Conclusion: PASI75/90/100 response rates progressively improved with treatment; PASI 75 responses were significantly improved vs placebo as early as W4 (TIL 200 mg 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 ≥3% through W52.

References:

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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 (TOF), 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 TOF 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. 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], ASAS 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 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/osteoitis on MRI (STIR) considered active MRI sacroiliitis (MRI-SI), was evaluated by 2 independent readers (radiologist and rheumatologist). TOFA was given in 5mg tablets bds over a period of 6 months, after which 35 patients underwent SI MRI. Me [Q25; Q75], Pearson’s χ2 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 (35.0%) 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’s χ2).

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.