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Table 1. RDA in patients with LDA according to diverse activity scores

RDA, n (%)	Remission and LDA according to disease activity scores, n (%)					
	MDA-5 n:35	MDA-6 n:13	VLDA n:3	DAPSA LDA n:72	PASDAS LDA n:22	GRACE LDA n:22
RDA_TJC	4 (11.4)	1 (7.7)	0	25 (34.7)	3 (13.6)	1 (4.5)
RDA_SJC	1 (2.9)	0	0	3 (4.2)	0	0
RDA_dactylitis	2 (5.7)	0	0	2 (2.8)	1 (4.5)	1 (4.5)
RDA_PASI	4 (11.4)	1 (7.7)	0	23 (31.9)	5 (22.7)	5 (22.7)
RDA_VAS pain	23 (65.7)	3 (23.1)	0	56 (77.8)	13 (59.1)	13 (59.1)
RDA_VAS	21 (60)	4 (30.8)	0	56 (77.8)	10 (45.5)	11 (50)
Global						
RDA_physician	26 (83.9)	8 (61.5)	1 (33.3)	64 (88.9)	15 (71.4)	16 (72.7)
VAS						
RDA_HAQ	1 (2.9)	1 (7.7)	0	16 (22.2)	1 (4.5)	0
RDA_LEI	1 (2.9)	1 (7.7)	0	24 (33.3)	3 (13.6)	2 (9.1)

RDA: residual disease activity, MDA: Minimal disease activity, VLDA: Very Low disease activity, LDA: Low disease activity, TJC: Tender joint count, SJC: Swollen joint count

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TIME TO RESPONSE FOR CLINICAL AND PATIENT-REPORTED OUTCOMES IN PATIENTS WITH PSORIATIC ARTHRITIS TREATED WITH TOFACITINIB, ADALIMUMAB OR PLACEBO

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Background: With multiple disease domains affected in PsA, clinical and patient-reported outcome (PRO) measures are important to assess disease improvement following treatment. Rapid, meaningful improvements in disease activity are a priority for physicians and patients (pts). Tofacitinib is an oral Janus kinase inhibitor for the treatment of PsA. Higher proportions of pts achieved responses in PROs and clinical measures when treated with tofacitinib for 3 months vs placebo (PBO).¹⁻⁵ Proportions of responders were also similar between tofacitinib and adalimumab (ADA) after 3, 6 and 12 months.^{2,3,5}

Objectives: To determine the time to initial response using responder definitions for selected PROs and clinical endpoints in pts with active PsA treated with tofacitinib, ADA or PBO switching to tofacitinib.

Methods: In this post hoc analysis, data were collected from two Phase 3 studies (OPAL Broaden [12 months; NCT01877668]; OPAL Beyond [6 months; NCT01882439]).^{3,4} Pts receiving tofacitinib 5 or 10mg twice daily (BID), subcutaneous ADA 40mg once every two weeks (Q2W; OPAL Broaden only), or PBO switching to tofacitinib 5 or 10mg BID at Month (M)3, were included. Responder definitions included: HAQ-DI ≥ 0.35 -point improvement from baseline (BL), Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-F) total score ≥ 4 -point improvement from BL, minimal disease activity (MDA) yes/no composite response (meeting at least 5 of 7 criteria) and PsA Disease Activity Score (PAS-DAS) post-BL score of ≤ 3.2 and >1.6 -point improvement from BL. First post-BL data were collected at Week 2 (eg for HAQ-DI) or M1. Time-to-event analyses were performed using the Kaplan-Meier (KM) method, with pts censored at the last observed visit. Log-rank tests compared time to initial response across treatment groups.

Results: KM analyses show days to initial response (Figure 1, Figure 2). Time to initial HAQ-DI response was significantly different between treatment groups in OPAL Broaden ($p < 0.01$): faster response in pts receiving tofacitinib 5mg BID, tofacitinib 10mg BID and ADA 40mg Q2W vs pts who switched from PBO to tofacitinib at M3 (Figure 1a). A similar, but not significant (ns), trend was observed for HAQ-DI responses in OPAL Beyond (Figure 1b). Generally, initial FACIT-F responses were achieved faster (ns) in pts receiving tofacitinib 5mg BID vs other treatment in both studies (Figure 1c, Figure 1d). Times to initial MDA and PASDAS responses were similar between tofacitinib and ADA treatment groups (Figure 2).

Conclusion: Times to initial response in functional ability and disease activity were similar in pts treated with either tofacitinib or ADA. Time to initial response prior to first post-BL observation (Week 2 or M1) was not estimable in this analysis. These results may help physicians better understand the time frame for a meaningful response in pts receiving tofacitinib.

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Figure 1. Times to initial response for (a, b) HAQ-DI and (c, d) FACIT-F total score responses

Responder definitions: HAQ-DI ≥ 0.35 -point improvement from baseline; FACIT-F total score ≥ 4 -point improvement from baseline. PBO group began treatment with tofacitinib at Month 3. BID, twice daily; Q, confidence interval; MDA, Minimal Disease Activity Score; NE, not evaluable; Q2W, once every two weeks; SC, subcutaneous.

Figure 2. Times to initial response for (a, b) MDA and (c, d) PASDAS responses

Responder definitions: MDA, yes/no composite response meeting at least 5 of 7 criteria; PASDAS, post-BL score ≤ 3.2 and >1.6 -point improvement from baseline. PBO group began treatment with tofacitinib at Month 3. BID, twice daily; Q, confidence interval; MDA, Minimal Disease Activity Score; NE, not evaluable; Q2W, once every two weeks; SC, subcutaneous.

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PERIPHERAL JOINT INFLAMMATION IS ASSOCIATED WITH MORE PROATHEROGENIC CARDIOVASCULAR RISK PROFILE IN PATIENTS WITH PSORIATIC ARTHRITIS

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