Figure 1. Patients achieving persistent-LDA during the 1st year of biological therapy, stratified by period of time and by disease. * Statistically significant difference with respect to p1.

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AB0742

CONVENTIONAL SYNTHETIC DMARDS IN PSORIATIC ARTHRITIS - CHANGING PRACTICE IN BIOLOGIC ERA: REAL-LIFE RESULTS FROM HURBIO-PSA REGISTRY

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Background: Conventional synthetic disease modifying anti-rheumatic drugs (csDMARDs) are recommended as the first-line treatment options for most of the psoriatic arthritis (PsA) patients. In the last two decades, biologic drugs become more accessible and their percentage in the daily practice is increasing continuously. However, how they influenced the utilization of csDMARDs still remains unknown, yet.

Objectives: To determine the utilization rates of PsA patients before, after and at the starting of biologic DMARDs

Methods: We analyzed all patients who received at least 1 dose of biologic DMARDs, registered to HURBIO-PsA database, and who have complete data regarding csDMARD use before (ever), after (at last control visit) and at the starting of biologic DMARD. Methotrexate, leflunomide and sulphasalazine were the csDMARDs recorded. Demographic data of these patients were also recorded.

Results: A total of 426 (70% female) PsA patients was included. Mean age and mean PsA disease duration were 48±12.4 and 9.3±8.3 years, respectively. Mean duration of csDMARD utilization before bDMARDs was 5.8±5.1 years, and mean follow-up duration under bDMARDs was 3.7±2.5 years. Distribution of the bDMARDs that ever-prescribed as follows: adalimumab 273 (64.2%), etanercept 125 (29.3%), certolizumab pegol 103 (24.2%), infliximab 102 (24.0%), secukinumab 63 (14.8%), golimumab 55 (12.9%), ustekinumab 24 (5.6%) and tofacitinib 11 (3.4%). Percentage of each csDMARDs used before (ever used), after (at last control visit) and at the starting of biologic DMARDs were given in **Figure**. Also the percentage of patients using csDMARD as monotherapy and combination therapy were given in **Figure**.

Conclusion: csDMARDs particularly sulphasalazine and methotrexate were important treatment options before bDMARD period, however they (particularly SSZ) were usually discontinued after bDMARD initiation. Rate of concomitant csDMARDs use remains relatively stable after starting the bDMARDs. Besides, rate of concomitant mono/csDMARD use is significantly higher after bDMARD initiation, in contrast to pre-bDMARD period.

Figure. Percentage of each csDMARDs, and mono or combination of csDMARDs used before (ever used), after (at last control visit) and at the starting of biologic DMARDs (com/csDMARD: combination csDMARD; mono/csDMARD: monotherapy of csDMARD; csDMARD: conventional synthetic disease modifying antirheumatic drug).

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AB0743

DISEASE CHARACTERISTICS OF PSORIATIC ARTHRITIS PATIENTS MAY DIFFER ACCORDING TO AGE AT PSORIASIS ONSET: CROSS-SECTIONAL ANALYSIS OF PSORIATIC ARTHRITIS-INTERNATIONAL DATABASE

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Background: Psoriasis and psoriatic arthritis (PsA) are heterogeneous diseases with various disease manifestations and phenotypes. Psoriasis has a bimodal age of onset being early (before the age of 40, type 1) and late. The impact of this classification on the PsA features is not well understood.

Objectives: To compare the PsA characteristics of patients with early- and late-onset psoriasis in a large, multicenter database

Methods: PSART-ID (Psoriatic Arthritis-International Database) is a prospective, multicenter web-based registry (www.trials-network.org) of patients with PsA. A detailed data collection was performed including demographics (sex, age, duration of education, smoking status, BMI), skin features (psoriasis onset date, type, initially involved site of skin, nail involvement (ever) and family history) and PsA characteristics (type of articular involvement and presence of axial, dactylitis (ever), enthesitis (ever), family history) and indices for disease activity and function (DAPSA, Leeds enthesitis index, BASDAI, BASFI, patient and physician global assessment, pain, HAQ-DI). We grouped according to the age at psoriasis onset (early onset, psoriasis before the age of 40 (EOPsO); late-onset, psoriasis after the age of 40 (LOPsO)), patient and disease characteristics of the groups were compared (1). Due to the differences among groups, following adjustments were made: BMI for age, nail involvement for PsO disease duration, axial PsA for PsA disease duration.

Results: A total of 1634 (62.8% females; EOPsO, 1108 (67.8%); LOPsO, 526 (32.2%)) patients with PsA was recruited. Rate of over-weight patients was higher in LOPsO group (66.8% vs. 86.8%, p<0.001; adjusted for age - aOR 1.55 (1.11-2.20; % 95 CI)). The EOPsO group had the scalp involvement as the initial site of skin disease more often than the LOPsO group (56.7%

vs. 43.0%, $p < 0.001$), whereas extremity involvement was more frequent as the initial finding in the LOPsO group (EOPsO vs. LOPsO 63.8% vs. 74.2%, $p < 0.001$). Nail involvement (ever) was more prominent in EOPsO group, however, the significance was disappeared when adjusted for psoriasis duration. Interaction between gender and both axial disease and psoriatic disease family history were found (axial disease in man; EOPsO vs LOPsO; 38.0% vs. 25.4%; $p = 0.005$; adjusted for PsA duration - aOR 0.56 (0.38-0.84; %95 CI) // psoriatic disease family history in females; EOPsO vs LOPsO; 39.5% vs. 30.1%; $p = 0.003$; OR 0.65 (0.50-0.86; %95 CI)). Duration between PsO and PsA was significantly longer in EOPsO group (148 vs. 24 months, $p < 0.001$). In EOPsO group, more patients had PsO preceding PsA than LOPsO group (81.8% vs. 60.6%, $p < 0.001$), however, synchronous disease -defined as the diagnosis of PsO and PsA within the same year- was more common in LOPsO group (16.6% vs. 30.3%, $p < 0.001$) (Table 1). Psoriatic disease activity parameters, patient and physician reported outcomes and HAQ-DI scores were similar in both groups.

Conclusion: Clinical features of PsA may be affected by the age at the onset of psoriasis. As the genetic background is different in early and late-onset psoriasis, this may suggest a different pathogenetic mechanism based on the psoriasis phenotype, also affecting the PsA features. Further prospective studies are needed to define whether the classification of PsA requires including psoriasis phenotypes as well.

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Table 1. Comparison of psoriatic arthritis patients' characteristics according to age at psoriasis onset

Variable	EOPsO (n=1108, 67.8%)	LOPsO (n=526, 32.2%)	Overall (n=1634)	Odds ratio (%95 CI)	P value
Age, mean (SD)	41.5 (11.8)	58.3 (8.3)	46.9 (13.3)	—	<0.001
Female, n (%)	674 (60.8)	352 (66.9)	1026 (62.8)	0.76 (0.61-0.95)	0.017
BMI, mean (SD)	27.6 (5.2)	29.5 (5.0)	28.2 (5.2)	—	<0.001
≥ 25, n (%)	736 (66.8) [†]	454 (86.8)	1190 (73.3)	3.26 (2.46-4.32) 1.55 (1.11-2.20) [†]	<0.001 0.011
Psoriasis (PsO)					
Age at diagnosis, mean (SD)	23.5 (9.4)	50.4 (7.2)	32.1 (15.3)	—	<0.001
Disease duration, mean (SD) (year)	18.1 (12.2)	7.8 (6.5)	14.7 (11.7)	—	<0.001
Initial scalp inv., n(%) [*]	560 (56.7)	193 (43.0)	753 (52.5)	1.74 (1.32-2.18)	<0.001
Initial torso inv., n(%) [*]	208 (21.1)	84 (18.7)	292 (20.3)	1.16 (0.87-1.54)	0.32
Initial extremity inv., n(%) [*]	629 (63.8)	333 (74.2)	962 (67)	0.61 (0.47-0.78)	<0.001
Initial genital inv., n(%) [*]	73 (7.4)	29 (6.5)	102 (7.1)	1.15 (0.74-1.80)	0.52
Plaque psoriasis (+), n(%) ^{**}	649 (80.8)	295 (80.2)	944 (80.6)	0.95 (0.70-1.30)	0.81
Pustular psoriasis (+), n(%) ^{**}	144 (17.9)	69 (18.8)	213 (18.2)	1.05 (0.76-1.45)	0.73
Nail involvement (ever), n(%)	552 (50.0)	222 (42.2)	774 (47.5)	1.36 (1.10-1.68) 0.99 (0.78-1.25) ^{††}	0.003 0.96
Psoriatic Arthritis (PsA)					
Age at diagnosis, mean (SD)	35.8 (11.2)	54.2 (8.4)	41.7 (13.4)	—	<0.001
Disease duration, mean (SD)	5.7 (7.6)	4.2 (5.2)	5.2 (7.0)	—	<0.001
Monoarthritis, n(%)	30 (2.7)	20 (3.8)	50 (3.1)	1.42 (0.80-2.53)	0.22
Oligoarthritis, n(%)	344 (31.1)	163 (31.2)	507 (31.1)	1.01 (0.82-1.26)	0.98
Polyarthritis, n(%)	542 (49.1)	246 (47.0)	789 (48.5)	0.90 (0.72-1.11)	0.42
Arthritis mutilans, n(%)	3 (0.3)	1 (0.2)	4 (0.2)	0.70 (0.07-6.78)	0.76
Axial disease, n(%)					
- Female	187 (27.8)	78 (22.3)	265 (25.9)	0.76 (0.56-1.03) [‡]	0.08
- Male	164 (38.0)	44 (25.4)	208 (34.4)	0.56 (0.38-0.84) [‡]	0.005
DIP involvement, n(%)	164 (14.8)	76 (14.5)	240 (14.7)	0.97 (0.72-1.30)	0.86
Dactylitis (ever), n(%)	245 (23.4)	123 (24.7)	368 (22.9)	1.07 (0.83-1.38)	0.56
Enthesitis (ever), n(%)	255 (25.0)	129 (26.3)	384 (23.5)	1.07 (0.84-1.37)	0.56
CASPAR, mean (SD)	3.64 (1.1)	3.58 (1.1)	3.62 (1.1)	—	0.25
CASPAR (+), n(%)	959 (86.7)	444 (84.7)	1403 (85.9)	0.85 (0.63-1.14)	0.28
Psoriatic disease					
PsO before PsA, n(%)					<0.001
- Yes	925 (83.6)	328 (62.1)	1253 (76.6)	3.14 (2.48-3.98)	<0.001
- No	20 (1.8)	51 (9.6)	71 (4.3)	0.17 (0.10-0.29)	<0.001
- Synchronous	161 (14.6)	149 (28.3)	310 (19.1)	0.43 (0.34-0.55)	<0.001
Family history, n(%)					0.003
- Female	266 (39.5)	106 (30.1)	372 (36.3)	0.65 (0.50-0.86)	0.003
- Male	127 (29.3)	52 (29.9)	179 (29.4)	1.03 (0.70-1.51)	0.87
Duration between PsO and PsA (month), med (min- max)	148 (-218, 797)	24 (-240, 313)	80 (- 240,797)	—	<0.001

*n=1435, **n=1171, †adjusted for age, ††adjusted for psoriasis duration, ‡adjusted for psoriatic arthritis duration
BMI: Body mass index, CASPAR: Classification criteria for Psoriatic Arthritis, DIP: Distal Interphalangeal

AB0744

PSORIATIC DISEASE AND BODY COMPOSITION: A SYSTEMATIC REVIEW OF THE LITERATURE

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Background: There is emerging evidence of a relationship between psoriasis and metabolic syndrome, increased prevalence of cardiovascular risk factors and adverse cardiovascular outcomes. Obesity is a risk factor for psoriatic disease itself but there has been less emphasis on body mass alterations and the distribution between separate compartments: fat-free tissue (lean body mass), extracellular water and adipose tissue. Body composition is a term used to describe the percentages of fat, bone, water and muscle in human bodies and is an emerging tool in assessment of physical fitness and metabolic health, although its role in disease is less well appreciated.

Objectives: To identify whether psoriatic patients, including those with psoriatic arthritis, confer specific and recognizable body composition changes compared

Figure 1. Flow diagram of articles included in this review

Table 1. Body composition outcomes by modality

	Study	Design	Pso vs HC
Biomechanical analysis (BIA)	Barone et al., 2018	Cross-sectional	+
	Barrea et al., 2015	Cross-sectional	+
	Barrea et al., 2016	Cross-sectional	+
	Demirel et al., 2013	Cross-sectional	ND
	Engin et al., 2014	Case-control	+
	Galluzzo et al., 2017	Cross-sectional	+
	Galluzzo et al., 2018	Prospective cohort	+
Dual energy X-ray absorptiometry (DXA)	Krjewska-Włodarczyk et al., 2017	Cross-sectional	+
	Romani, Caixas et al., 2012	Cross-sectional	+
	Romani, Caixas, Cepenuelo et al., 2012	Cross-sectional	+
	Diniz Mdos et al., 2016	Cross-sectional	+
	Kofoed et al., 2012	Cross-sectional	+
	Leite et al., 2015	Cross-sectional	+
	Leite et al., 2018	Randomised control trial	+
Ultrasonography	Renzo et al., 2011	Prospective cohort	+
	Tournadre et al., 2017	Cross-sectional	+
	Gonul et al., 2017	Cross-sectional	+
	Akyildiz et al., 2014	Cross-sectional	+
Trans thoracic echocardiography	Balci et al., 2010	Cross-sectional	+
	Balci et al., 2014	Cross-sectional	+
	Aguiar et al., 2014	Cross-sectional	+
Computed tomography (CT)	Andreevskaia et al., 2013	Cross-sectional	+
	De La Brassine et al., 2016	Cross-sectional	+
	Ganguly et al., 2016	Cross-sectional	+
Other			
	Mean muscle index		
Body fat (%)			
Body fat (%)			
Lipid accumulation product index			
MRI of abdominal fat distribution			
	Ferguson et al., 2019	Prospective cohort	+

ND: no difference