Table.

	Uveitis (n=10)	Non uveitis (n= 310)	p
Baseline general features			
Age, years (mean±SD)	42.2 ± 16.8	46.4 ± 11.9	0.38
Sex, n (m/w) (%)	4/6 (40/60)	134/176 (43.2/56.8)	0.90
HLA-B*27, positive %	60	11.8	<0.01
Disease Characteristics			
Axial arthritis, %	40.0	37.0	0.88
Peripheral arthritis, %	80.0	72.9	0.89
Hip affection, %	30.0	20.0	0.71
Enthesitis, %	60.0	40.5	0.55
Dactylitis, %	20.0	29.5	0.77
Scores			
BASDAI (mean ± SD)	3.3 ± 2.08	2.4 ± 1.9	0.26
BASFI (mean ± SD)	2.7 ± 1.9	1.6 ± 1	0.31

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ASSOCIATION BETWEEN PATIENT-REPORTED OUTCOMES AND DISEASE ACTIVITY IN BIMEKIZUMAB-TREATED PATIENTS WITH PSORIATIC ARTHRITIS

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Background: Bimekizumab (BKZ) is a humanised IgG1 monoclonal antibody, which selectively neutralises interleukin (IL)-17A and IL-17F. There is support for the BKZ mechanism of action as a novel therapeutic approach for psoriatic arthritis (PsA).¹⁻³ The phase 2b dose-ranging BE ACTIVE study assessed the efficacy and safety of BKZ in patients (pts) with PsA; data are reported elsewhere.⁴ Patient-reported outcomes (PROs) are increasingly recognised as important endpoints in clinical trials.⁵ The Psoriatic Arthritis Impact of Disease-9 (PsAID-9) questionnaire was specifically developed to assess health-related quality of life (QoL) in pts with PsA⁵ and its validity in clinical practice has been demonstrated.⁵⁻⁶

Objectives: To report the association between PsAID-9 score (a PRO) and disease activity response (very low disease activity [VLDA], minimal disease activity [MDA] or Disease Activity Index for Psoriatic Arthritis [DAPSA] remission) during 48 weeks' (wks') BKZ treatment.

Methods: Details of the study design (NCT02969525) are reported elsewhere.⁴ Here, we report the proportion of pts who achieved a PsAID-9 score ≤3, and the association between PsAID-9 score at Wk 48 (range 0–10, where 10 corresponds to worst QoL) and VLDA/MDA (binary states of disease control) or DAPSA (range 0–28 where 0–4 is remission, 5–14 is low, 15–28 is moderate, and >28 is high disease activity) at Wk 12.

Results: Across 206 randomised pts at baseline, 66.5% had psoriasis body surface area (BSA) ≥3%, 18.9% had prior tumour necrosis factor inhibitor (TNFi) exposure, and 63.6% received concomitant methotrexate. A substantial proportion of pts achieved MDA and/or DAPSA remission by Wk 12, which generally increased through to Wk 24 and 48 (**Table 1**). The 160 mg BKZ group saw the highest Wk 48 rates of MDA response (60.0%) and DAPSA remission (45.0%) (**Table 1**). The proportion of pts achieving a PsAID-9 score ≤3 was consistently high across all active treatment arms (**Figure 1**). PsAID-9 score was consistently lower (indicating better QoL) for pts with VLDA or MDA, and those in DAPSA remission (**Figure 2**), indicating that low disease activity was associated with improved PROs.

Conclusion: In BKZ-treated pts, improvements in PsAID-9 were associated with achievement of VLDA/MDA response and DAPSA remission. These results suggest that pts achieving higher disease control have improved QoL.

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Table 1. MDA and DAPSA responder rates

Treatment arm	MDA (%) [a]			DAPSA remission (%) [b]		
	Wk 12	Wk 24	Wk 48	Wk 12	Wk 24	Wk 48
BKZ 160 mg (n=40)	47.5	50.0	60.0	20.0	35.0	45.0
BKZ 160 mg LD (n=37) [c]	43.2	59.5	54.1	29.7	48.6	37.8
BKZ 320 mg (n=41)	29.3	36.6	46.3	12.2	19.5	34.1

[a] DBS, pts with missing data were counted as non-responders; [b] DBS, missing data are imputed using last observation carried forward; [c] 160 mg with 320 mg LD at baseline. BKZ: bimekizumab; DAPSA: Disease Activity Index for Psoriatic Arthritis; DBS: dose-blind set; LD: loading dose; MDA: minimal disease activity.

Figure 1. Proportion of patients achieving PsAID-9 score ≤3

Figure 2. Association between PsAID-9 and VLDA, MDA, and DAPSA disease states at Wk 48

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DOES DACTYLITIS/ENTESITIS PREDICT THE RESPONSE TO A SPECIFIC BIOLOGICAL TREATMENT IN PSORIATIC ARTHRITIS?

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