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 (0-100mm) were 45.9 vs. 53.4 for the SJC ≤ 4 group vs. for 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 $\geq 5\%$ of either group (SJC ≤ 4 vs. SJC >4) included hypertension (30.2% vs. 37.5%), hypercholesterolemia (13.2% vs. 16.7%), uveitis (1.9% vs. 8.3%), malignancy (0.0% vs. 8.3%), heart failure (5.7% vs. 8.3%), and depression (5.7 vs. 4.2%).

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 joints involvement, patients with limited joint involvement had an associated substantial burden of disease, with more than half not achieving PsAID PASS.

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AB0785

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

U. Karjigi¹, C. Kodishala¹, S. Chandrashekar¹, S. Kumar¹, V. Haridas¹, S. R¹, R. Jois¹, M. Daware¹, V. K. R. Rao¹, B. G. Dharmanand¹, V. R. K. Jain¹, Y. S. Singh¹, S. Singhal¹, P. Chebbi¹, C. Dharmapalaiah¹, A. Kamath¹, S. Prasad¹, P. C¹, R. Aithala¹, B. Pinto¹, B. Nazir¹, H. Alur Shivakumar¹, M. K M¹, V. Shobha¹. ¹KPSAC Study Group, Karnataka, India

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 mainstay 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 KPSAC (n=549) which is a cross sectional, non-interventional study conducted across 17 rheumatology practicing centres 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 csDMARD 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 (SSz) and Mtx+Apremilast(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 +Ssz 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, sulphasalazine 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.

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Table. Characteristics and comparison of combination csDMARDs

	MTX+SSZ (N=39)	MTX+LEF (n=77)	MTX+APR (N=45)
Median Age (years)	37	39	35
Median disease duration (months)	96	101	112
Enthesitis (Ever)	6(15%)	21(27%)	4(8%)
Dactylitis (Ever)	9(23%)	28(36%)	12 (26%)
DAPSA			
< 4	6(15%)	9(11%)	10(22%)
4-14	14(36%)	25(32%)	13(29%)
14-28	7(18%)	24(31%)	11(24%)
PASI >10	7(18%) #	14(18%) *	1(2%) #
HAQ < 0.5	30(77%)	60(78%)	37(82%)
MDA 5 achieved	16(41%)	25(32%)	19(42%)

*P value < 0.009 #P value <0.02

Disclosure of Interests: None declared

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AB0786

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

E.R. Kasiem¹, M. R. Kok², I. Tchetverikov³, K. Wervers⁴, J. Hazes¹, J. Luime^{4,5}, M. Vis¹ on behalf of CICERO. ¹Erasmus Medical Center, Rheumatology, Rotterdam, Netherlands; ²Maasstad Hospital, Rheumatology & Clinical Immunology, Rotterdam, Netherlands; ³Albert Schweitzer Hospital, Rheumatology, Dordrecht, Netherlands; ⁴Erasmus Medical Center, Rotterdam, Netherlands; ⁵Rheumatology, Rotterdam, Netherlands

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)¹, 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]).²

General HRQoL was assessed with the Short-Form 36 (SF-36[Physical component scale and Mental component scale]). Skin-specific HRQoL was measured with the Skindex-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 Skindex17. This reduction in HRQoL was not seen when measured with the SF-36 (Figure 2).

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 Skindex17 psychosocial score and symptoms score per psoriasis severity category and per DAPSA category at baseline. C,D: Mean SF36 Physical component score (PCS) and Mental component score (MCS) per psoriasis severity category and per 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 HDA (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.

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AB0787

EFFECTIVENESS OF IL-17 INHIBITORS REVEALED BY MINIMAL DISEASE ACTIVITY (MDA) ACHIEVEMENT OF PSORIATIC ARTHRITIS PATIENTS

M. Kato¹, H. Shimada¹, S. Nakashima¹, M. Mahmoud Fahmy Mansour¹, R. Wakiya¹, T. Miyagi¹, K. Sugihara¹, Y. Ushio¹, T. Kameda¹, H. Dobashi¹.

¹Kagawa university, Division of Hematology, Rheumatology and Respiratory Medicine, Department of Internal Medicine, Kagawa, Japan

Background: Recently, several type of biologics such as TNF inhibitors, IL-17 inhibitors, IL-12/23 (p40) inhibitors and IL-23 (p19) inhibitors are approved for PsA. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA) 2015 Treatment Recommendation suggests the treat-to-target strategy for PsA¹, however,

this recommendation does not indicate how to determine which biologics to use. Recent reports revealed that IL-17 inhibitors were as effective as TNF inhibitors². 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)³.

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 (TNFi) and 7 cases (23.3%) were IL-17 inhibitors (naïve group). In 9 cases, TNFi were switched into IL-17 inhibitors (switch group), 7 cases continued TNFi (TNFi 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 TNFi 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 TNFi group, 67% have not achieved MDA at twentieth 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.

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

	IL-17 naïve group (n=7)	IL-17 switch group (n=9)	TNF group (n=7)	p value
Age, year	60.7 ± 18.9	53.8 ± 15.4	50.7 ± 13.6	N.S
Disease duration, year	20.3 ± 25.8	17.4 ± 9.5	9.9 ± 12.4	N.S
Male, n (%)	3 (43)	6 (67)	5 (71)	N.S
MTX, n (%)	2 (29)	4 (44)	5 (71)	N.S
CRP(mg/dl)	0.41 ± 0.50	1.87 ± 3.13	1.07 ± 1.77	N.S
Swollen joint count	6.7 ± 7.3	3.6 ± 4.2	6.2 ± 6.9	N.S
Tender joint count	6.6 ± 7.0	2.2 ± 2.6	6.9 ± 9.0	N.S
Patient pain VAS	55.7 ± 22.3	47.1 ± 34.9	35.4 ± 13.6	N.S
BSA (%)	12.5 ± 17.3	7.7 ± 14.8	7.4 ± 7.2	N.S
Biologics, n	Secukinumab: 2 Ixekizumab: 5	secukinumab: 3 Ixekizumab: 5 Brodalumab: 1	Infliximab: 3 Adalimumab: 3 Etanercept: 1	

TNF: Tumor Necrosis Factor, MTX: Methotrexate, VAS: visual analog scale, BSA: body surface area, N.S: not significant

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 TNFi. We suggest that TNFi should be switched into IL-17 inhibitors rapidly in the case of ineffective for TNFi.

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AB0788

GENDER DIFFERENCES IN PSORIATIC ARTHRITIS DISEASE CHARACTERISTICS: EVIDENCE FOR WORSE DISEASE IN WOMEN.

A. Grivas¹, I. Kapniari², K. Tzannis³, D. Tseronis¹, M. Aggelakos¹, D. Kassara¹, K. Havatza¹, S. Flouda¹, D. Nikolopoulos⁴, T. Karageorgas¹, E. Papadavid², D. Boumpas¹, P. Katsimpr¹. ¹Attikon University Hospital, 4th Department