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Variable	Line of Therapy					P-value*
	All (n=1516)	1 st (n=396)	2 nd (n=453)	3 rd (n=333)	4th-or-Higher (n=334)	
Minimal Disease Activity, n (%)	235 (20.3)	73 (23.9)	83 (23.2)	44 (17.4)	35 (14.4)	0.01
Tender Joint Count ≥8, mean±SD	4.5±5.8	4.2±5.3	4.3±6.0	4.8±6.2	4.7±5.7	0.21
Swollen Joint Count ≥8, mean±SD	2.5±3.6	3.0±4.0	2.5±3.7	2.3±3.5	2.3±3.1	0.01
Enthesitis category >0, n (%)	380 (30.1)	96 (27.7)	102 (26.4)	96 (35.8)	86 (33.1)	0.03
Dactylitis category >0, n (%)	190 (15.1)	70 (20.2)	49 (12.7)	34 (12.7)	37 (14.2)	0.02
HAQ ≥1, n (%)	483 (39.1)	108 (32.3)	146 (38.2)	104 (39.7)	125 (48.8)	0.001
Body surface area ≥3% affected by psoriasis, n (%)	790 (64.2)	215 (64.8)	239 (62.9)	165 (62.7)	171 (67.1)	0.69
Patient reported fatigue 0-100, mean±SD	50.7±28.2	45.1±28.7	49.7±29.4	53.4±25.8	56.8±26.4	<0.001
Patient overall pain 0-100, mean±SD	51.5±28.2	46.6±29.0	49.2±28.6	54.8±26.4	58.2±27.0	<0.001
Morning stiffness ≥30 min, n (%)	950 (77.2)	241 (72.2)	293 (77.1)	212 (80.9)	204 (80.0)	0.046

HAQ, Health Assessment Questionnaire; SD, standard deviation.

*P-values from chi-square tests (categorical variables) and one-way analysis of variance (continuous variables) across lines of therapy.

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FRI0439 PERCEIVED INFLUENCE OF HEALTH STATUS ON SEXUAL ACTIVITY IN PATIENTS WITH PSORIATIC ARTHRITIS IS ASSOCIATED WITH MUSCULOSKELETAL MANIFESTATIONS BUT NOT WITH PSORIASIS SKIN MANIFESTATIONS

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Background: Psoriatic arthritis (PsA) is a heterogeneous disease involving multiple domains including the musculoskeletal system and the skin. The disease may have a significant impact on various aspects of quality of life including sexuality.

Objectives: To explore the prevalence of self-reported problems with sexual activity in patients with PsA, and any associations with demographic and disease related variables as well as treatment.

Methods: PsA patients were consecutively recruited from a Norwegian rheumatology outpatient clinic. Data collection included information on demographics, measures of PsA disease activity (both skin and musculoskeletal manifestations), patient reported outcome measures and treatment. The perceived effect of health status on sexual activity was assessed using question 15 in the Health Related Quality of Life (HRQoL) instrument 15D. The question reads: My state of health: 1. Has no adverse effect on my sexual activity. 2. Has a slight effect on my sexual activity. 3. Has a considerable effect on my sexual activity. 4. Makes sexual activity almost impossible. 5. Makes sexual activity impossible. For analytical purposes the answers were dichotomized into "no/little negative effect" (answers 1 and 2) and "large negative effect" (answers 3-5). For group comparisons we used Chi-square test for categorical variables and student t-test for continuous variables. Adjusted logistic regression models were also applied.

Results: Among the 135 PsA patients assessed mean (SD) age was 52.1 (10.2) years and 51.1% were men. The majority of patients (111 patients, 82.2%) reported their state of health to have no/little effect on their sexual activity and 24 patients (17.8%) reported their state of health to have large negative effect on their sexual activity.

Patients with a large negative effect of their health status on sexual activity had significantly longer disease duration as well as higher DAPSA, MASES and fatigue score compared with the patients reporting no/little impact of their health status on sexual activity (table).

In adjusted logistic regression models with disease duration, DAPSA, MASES and fatigue in the model, only disease duration and MASES were independently associated with a large negative effect on sexual activity, this also when adjusting for age and sex.

Conclusion: Approximately 20% of the PsA patients reported their health status to have a large negative effect on their sexual activity. Only disease duration and measures reflecting musculoskeletal disease were found to have a negative effect on sexual activity among PsA patients; skin psoriasis did not have an impact.

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	Total (n=135)	No/little effect (n=111)	Large negative effect (n=24)	P-values
Age (SD) years	52.1 (10.2)	51.8 (10.3)	53.3 (10.3)	0.54
Men, n (%)	69 (51.1%)	58 (52.3%)	11 (45.8%)	0.57
BMI (SD) kg/m2	28.2 (4.4)	28.1 (4.2)	29.1 (5.0)	0.34
Smoking	21 (15.6%)	16 (14.4%)	5 (20.8%)	0.43
Disease duration (SD) years	8.7 (6.7)	8.1 (6.6)	11.6 (6.5)	0.02
68 Tender Joint Count	10.1 (11.1)	9.1 (10.2)	14.7 (13.8)	0.07
66 Swollen Joint Count	0.6 (1.1)	0.6 (1.1)	0.6 (0.9)	0.96
DAPSA	18.2 (14.2)	16.8 (13.3)	24.8 (16.6)	0.01
MASES	2.9 (3.1)	2.5 (2.9)	4.4 (3.5)	0.01
Fatigue (VAS 0-100)	45.1 (32.4)	42.2 (32.4)	58.1 (29.6)	0.03
Pain (VAS 0-100)	33.7 (23.1)	32.1 (22.8)	41.3 (23.5)	0.08
MHAQ	0.42 (0.40)	0.39 (0.34)	0.58 (0.58)	0.12
PASI skin score	2.5 (3.6)	2.4 (3.6)	3.1 (4.0)	0.38
Current Biologics	44 (32.6%)	36 (32.4%)	8 (34.8%)	0.83
Current DMARDs	79 (58.5%)	68 (61.3%)	11 (45.8%)	0.16

FRI0440 THE EFFECT OF GUSELKUMAB ON PASDAS, GRACE INDEX, MCPDAI, AND DAPSA: RESULTS FROM A PHASE 2 STUDY IN PATIENTS WITH ACTIVE PSORIATIC ARTHRITIS

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Background: Psoriatic Arthritis Disease Activity Score (PASDAS), GRAppa Composite scorE (GRACE) Index, modified Composite Psoriatic Disease Activity Index (mCPDAI), and Disease Activity Index for Psoriatic Arthritis (DAPSA) are composite indices recently developed to assess disease activity in psoriatic arthritis (PsA).^{1,2}

Objectives: The effect of guselkumab (GUS) on these indices was evaluated in a phase 2 study in patients with active PsA.

Methods: Patients with ≥3 tender and ≥3 swollen joints, C-reactive protein ≥3 mg/L, and ≥3% body surface area (BSA) of plaque psoriasis despite treatment were randomized 2:1 to receive GUS 100 mg subcutaneously (N=100) or placebo (PBO, N=49) at Weeks 0, 4, and every 8 weeks thereafter through Week44. At Week16, patients with <5% improvement in both swollen and tender joint counts were eligible for early escape (EE) to open-label ustekinumab. All remaining PBO patients crossed-over to receive GUS 100 mg at Weeks 24, 28, 36, and 44 (PBO→GUS). The PsA composite indices through Week24 were analyzed using last-observation-carried-forward for missing data and data post EE. After Week24, observed data were used. Missing baseline data were excluded in the analyses.

Results: Baseline PASDAS, GRACE, mCPDAI, and DAPSA showed moderate to high disease activity (mean (SD): 6.53 (1.079), 6.08 (1.208), 7.6 (2.15), and 46.65 (20.391), respectively), and were generally comparable between PBO and GUS. At Week24, GUS significantly decreased PASDAS, GRACE, mCPDAI, and DAPSA scores (mean (SD) change from baseline: -2.50 (1.59), -2.73 (1.76), -3.8 (2.72),