Figure. PASI 75/90/100 response rates up to week 52 across treatments and time points

Response rates were calculated in patients with BSA $\geq 3\%$ at baseline. Black symbols and corresponding p-values were analysed using nonresponse imputation for missing responses. Error bars represent two-sided 95% CI based on the normal approximation for binomial proportions. P-values are based on Cochran-Mantel-Haenszel test (with prior anti-TNF use and baseline body weight as stratification factors) for nonresponse imputation dataset. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$ vs placebo. BSA, body surface area; CI, confidence interval; PASI, Psoriasis Area and Severity Index; Q4W, every 4 weeks; Q12W, every 12 weeks; TIL, Itrixolizumab; TNF, tumour necrosis factor.

Conclusion: PASI75/90/100 response rates progressively improved with treatment; PASI 75 responses were significantly improved vs placebo as early as W4 (TIL 200mg Q12W), and all response rates were significantly improved vs placebo at W24. Response rates continued to improve through W36 and were sustained through W52. These results demonstrate TIL significantly reduced psoriasis disease activity and was generally well tolerated in a mixed population of anti-TNF-naïve and -experienced patients with PsA and BSA $\geq 3\%$ through W52.

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SAT0418

EFFECT OF TOFACITINIB TREATMENT ON ACTIVE MRI SACROILIITIS AND DISEASE ACTIVITY REDUCTION IN PSORIATIC ARTHRITIS PATIENTS. DATA FROM CLINICAL PRACTICE

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Background: Axial involvement in psoriatic arthritis (PsA) is quite common. Tofacitinib (TOFA) is an oral Janus kinase inhibitor. There is no data on the use of TOFA in PsA patients (pts) with axial involvement, nor is there any data on its effect on active MRI sacroiliitis (MRI-SI). There are only preliminary results of a randomized clinical trial on TOFA efficacy on active SI in AS (1).

Objectives: To study the effect of TOFA therapy on active MRI-SI in PsA pts.

Methods: 40 pts (F/M – 23/17) with active PsA fulfilling the CASPAR criteria were examined. No patients with inflammatory back pain (IBP) were specifically selected. Median (Me) age 41.0 [35.0; 50.0] yrs, Me PsA duration 6.0 [3.0; 10.0] yrs. Pts underwent a standard clinical examination of PsA activity: Me tender joint count 19 [12; 24], swollen joint count 11 [8; 16], patient's global disease activity measured by Visual Analogue Scale (VAS) 70 [50; 80], patient's pain VAS 65 [50; 75], Me activity indexes: DAPSA 44.2 [37.8; 55.3], BASDAI 6.0 [4.2; 7.0], ASDAS 3.8 [2.8; 4.4]. Me CRP 21.3 [3.2; 72.3] mg/L, ESR 28 [12; 52] mm/h. Enthesitis was observed in 65.9% of pts, dactylitis in 53.7% of pts. Apart from a standard clinical examination, all 40 pts underwent sacroiliac joint (SIJ) MRI on scanner Siemens General Electric 1.5 TESLA. Bone marrow edema/osteitis on MRI (STIR) with one lesion on two consecutive slices or at least two lesions on a single slice, was considered active MRI-SI. MRI results were evaluated by 2 independent readers (radiologist and rheumatologist). TOFA was given in 5 mg tablets bds over a period of 6 months, after which 35 patients underwent SIJ MRI. Me [Q25; Q75], Pierson- χ^2 tests were performed. All $p < 0.05$ were considered to indicate statistical significance.

Results: Prior to TOFA therapy, active MRI-SI was detected in 14 of 40 (35%) pts: bilateral in 9 pts, unilateral in 5 pts. At the end of 6 months therapy, active MRI-SI was detected in 4 of 35 (11.4%) pts observed: in 1 pt with baseline bilateral MRI-SI and in 2 pts with unilateral MRI-SI. 1 pt showed negative dynamics, that is, development of active MRI-SI (absent at baseline). The decrease in number

of active MRI-SI patients is statistically significant ($p = 0.017$; Pearson- χ^2). At baseline, inflammatory changes were detected in 23 of 80 (28.8%) SIJs, after 6 months of therapy they were found in 5 of 70 (7.1%) SIJs observed. Decrease in number of SIJs with active inflammation is statistically significant ($p = 0.001$; Pearson- χ^2). At baseline, Me BASDAI 6.0 [4.2; 7.0], Me ASDAS 3.8 [2.8; 4.4]. After 6 months of treatment, Me BASDAI 1.4 [0.6; 3.2], Me ASDAS 1.5 [1.0; 2.1] ($p = 0.001$ for both comparisons).

Conclusion: JAK inhibition using TOFA therapy shows high efficacy in reducing active MRI-SI and decreasing activity of axial involvement in PsA. More extensive studies are needed.

References:

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SAT0419

ASSOCIATION OF ACTIVE MRI SACROILIITIS WITH DACTYLITIS AND WORK PRODUCTIVITY IMPAIRMENT IN PSORIATIC ARTHRITIS PATIENTS. POSITIVE EFFECTS OF TOFACITINIB TREATMENT. DATA FROM CLINICAL PRACTICE

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Background: Psoriatic arthritis (PsA) is a heterogeneous disease with multiple manifestations and choosing among treatments can be a complex decision. Patients (pts) with axial involvement and pts having dactylitis are more likely to develop a severe disease (1, 2). Tofacitinib (TOFA), an oral Janus kinase inhibitor, showed efficacy in treating PsA pts with dactylitis (3). However, its efficacy in treating PsA pts with active sacroiliitis (SI) and dactylitis has not been studied.

Objectives: To study the effect of TOFA therapy in PsA pts having active SI on MRI (MRI-SI) and dactylitis.

Methods: 40 pts (M/F – 23/17) with active PsA fulfilling the CASPAR criteria were examined. Median (Me) age 41.0 [35.0; 50.0] yrs, Me PsA duration 6.0 [3.0; 10.0] yrs. A standard clinical examination of PsA activity was performed: Me tender joint count 19 [12; 24], swollen joint count 11 [8; 16], patient's global disease activity measured by Visual Analogue Scale (VAS) 70 [50; 80], patient's pain VAS 65 [50; 75], Me activity indexes: DAPSA 44.2 [37.8; 55.3], BASDAI 6.0 [4.2; 7.0], ASDAS 3.8 [2.8; 4.4]. CRP 21.3 [3.2; 72.3] mg/L, ESR 28 [12; 52] mm/h. Enthesitis was observed in 65.9% of pts with Me LEI index 1 [0; 1], dactylitis in 53.7% of pts, Me digits with dactylitis 1 [0; 2]. Apart from a standard clinical examination, MRI of sacroiliac joints (SIJs) was performed in all 40 pts using MRI scanner Siemens General Electric 1.5 TESLA. Bone marrow edema/osteitis on MRI (STIR) considered active MRI sacroiliitis (MRI-SI), was evaluated by 2 independent readers (radiologist and rheumatologist). TOFA was given in 5 mg tablets bds over a period of 6 months, after which 35 patients underwent SIJ MRI. Me [Q25; Q75], Pierson- χ^2 tests were performed. All $p < 0.05$ were considered to indicate statistical significance.

Results: Prior to TOFA therapy, MRI-SI was detected in 14 of 40 (35.0%) pts. At the end of 6 months therapy, MRI-SI was detected in 4 of 35 (11.4%) pts: in 3 pts with baseline SI; 1 pt showed negative dynamics, that is, development of active SI (absent at baseline). The decrease in number of active MRI-SI pts is statistically significant ($p = 0.017$; Pearson- χ^2). Significant differences between baseline symptoms in patients with MRI-SI ($n = 14$) and without it ($n = 26$) were defined by **number of digits with dactylitis:** 2 [0; 4] and 0 [0; 2] ($p = 0.047$), **by ESR:** 47 [26; 76] and 20 [6; 37] mm/h ($p = 0.025$), and **by WPAI overall work impairment due to health index:** 80 [60; 84]% and 20 [0; 60]% ($p = 0.033$), respectively; these parameters were higher in MRI-SI subgroup. After 6 months of therapy number of digits with dactylitis, ESR and WPAI indexes were significantly lower as compared with the baseline ones (Table 1).