also analyzed the usefulness of the MDA criteria and the DAPSA categories for clinical decision making in real practice.

Methods: A cross-sectional study was conducted with 136 consecutive patients with PsA (CASPAR criteria). Sociodemographic and anthropometric data, CVRF, disease activity according to DAPSA categories, HAQ, MDA, and CVR measured by SCORE chart, was collected. An IMT > 800 μ m and/or the presence of carotid plaque (Mannheim consensus), defined a high CVR by ultrasound. We analyzed the concordance (kappa) between the MDA response and the low activity and remission categories according to the DAPSA. Clinical variables of PsA associated with a high CVR were evaluated by multivariate analyses.

Results: Intima-media thickness values correlated well with CVR categories according to SCORE ($p < 0.0001$). 40% of patients included in the low and moderate risk categories according to the SCORE risk chart were reclassified as high CVR after the ultrasound examination.

	High cardiovascular risk (ultrasound)		p value
	No n (%)	Yes n (%)	
SCORE risk chart	51 (87.9)	7 (12.1)	<0.0005
Low	35 (71.4)	14 (28.6)	
Moderate	11 (39.3)	17 (60.7)	
High			

In the multivariate analysis, some characteristics of the disease were independently associated with a high CVR.

	OR (95% CI)	p value
Age	1.08 (1.03–1.13)	0.00
HAQ	1.94 (0.68–5.56)	0.22
DM	1.65 (0.42–6.40)	0.47
AHT	0.75 (0.24–2.31)	0.62
DL	2.61 (0.91–7.48)	0.07
Tobacco	4.26 (1.44–12.65)	0.01
Enthesitis	3.76 (1.36–10.40)	0.01
Erosions	5.23 (1.33–20.53)	0.02

This reveals that patients with enthesitis and/or structural damage are those who tend to have a high CVR.

When comparing DAPSA and MDA criteria, we found a moderate correlation between the MDA response and the DAPSA low activity ($\kappa = 0.52$, $p < 0.0001$) and between MDA and DAPSA remission ($\kappa = 0.47$; $p < 0.0001$).

Conclusion: A high percentage of patients with low-moderate risk according to the SCORE risk chart are reclassified as patients with high CVR after the ultrasound examination.

The high CVR in our population is related not only to classical CVRF, but also to the inflammatory load (enthesitis) and structural damage (erosions) of PsA.

DAPSA is an appropriate instrument for clinical decision making in routine practice because it correlates reasonably well with stringent therapeutic goals such as MDA.

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AB0780

PERSISTENCE OF MOLL AND WRIGHT CLASSIFICATION CRITERIA OVER TIME

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Background: In 1973 Moll and Wright published the first paper on the classification criteria for Psoriatic Arthritis (PsA) which included several phenotypes of PsA: Oligoarticular, Polyarticular, Axial, DIP, and Mutilans. Whether these subtypes change over time or are related to treatment response is not known. The hypothesis of this study is that with some exceptions, the Moll and Wright subtype classification criteria are stable over time and the pattern may have important therapeutic implications.

Objectives: The objective of this study was to evaluate the persistence of the Moll and Wright classification criteria in PsA patients.

Methods: This study is a retrospective chart review of PsA patients seen at a single center between January 1, 2013 and December 31, 2016. The patients in this study were identified using the ICD-9 or ICD-10 codes for PsA and were then classified using the CASPAR classification criteria for psoriatic arthritis. Patients who met CASPAR classification