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 (CVR) 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