Results: Currently, 77 patients have been included in the analysis (SJC ≤4: n=53; SJC >4: n=24) (Table 1). Mean baseline PsAID scores were 4.4 vs. 4.8 for the SJC ≤4 vs. SJC >4 groups (Figure 1). The proportions of patients who were not in the PsAID-defined Patient Acceptable Symptom State (PASS) were 58.7% for the SJC ≤4 group and 62.5% for the SJC >4 group. Mean pain visual analog scale (VAS) scores (0-100 mm) were 45.9 vs. 53.4 for the SJC ≤4 group vs. the SJC >4 group. Mean scores for the individual PsAID domains for the SJC ≤4 vs. SJC >4 groups were generally comparable (Figure 2). Presence of specific manifestations of PsA for patients in the SJC ≤4 group vs. the SJC >4 group, respectively, were: moderate to severe psoriasis (psoriasis-involved body surface area [BSA] >3: 31.4% vs. 21.7%), nail psoriasis (45.3% vs. 41.7%), enthesitis (Leeds Enthesitis Index >0: 43.4% vs. 45.8%), dactylitis (18.9% vs. 33.3%), and axial involvement (3.8% vs. 8.3%). Comorbidities in ≥5% of either group (SJC ≤4 vs. SJC >4) included hypertension (30.2% vs. 37.5%), hypercholesterolemia (13.2% vs. 16.7%), obesity (2.6% vs. 9.2%), and anemia (0.0% vs. 3.8%). Comorbidities in ≥5% of either group (SJC ≤4 vs. SJC >4) included hypertension (30.2% vs. 37.5%), hypercholesterolemia (13.2% vs. 16.7%), obesity (2.6% vs. 9.2%), and anemia (0.0% vs. 3.8%).

Conclusion: In this real-world study, no strong associations between SJC and patient-reported impact of disease or pain were observed. Similar to patients with more extensive joint involvement, patients with limited joint involvement had an associated substantial burden of disease, with more than half achieving PsAID PASS.

References:

Disclosure of Interests: Tim Jansen Grant/research support from: AbbVie, Celgene Corporation – consultant, Speakers bureau: Grunenthal, Sobi – speakers bureau, Arie Van Vliet Employee of: Amgen Inc. – employment; Celgene – employment at the time of study conduct, Marijn Vis Grant/research support from: Novartis, Pfizer – consultant

AB0785

REAL LIFE EXPERIENCE OF METHOTREXATE BASED DUAL COMBINATION DMARDs IN PSORIATIC ARTHRITIS- RESULTS FROM KARNATAKA PSORIATIC ARTHRITIS COHORT (KPSAC)

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Background: Biologics have been the focus of recent treatment guidelines and ‘Treat to Target’ strategies for both psoriasis (PsO) & psoriatic Arthritis (PsA). However, in day-to-day practice, combination DMARDs anchored around methotrexate are mainstream in majority of patients.

Objectives: To describe experience and effectiveness of Methotrexate in combination with conventional DMARDs in Karnataka Psoriatic Arthritis Cohort.

Methods: Treatment information was extracted from KPSC (n=549) which is a cross sectional, non-interventional study conducted across 17 rheumatology centers in Karnataka, India using a structured proforma. This study was approved by respective Ethical committee. Information on efficacy was extracted for various csDMARDs in combination with methotrexate. Standard disease activity outcome measures were used for assessing the response to therapy (DAPSA, PASI, HAQ, MDA5). All participating rheumatologists underwent training to calculate PASI and other outcome scores.

Results: Nearly half of the patients in our cohort were on methotrexate (44%) monotherapy. Proportion of patients who received combination csDMARDs anchored on methotrexate were 29%. The choice of add on csDMARD was as per clinician discretion or subject preference. Patients were divided in to three groups based on treatments they were receiving at the time of study: Methotrexate (Mtx)+Leflunomide (Lef), Mtx+Sulfasalazine (Szz) and Mtx+Apresmilast(Apr). Their characteristics along with outcome measures are depicted in table 1. In Mtx+Apr group: remission or low disease activity was present in 42%, HAQ score of <0.5 was seen in 82%, and only one patient had a PASI of >10. PASI was significantly lower in the Mtx+Apr group compared to Mtx+Lef group (p<0.009) and Mtx+Szz group (p < 0.020).

Conclusion: Apremilast is an orally administered, small molecule inhibitor of phosphodiesterase 4 (PDE4)**. In this observational study, 3 groups of methotrexate plus csDMARD- leflunomide, sulfasalazine and apremilast fared similarly for articular domain of PsA. However, in cutaneous domain, PASI was significantly lower in apremilast + methotrexate group. To our knowledge, this is the first real life report of the use of combination DMARDs in unselected PsA patients demonstrating effectiveness of apremilast in cutaneous domain. Methotrexate remains anchor DMARD for treatment of PsA in 2/3rd of PsA patients. Addition of apremilast to methotrexate inadequate responders appears to be beneficial in PsA with persistent cutaneous disease. However, being an observational study, this needs to be confirmed in controlled clinical trials.


AB0786

IMPACT OF PSORIASIS SEVERITY ON HEALTH-RELATED QUALITY OF LIFE IN EARLY PSORIATIC ARTHRITIS: RESULTS FROM REAL WORLD DATA, THE DEPAR STUDY

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Background: Psoriasis is an important feature of psoriatic arthritis (PsA). Psoriasis itself is known to have a significant impact on Health-related Quality of life (HRQoL), however its role within PsA is less well understood. In daily practice, assessment of psoriasis may not always be a priority for rheumatologists, having been trained to focus on articular involvement. In order to assess whether psoriasis deserves more attention from rheumatologists, the aim of this study is to evaluate the influence of psoriasis on HRQoL in early PsA patients.

Objectives: To describe the evolution of psoriasis severity during the first year of follow up in patients with early PsA and to evaluate the impact of psoriasis severity on HRQoL.

Methods: Real world data were used from the Dutch south west Psoriatic Arthritis cohort (DEPAR) study, consisting of newly diagnosed PsA patients included between July 2013 and February 2019. Psoriasis severity was assessed using the Psoriasis Area and Severity Index (PASI) and categorized in: no psoriasis (PASI 0), mild psoriasis (PASI<7), moderate psoriasis (PASI 7-12) and severe psoriasis (PASI>12). Musculoskeletal disease severity was measured with the Disease Activity in Psoriatic Arthritis (DAPSA) score as contrast for psoriasis severity. DAPSA was categorized in: remission (REM)[DAPSA<4], low disease activity (LDA[DAPSA≤14]), moderate disease activity (MDA[DAPSA≤28]) and high disease activity (HDA[DAPSA>28]).

General HRQoL was assessed with the Short-Form 36 (SF-36)[Physical component scale and Mental component scale]. Skin-specific HROQL was measured with the SkinIndex-17 (psychosocial scale and symptoms scale).

Results: In total, 435 patients were included. Mean (sd) age was 49.7 (13.4) years and 53% (n=229) was male. Psoriasis severity does not fluctuate much over the course of the first year and the majority of patients had mild psoriasis (Figure 1). HRQoL worsened with increasing psoriasis severity, when measured by the SkinIndex17. This reduction in HRQoL was not seen when measured with the SF-36 (Figure 2).
Recent reports revealed that IL-17 inhibitors were as effective as TNF inhibitors. On the other hand, based on the Tight Control of Psoriatic Arthritis (TICOPA) study, present treatment strategies for PsA aim to reach on minimal disease activity (MDA).

Objectives: We investigate the effectiveness of IL-17 inhibitors focusing on MDA achievement which were administered for the Psoriatic Arthritis (PsA) patients in our institution.

Methods: We examined 46 patients whom were diagnosed and treated in our institution. We analyzed DAS28-CRP as the evaluation of arthritis and Minimal Disease Activity (MDA) achievement as that of overall disease activity.

Results: Biologics were administered in 30 cases (65.2%) of all 46 cases. In 30 cases, 19 cases (63.3%) initiated TNF inhibitors (TNF) and 7 cases (23.3%) were IL-17 inhibitors (naïve group). In 9 cases, TNF were switched into IL-17 inhibitors (switch group), 7 cases continued TNF (TNF group). Patients characteristics in the cases which could collect the data were shown in Table 1. As for arthritis, DAS28-CRP has significantly improved at fourth weeks in naïve and TNF group. In switch group, DAS28-CRP has not demonstrated significant improvement, however, IL-17 inhibitors were effective for the cases to which they were initiated for arthritis. As for MDA, 71% and 78% have also achieved MDA at twentieth weeks in both naïve and switch groups. In the TNF group, 67% have not achieved MDA at twenty weeks because of no improvement of rash (Figure 1). In switch group, all cases to which IL-17 inhibitors were initiated for either arthritis or rash have achieved MDA, however, 40% of cases which were introduced for both arthritis and rash have not achieved MDA.

Conclusion: In our study, IL-17 inhibitors could bring high rate of MDA achievement for both naïve and switch from TNF. We suggest that TNFi should be switched into IL-17 inhibitors rapidly in the case of ineffective for TNFi. We recommend treatment strategies for PsA aim to reach on minimal disease activity (MDA).

References:

Disclosure of Interests: None declared.

Figure 1. Psoriasis severity categories during the first year of follow up. No psoriasis (PASI 0), mild psoriasis (PASI<7), moderate psoriasis (PASI 7-12) and severe psoriasis (PASI>12).

Figure 2. A, B: Median SkinIndex17 psychosocial score and symptoms score per psoriasis severity category and DAPSA category at baseline. C,D: Mean SF36 Physical component scale (PCS) score and Mental component scale (MCS) score per psoriasis severity category and DAPSA category at baseline. No psoriasis (PASI 0), mild psoriasis (PASI<7), moderate psoriasis (PASI 7-12) and severe psoriasis (PASI>12). REM (DAPSA<4), LDA (DAPSA<14), MDA (DAPSA<28) and HSM (DAPSA=28).

Conclusion: In early PsA patients, psoriasis severity is mostly mild, but considerably impacts HRQoL when measured using a skin specific questionnaire. For optimal management of PsA patients, we therefore recommend rheumatologists to additionally acquire information on the degree of psoriatic involvement. In our opinion, this information is valuable for the adequate assessment of HRQoL.

Disclosures of Interests: Fazira R. Kasiem: None declared, Marc R. Kok Grant/research support from: BMS and Novartis, Consultant of: Novartis and Galapagos, Ilja Tchetverikov: None declared, Kim Wervers: None declared, Johanna Hazes: None declared, Jolanda Luime: None declared, Marijn Vis Grant/research support from: Novartis, Pfizer – grant/research support, Consultant of: Abbvie, Celgene Corporation, Eli Lilly, Novartis, Pfizer – consultant

DOI: 10.1136/annrheumdis-2020-eular.30527

Table 1. Comparison of clinical characteristics at baseline in 3 groups.

<table>
<thead>
<tr>
<th>Age, year</th>
<th>IL-17 naïve group (n=7)</th>
<th>IL-17 switch group (n=9)</th>
<th>TNF group (n=7)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.7 ± 7</td>
<td>60.7 ± 18.9</td>
<td>53.8 ± 15.4</td>
<td>50.7 ± 13.6</td>
<td>N.S</td>
</tr>
<tr>
<td>Male, n (%)</td>
<td>3 (43)</td>
<td>6 (67)</td>
<td>5 (71)</td>
<td>N.S</td>
</tr>
<tr>
<td>MTX, n (%)</td>
<td>2 (29)</td>
<td>4 (44)</td>
<td>5 (71)</td>
<td>N.S</td>
</tr>
<tr>
<td>CRP (mg/dL)</td>
<td>0.41 ± 0.50</td>
<td>1.87 ± 3.13</td>
<td>1.07 ± 1.77</td>
<td>N.S</td>
</tr>
<tr>
<td>Swollen joint count</td>
<td>6.7 ± 7</td>
<td>3.6 ± 2.0</td>
<td>6.2 ± 6.9</td>
<td>N.S</td>
</tr>
<tr>
<td>Tender joint count</td>
<td>6.6 ± 7</td>
<td>2.2 ± 2.6</td>
<td>6.9 ± 9.0</td>
<td>N.S</td>
</tr>
<tr>
<td>Retent pain VAS</td>
<td>55.7 ± 22.3</td>
<td>47.1 ± 34.9</td>
<td>35.4 ± 13.6</td>
<td>N.S</td>
</tr>
<tr>
<td>BSA (%)</td>
<td>12.5a 173</td>
<td>7.7 ± 14.8</td>
<td>74 ± 7.2</td>
<td>N.S</td>
</tr>
<tr>
<td>Biologics, n</td>
<td>Secukinumab: 2</td>
<td>secukinumab: 3</td>
<td>Infliximab: 3</td>
<td>N.S</td>
</tr>
<tr>
<td>LDA: 1</td>
<td>Lixizumab: 2</td>
<td>Lixizumab: 5</td>
<td>Adalimumab: 3</td>
<td>N.S</td>
</tr>
</tbody>
</table>

Table 1. Comparison of clinical characteristics at baseline in 3 groups.

Conclusion: In our study, IL-17 inhibitors could bring high rate of MDA achievement for both naïve and switch from TNF. We suggest that TNFi should be switched into IL-17 inhibitors rapidly in the case of ineffective for TNFi.

References:

Disclosure of Interests: None declared.

DOI: 10.1136/annrheumdis-2020-eular.5575

Figure 1. MDA achievement in 3 groups.

Conclusion: In our study, IL-17 inhibitors could bring high rate of MDA achievement for both naïve and switch from TNF. We suggest that TNFi should be switched into IL-17 inhibitors rapidly in the case of ineffective for TNFi.

References:

Disclosure of Interests: None declared.

DOI: 10.1136/annrheumdis-2020-eular.5575

This recommendation does not indicate how to determine which biologics to use.