Table 1. Initial demographic and clinical datas of patients with PsA

	PsA Patients (n=355)
Females, n (%)	227 (63,9)
Age of diagnosis, years*	34,6 (27-42)
CRP baseline*	6 mg/ L (3-15)
ESR baseline*	24 mm/h (10-38)
Smoking, n (%)	
Current	99 (28,5)
Never	192 (55,3)
Previous	56 (16,2)
HLA B27 positivity, n (%)	41 (26,4)
First biologic agent, n (%)	
-TNFi	332 (95,4)
Adalimumab	125 (37,6)
Etanercept	80 (24,1)
Golimumab	52 (15,6)
Certolizumab	44 (13,3)
Infliximab	31 (9,4)
- Other biologic agents	16 (4,6)
Secukinumab	13 (81,3)
Ustekinumab	3 (18,7)

* median (min-max)

Conclusion: The results of this study establish that more than half of patients with PsA can remain in their initial biologic treatment over a long term. It has been observed that the choice of biologic treatment did not effect the drug survival in PsA.

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SAT0424

OBESITY LINKS TO PSORIATIC ARTHRITIS (PSA) ACTIVITY, HIGHER PREVALENCE OF CARDIOMETABOLIC DISORDERS AND WORSE PATIENT REPORTED OUTCOMES (PROS): DATA FROM THE RUSSIAN PSA REGISTRY (RU-PSART)

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Background: PsA patients (pts) have an increased risk of cardiovascular (CV) and metabolic (Met) disorders due to the combination of inflammation and increased prevalence of traditional CV risk factors. Only limited data are available on Russian PsA pts. Data was collected from 25 rheumatology clinics of the Russian Federation

Objectives: to study, in clinical practice, the prevalence of obesity and its association with PsA activity, CV/Met comorbidities and PROs

Methods: 614 (M/F=331(54%)/283(46%)) PsA pts fulfilling the CASPAR criteria were included from the RU-PSART cohort. Mean age 45.2±0.52 yrs, PsA duration 5.7±0.27 yrs, PsO duration 15.71±0.56 yrs, DAPSA 28.79±0.75. At baseline (BL) PsA activity was evaluated by Tender Joint Count (TJC68), Swollen Joint Count (SJC66), PGA, physician global assessment by Visual Analog Scale (VAS), DAPSA; PROs according to PtGA VAS, PtPain VAS, HAQ, Work Productivity and Activity Index (WPAI) and Body Mass Index (BMI, kg/m²) were calculated. All pts were split into three groups by BMI (kg/m²): normal<25 (I group), overweight 25-30 (II group), obese>30 (III group). M±m, %, Me [Q25; Q75], χ² or Fischer's exact tests were performed

Results: At BL the BMI was 27.7±0.23 kg/m² with the following BMI categories: normal - 213 pts (34.7%), overweight - 214 pts (34.8%) and obese - 187 (30.5%). Increased BMI was observed in 65.3% of PsA pts. In all groups, comorbidities were found in 297 out of 614 pts (48%): arterial hypertension in 190 (64%), diabetes mellitus in 44 (14.8%), Met syndrome in 36 (12.1%), Coronary Heart Disease in 22 (7.4%). CV and Met disorders were significantly more common in obese pts with BMI>30 compared to overweight pts and to normal BMI pts; female prevailed (Table 1).

Table 1. CV/Met comorbidity in three groups, n (%).

	I group BMI<25 kg/m ²	II group BMI 25-30 kg/m ²	III group BMI>30 kg/m ²	p
Arterial hypertension	28(13.2)	55(25.7)	85(46.5)	p<0.0001*
Diabetes mellitus	0	15(7)	25(14)	p<0.0001**
Metabolic syndrome	0(0)	6(2.8)	23(12.8)	p<0.0001**
Coronary heart disease	2(0.9)	6(2.8)	10(5.6)	p<0.026***

*III vs I and II groups, ** III vs II, *** III vs I group

At BL pts with BMI>30 had higher PsA activity by DAPSA, HAQ, daily activity impairment by WPAI, PtPain compared to I and II groups (table 2).

Table 2. PsA activity and PROs based on BMI categories.

	I group BMI<25 kg/m ²	II group BMI 25-30 kg/m ²	III group BMI>30 kg/m ²	p
DAPSA	22.7 [14.7; 35.8]	24.9 [13.5; 38.5]	27 [17.2; 44.4]	p<0,05*
HAQ	0.9 [0.5; 1.3]	0.9 [0.5; 1.3]	1 [0.8; 1.6]	p<0,05*
Daily activity impairment	0.3 [0; 0.5]	0.3 [0; 0.5]	0.4 [0; 0.6]	p<0,05*
PtPain, mm VAS	50 [30; 66.5]	50 [30; 68]	50 [40; 70]	p<0,05**

*p<0.05 III vs I and II groups, ** p<0.05 III vs II group

Conclusion: In clinical practice, BMI increase was found in the majority of PsA pts. Obesity was associated with higher PsA activity, more prevalence of CV/ Met disorders and worse PROs. Obesity requires a change of the pts' lifestyle, nutrition correction and a right choice of therapy

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SAT0425

NOVEL COMPUTER-ASSISTED METHODOLOGY FOR QUANTITATIVE ASSESSMENT OF MRI TREATMENT RESPONSES TO APREMILAST IN PATIENTS WITH PSORIATIC ARTHRITIS

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Background: Response to treatment in psoriatic arthritis (PsA) can be captured using the OMERACT PsA Magnetic Resonance Imaging Score (PsAMRIS). While reliable and valid, PsAMRIS interpretation requires a trained reader to assess inflammatory lesions such as synovitis and flexor tenosynovitis on a discrete scale ranging from 0 to 3, which might not have sufficient sensitivity to capture early and subtle changes in inflammation in small cohorts.