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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AB0778

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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AB0779

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

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Background: Spondylarthritis are diseases with a pathophysiological focus in entheses with a different extent of synovial component. In the event of therapeutic failure with DMARDs, the clinician may consider biological therapy with anti-TNF drugs or other targets such as IL23. Despite this, most patients receive first-line anti-TNFs. Given that IL19 and IL23 activity is recognized at the level of the entheses.

Objectives: To evaluate whether the presence of dactylitis/entesitis could be useful in the choice of a particular biological therapy.

Methods: A secondary analysis of a previous study was performed based on an electronic survey completed by patients with PsA and distributed among members of the patient association "Acción Psoriasis". Records from 191 respondents who had received at least one biological therapy were included. Patients were grouped according to the presence or absence of dactylitis or enthesitis. The rate of need to progress to the next therapeutic biologic line was compared.

Results: 61 patients reported dactylitis and 155 enthesitis. Distribution of treatments in patients with dactylitis: 33 patients received an anti-TNF-alpha, 11 Secukinumab and 12 Ustekinumab. 15 patients in the group receiving an anti-TNF-alpha had to substitute another treatment within 2 years (45.4%). 3 patients in each of the remaining groups had to substitute treatment within 2 years (27.2% and 25%, respectively). Compared to those receiving anti-TNF-alpha therapy, patients treated with Secukinumab or Ustekinumab had greater therapeutic persistence at 2 years ($P < 0.001$, in both cases). Distribution of treatments in patients with enthesitis (not including dactylitis): 115 received an anti-TNF-alpha, 25 received Secukinumab and 18 received Ustekinumab. 38 patients who received an anti-TNF-alpha had to substitute it within 2 years (24.5%). 4 patients who received Secukinumab and 3 who received Ustekinumab had to substitute their treatments in less than 2 years (16% and 16.6%, respectively). Compared to patients receiving anti-TNF-alpha therapy, patients treated with Secukinumab and Ustekinumab had a higher proportion of therapeutic persistence at 2 years ($P < 0.05$ for both cases).

Conclusion: The presence of dactylitis more than enthesitis, is associated with a higher proportion of therapeutic persistence in those patients treated with anti-IL17 or anti-IL23 therapies. Although there are multiple factors that condition the choice of biological therapies in patients with PsA, the presence of enthesitis and dactylitis (understood as polyenthesitis) should be considered among the most important ones.

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AB0780

TREATMENT PERSISTENCE OF BIOLOGICS AMONG PATIENTS WITH PSORIATIC ARTHRITIS (PSA)

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Background: Persistence in biologic therapy in psoriatic arthritis is critical to optimize symptom remission, functional capacity and health care costs.

Objectives: To estimate the persistence to biologic treatment prescribed to PsA patients in a real-life setting as well as factors associated with improved biologic drug survival in these patients.

Methods: Patients with PsA from a large health care provider database with at least two consecutive dispensed prescriptions of a biologic agent indicated for PsA from January 1st, 2002 until December 31st, 2018 were identified and followed until medication stop date or the end of observation period. Patients were considered non-persistent whenever a new prescription was dispensed and a permissible gap of 6 months was exceeded prior to starting on this biologic agent from the prescription date. Treatment changes were based on physician decisions and patient preferences. Demographic data including age, sex, BMI, ethnicity, smoking history and socioeconomic status as well as Charlson comorbidity index were retrieved. Data regarding use of steroids and non-biologic disease-modifying anti-rheumatic drugs were also extracted. Descriptive statistics, including means (standard deviations) for continuous variables and frequencies (%) for categorical variables, were used. Persistence estimates were derived using non-parametric survival analysis using Kaplan-Meier functions, with treatment discontinuations as failure events. Cox regression hazard ratio models were conducted to investigate factors associated with drug persistence.

Results: 2301 PsA patients with 2958 treatment periods were identified and included in the analyses. The mean age was 50.9±14 years of whom 54% were females, 70.4% of the study population had a BMI>25, and 36% were obese (BMI>30), 40% were current smokers, and 76% had a Charlson comorbidity index higher than 1. The most commonly prescribed drug was etanercept, followed by adalimumab, golimumab, secukinumab, ustekinumab and infliximab at 33%, 29%, 12%, 10%, 8% and 8%, respectively. Only about 20% of patients remained on a particular biologic agent after 5 years, whereas about 40% persisted on therapy following 20 months of treatment. A Kaplan-Meier survival analysis with pairwise comparisons of all treatment choices with respect to lines of therapy was conducted. When analyzing the data for all treatment periods and taking into account all lines of therapy, secukinumab had a higher

persistence than adalimumab, infliximab and ustekinumab, with a Log Rank of 0.022, 0.047 and 0.001, respectively, as is shown in figure 1. Female sex and smoking were associated with lower drug persistence (HR=1.25, 95%CI 1.13-1.38 and HR=1.109, 95%CI 1.01-1.21, respectively). When analyzing the data regarding second-line biologic agents, secukinumab was found to be superior to adalimumab, etanercept, infliximab and ustekinumab but not to golimumab with a Log-Rank P value of 0.001, 0.004, 0.025 and 0.002, respectively (figure 2). On analyzing the data using only the first indicated biologic line, no superiority of any single anti-Tumor Necrosis Factor-alpha (anti-TNFα) agent was observed.

Conclusion: In this large observational cohort, in the era of biologic therapy, a relatively low persistence was observed, with female sex and smoking having a negative impact on persistence. None of the anti-TNFα agents as first line therapy was found to be more persistent than others, while secukinumab was found to be superior to other biologics when indicated as second line of therapy.

References: None

Figure 1.

Figure 2.

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AB0781

OPTIMIZATION OF APREMILAST USE IN DAILY PRACTICE BY EXPECTATION MANAGEMENT

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