Figure 1. Baseline and last visit disease activity by BMI categories: $p: 0.03^*$; $p: 0.01^*$; $p: 0.001^*$; $p: 0.002^*$; $p < 0.05$; BMI: Body mass index, DAS: Disease Activity Score, BASDAI: Bath Ankylosing Spondylitis Disease Activity Index, DAPSA: Disease Activity index for Psoriatic Arthritis, PSAID: Psoriatic Arthritis Impact of Disease

Figure 2. Retention rate for biological DMARD by BMI categories Median of retention rate of first bDMARD: BMI > 30 kg/m² and < 30 kg/m² 54.2 and 79, respectively. Log rank p-value between BMI > 30 kg/m² and < 30 kg/m²: 0.03^*

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AB0764

SAFETY OF SYSTEMIC CORTICOSTEROIDS IN A SHORT REGIMEN IN PATIENTS WITH PSORIATIC ARTHRITIS. RETROSPECTIVE ANALYSIS OF A LARGE OBSERVATIONAL COHORT.

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Background: There is controversy surrounding the use of systemic corticosteroids in psoriatic arthritis (PsA). It's an accepted fact that the use of systemic corticosteroids can trigger severe flare-up of erythroderma or pustular psoriasis. Nevertheless, corticosteroids have been used to achieve faster improvement of joint symptoms of PsA.

Objectives: To analyze the use of systemic corticosteroids at intermediate doses in a short regimen in patients with PsA, as well as the serious complications of psoriasis upon withdrawal.

Methods: Retrospective analysis of an observational cohort of 453 patients from a university hospital, following a specific protocol from 1992 to 2019. The following variables have been collected: corticosteroid treatment (methylprednisolone ≤16mg /day in a slow tapering regimen in 2 months), demographic and disease factors, comorbidities that could be associated (diabetes mellitus, high blood pressure, severe infections) and serious complications of psoriasis (erythroderma or pustular psoriasis). To assess the activity of psoriasis, physician global assessment is mostly used and occasionally to a lesser extent body surface area and psoriasis area severity index.

Statistical analysis (SPSS v.25): descriptive analysis, Chi-squared test for qualitative variables and t-student test for quantitative variables.

Results: In our series, 35.98% (163/453) of patients have received short corticosteroid regimen at some point in follow-up care, of which 93.8% received concomitant treatment with disease modifying antirheumatic drugs (DMARD). Only 6.2% of the patients who received short corticosteroid regimen presented a flare-up of psoriasis, most of them mildly. No patient developed an erythroderma or severe pustular psoriasis.

After analyzing the data, a greater use of this regimen of treatment has been observed in patients with dactylitis (44.6% with dactylitis vs 27.8% without dactylitis, $p < 0.001$) and a lower use of corticosteroids in axial PsA (14% of axial PsA vs 41% of non-axial PsA, $p < 0.001$).

There were no significant differences in the use of corticosteroids in respect to sex, age, age of onset of PsA, duration of PsA or high blood pressure. Nor in factors of poor radiographic prognosis: number of damaged joints, mutilating PsA and carpalis.

Conclusion: In our series, no patient developed an erythroderma or severe pustular psoriasis and most of the flare-ups of psoriasis were mild. The use of systemic corticosteroids at intermediate doses in a slow tapering regimen concomitantly with DMARD can be safely used in patients with PsA.

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AB0765

CAN A 6-JOINT ULTRASOUND SCORE DIFFERENTIATE RHEUMATOID ARTHRITIS FROM PSORIATIC ARTHRITIS? A CROSS SECTIONAL STUDY

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Background: Ultrasonography (US) is a well established technique both for diagnosis and follow up in Rheumatoid Arthritis (RA) and Psoriatic Arthritis (PSA)¹. To date, there is no consensus regarding a standardized US evaluation of joint involvement by a validated score to be used for differential diagnosis.

Objectives: 1) To differentiate the ultrasound features of patients affected by active RA or active PSA by using a 6-joints score². 2) To analyze correlations between those findings and clinical patterns of PSA disease.

Methods: 68 RA and 38 PSA patients (divided in two equal subgroups according to the clinical involvement i.e. polyarticular or oligoarticular) were enrolled in a multi-center cross-sectional study. All patients underwent clinical evaluation including demographic data, disease characteristics, laboratory test and tender/swollen joints count. SDAI and DAPSA were calculated in accordance to the disease and standard of care. The sonographic evaluation of wrists, II MCFs and knees, was performed using a multifrequency linear probe (13-18 MHz) with power Doppler (7.5 MHz, PRF500 Hz). High-end equipment was used and the scanning technique as well as the lesion assessment was previously agreed among the participants, who performed a consensus session 100 images. A validated ultrasound score², which included effusion, synovial hypertrophy and synovial hypervascularization at 6 joints sites was used. Those lesions were assessed according to OMERACT definitions and semi-quantitatively graded (0-3). By summing the scores obtained at each joint site and globally, a joint score for articular involvement, a score for the severity of each lesion and a global 6-joint score for all abnormalities were calculated.

Results: Clinical evaluation showed no statistically significant differences between RA and PSA (table I). Ultrasound detected significant differences in the score of joint effusion (SE) ($p < 0.021$), synovial hypertrophy (SH) ($p < 0.001$) and Doppler signal ($p < 0.011$) between oligoarticular PSA and RA. Significant differences in the joint score of II MCF ($p < 0.000$) and wrist ($p < 0.032$) were also found between oligoarticular PSA and RA. The global 6-joint score was 10,88 in RA, 6,05 in PSA oligoarticular, 16,32 in PSA polyarticular. No differences were found between RA and polyarticular PSA.

Conclusion: Ultrasound evaluation of 6 target joints might help to discriminate RA and PSA oligoarticular subset. The study of a limited number of joints is

Table 1.

Dependent variables	Study Population	p values
US_SEScore	RA	PSA OLIGO .021
		PSA POLY .356
	PSA	RA .021
	OLIGO	PSA POLY .014
	PSA	RA .356
US_SHScore	POLY	PSA OLIGO .014
	RA	PSA OLIGO .001
		PSA POLY .336
	PSA	RA .001
	OLIGO	PSA POLY .004
US_PDScore	PSA	RA .336
	POLY	PSA OLIGO .004
	RA	PSA OLIGO .011
		PSA POLY .102
	PSA	RA .011
US_MCP2Score	OLIGO	PSA POLY .006
	PSA POLY	RA .102
		PSA OLIGO .006
	RA	PSA OLIGO .000
	PSA	RA .276
US_WRIStScore	OLIGO	PSA POLY .002
	PSA POLY	RA .276
		PSA OLIGO .002
	RA	PSA OLIGO .032
	PSA	RA .610
US_KNEEScore	OLIGO	PSA POLY .032
	PSA POLY	RA .047
		PSA OLIGO .610
	RA	PSA OLIGO .047
	PSA OLIGO	PSA POLY 1.000
US_KNEEScore	PSA	RA .133
	OLIGO	PSA POLY 1.000
	PSA POLY	RA .180
		PSA OLIGO .133
	RA	PSA OLIGO 1.000
US_KNEEScore	PSA	RA .180
	OLIGO	PSA POLY .133
	PSA POLY	RA .180
		PSA OLIGO .133
	RA	PSA OLIGO .180

US: ultrasound; SE synovial effusion; SH synovial hypertrophy;
PD power Doppler; MCP metacarpophalangeal; PSA psoriatic arthritis;
OLIGO oligoarticular; POLY polyarticular

therefore a complementary tool to the clinic, fast and well integrated into the overall assessment of the arthritic patient.

References:

[1] Zabotti A. et al. Clin Exp Rheumatol. 2018; 36:519-525.

[2] Perricone C et al. Rheumatology (Oxford) 2012; 51:866-73.

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AB0766 ACCURACY OF PATIENT REPORTED OUTCOME REPORTING IN RANDOMIZED CONTROLLED TRIALS IN PSORIATIC ARTHRITIS

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Background: Patient-reported outcomes (PROs) allow incorporating the patient's perspective and health related quality of life (HRQoL) into shared decision making when choosing the optimal treatment strategy in patients suffering from psoriatic arthritis (PsA). PsA is a chronic inflammatory disease with heterogeneous manifestations with a range of symptoms, co-morbidities and reduced quality of life. International working groups (1) emphasized to integrate these outcomes as endpoints in clinical trials and as part of the core set of measures.

Objectives: To evaluate the quality of PRO reporting in randomized clinical trials in PsA.

Methods: We conducted a systematic literature review (PROSPERO ID 160930) searching PUBMED, MEDLINE and the Cochrane Library for publications (in English language) on randomized controlled trials investigating biological or targeted synthetic disease modifying drugs in adult PsA patients that included some PROs to evaluate the response to treatment. Two of the authors (BFS, AK) screened, selected and extracted the data of the trials that fulfilled inclusion criteria. Statistics were descriptive.

Results: Of 1392 articles in total 880 were screened (512 duplicates); 92 were selected for detailed analysis with 48 finally analysed. 87% were primary publications where some patient-outcome measure were reported. The Health Assessment Questionnaire Disability Index (HAQ-DI) was reported in all RCTs (100%), while 70% of trials reported on the Short Form (36) Health Survey (SF36). Fatigue (FACIT-F) was reported in 29% of trials with different rates of articles published before and after the OMERACT working group recommendations (27% vs 50%) (1). Data on burden of psoriasis through the Dermatology Life Quality Index in 45%. Other PRO measurements to assess potentially affected health domains such as sleep disturbance, psychological disorders or well-being at work were reported only rarely.

Conclusion: Our SLR shows that all trials report data on HAQ-DI. However, important domains as also emphasized by the OMERACT working group (1) are not routinely reported. Especially fatigue, included in 2016 as part of the OMERACT "Inner core" of the PsA Core Domain Set is only reported in about one quarter of studies, although 50% of studies published after 2016 report on fatigue. Data on emotional well-being, psychological status, productivity losses, and sleep disturbance remain rarely reported in PsA randomized controlled trials.

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AB0767 PATIENTS WITH RHEUMATOID ARTHRITIS HAVE A LOWER BONE DENSITY THAN PATIENTS WITH PSORIATIC ARTHRITIS

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Background: Osteoporosis is a skeletal disease characterized by the loss of bone density resulting in an increased fracture risk. Female sex, advanced age, Caucasian ancestry, previous history of fractures, menopause and certain genetic factors predispose for osteoporosis. In addition, recent studies could prove that chronic inflammatory diseases such as Rheumatoid Arthritis (RA) and long-term treatment with higher doses of glucocorticoids (GCs) represent independent risk factors for the development of osteoporosis. On the other hand, the intake of vitamin D, a calcium-rich diet and physical exercise can be protective. Data describing the prevalence of osteoporosis in patients with other rheumatic diseases like psoriatic arthritis (PsA) are lacking.

Objectives: We compared the prevalence of osteopenia and osteoporosis in patients with RA and PsA, respectively, based on data obtained from our ongoing prospective monocentric study Rh-GIOP investigating glucocorticoid (GC)-induced osteoporosis in patients with different rheumatic diseases (NCT02719314).

Methods: Bone mineral density data measured by dual x-ray absorptiometry (DXA) in patients with PsA (n=92) were compared with data measured in 92 age- and