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Background: Methotrexate (MTX) is the most common first-line disease-modified anti-rheumatic drugs in psoriatic arthritis (PsA), despite the controversies.

Objectives: In this study, we aimed to determine the rate of withdrawal rate of MTX in PsA and reasons for discontinuing.

Objectives: In this study, we aimed to determine the rate of withdrawal rate of MTX in PsA and reasons for discontinuing.

Methods: A large prospective international multicenter PsA registry was used for this study. Data were collected either at enrolment, based on history, or prospectively if there was a follow up. We analyzed the frequency of MTX usage, discontinuation and the reason for discontinuation. The time on MTX was compared according to the reason of discontinuation (inefficacy vs side effects) using Kaplan-Meier and Cox regression analyses to identify risk factors for discontinuation.

Results: At the time of analyses, 1670 patients had been recruited to the registry and 1359 PsA patients had used MTX during the course of the disease (81.3%). Within these, 942 (69.3%) were still on MTX at the time of analysis, and 417 (30.7%) patients have discontinued (Table). The most common reasons for withdrawal were side effects (219/417, 52.5%) and ineffectiveness (88/417, 21.1%). Other reasons included pregnancy, remission, self-decision (11.9% for all). For 60 patients (14.3%), the reason could not be identified. In patients who were still on MTX, the median duration of MTX therapy was 31 months (IQR=59) compared to 17 months (IQR=43) in the withdrawal group. The most common side effects were gastrointestinal symptoms (47%) and abnormal liver function tests (25%). There was a significant difference in survival plots (Log-rank $p=0.026$) with discontinuing due to side effects occurring earlier than inefficacy (Figure 1). In cox regression model, longer disease duration was found as an independent predictor of MTX discontinuation due to all reasons [Hazard Ratio (HR)=1.01, 95% Confidence interval (CI)=1.0-1.02; $p=0.003$].

Conclusion: MTX is frequently used on PsA treatment, despite the controversies in the literature. One third of patients with PsA discontinue MTX, most commonly due to side effects or inefficacy. Patients discontinue MTX earlier in case of having side effects. Longer disease duration is linked to MTX discontinuation.

Table. Demographics and disease characteristics of study groups

	All patients n=1359	Still on MTX n=942	Withdrawal MTX any reason n=417	p
Age, mean (SD)	46.4 (13.4)	46.1 (13.4)	47.7 (14.0)	0.038
Male gender, n (%)	523 (38.5)	360 (38.2)	163 (39.1)	0.761
Ever smoking, n (%)	569/1258 (46.2)	390/861 (45.3)	179/397 (45.1)	0.966
Psoriasis duration (years), mean (SD)	14.2 (11.7)	14.0 (11.2)	16.4 (12.7)	0.003
Polyarthritis, n (%)	657/1343 (48.9)	471/931 (50.6)	186/412 (45.1)	0.066
Axial disease, n (%)	388/1343 (28.9)	267/931 (28.7)	121/412 (29.4)	0.797
Nail involvement (ever), n (%)	644 (47.8)	435 (46.6)	209 (50.5)	0.191
Swollen Joint Count, mean (SD)	1.5 (2.6)	1.4 (2.6)	2.0 (3.2)	<0.001
Tender Joint Count, mean (SD)	3.0 (4.4)	3.5 (5.0)	4.2 (5.4)	<0.001
HAQ, mean (SD)	0.6 (0.6)	0.7 (0.7)	0.8 (0.7)	0.035
BASDAI, mean (SD)	37 (22)	39 (23)	46 (25)	0.001

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declared, Levent Kılıç: None declared, Servet Akar: None declared, Sema Yılmaz: None declared, Meryem Can: None declared, Sule Yavuz: None declared, Orhan Küçükşahin: None declared, Sibel Bakırçı: None declared, Sibel Aydın: None declared

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SAT0441

BODY COMPOSITION AND FAT DISTRIBUTION IN PATIENTS WITH PSORIASIS OR PSORIATIC ARTHRITIS.

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Background: Obesity is a leading comorbidity in both psoriasis (Pso) and psoriatic arthritis (PsA) and is associated with common metabolic complications and increased cardiovascular (CV) risk. Obesity is also a risk factor for the onset of these diseases. Body composition and fat distribution have been rarely evaluated in Pso and PsA.

Objectives: In this study, we aimed to characterize the fat mass distribution in patients with Pso or PsA compared to a control group, with a special emphasis on the android/visceral region.

Methods: case-control study (NCT02849795). Patients with Pso (plaque psoriasis) or PsA (CASPAR criteria) were evaluated. Each patient was paired to a control subject, recruited in the same outpatient population, and matched for sex, age and body mass index (BMI) category. Clinical assessment included BMI, anthropometric measurements (waist circumference, waist /hip ratio), disease activity (PASI for Pso, CPDAI for PsA) and the SCORE CV risk score. Laboratory parameters of inflammation (ESR, CRP, IL-6), lipid parameters (total cholesterol, LDL and HDL cholesterol, triglycerides), metabolic parameters (glycemia, insulin, HOMA), serum adipokines (total and high molecular weight [HMW] adiponectin, leptin, resistin and retinol binding protein 4 [RBP4]) were measured. Body composition (lean mass, fat mass) and fat distribution (android/gynoid regions and visceral fat) were evaluated (DEXA, Lunar GE, CoreScan). Our primary criteria was the fat mass in the android/visceral region. Comparisons between patients and controls were performed with paired t tests, between all groups with ANCOVA (adjusted for age, sex, and BMI category) and Tukey post-hoc tests. Pearson correlations between CV risk and fat mass were calculated within groups.

Results: 52 patients with Pso and 52 patients with PsA and their respective paired-control were evaluated. Total fat mass was increased in Pso but not in PsA. Android fat and visceral fat were found higher in Pso ($p<0.05$) while the fat mass measurements did not differ between the patients with PsA and their controls. Waist circumference was higher in patients with Pso compared to their controls. Leptin, leptin/fat mass ratio, and total adiponectin were elevated in PsA while only the HMW/total adiponectin ratio was decreased in Pso. Insulin levels and HOMA were increased in both Pso and PsA groups. Finally, RBP4 was higher in both Pso and PsA patients compared to their respective controls. In patients with Pso, android and visceral fat were correlated with SCORE ($r=0.3$, $p=0.02$ and $r=0.6$, $p<0.0001$ respectively). In ANCOVA analysis, visceral fat was higher in Pso patients ($p=0.0029$), with a trend toward higher android fat ($p=0.055$), compared to PsA patients.

Conclusion: visceral fat is increased in patients with Pso but not in PsA. In parallel, both groups showed an elevation of circulating RBP4. Patients with Pso and PsA were also characterized by metabolic disturbances as showed by the increase in HOMA, and specific adipokine changes. In the Pso group, visceral fat is associated with CV risk evaluated by SCORE. Weight control and reduction of fat mass, especially visceral fat mass, may thus be an important concern in patients with Pso and appears less relevant in PsA.

Disclosure of Interests: None declared

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SAT0442

EVOLVEMENT OF SWOLLEN JOINTS IN THE FIRST YEAR OF EARLY PSORIATIC OLIGOARTHRITIS.

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