VITAMIN D ROLE IN VASCULAR DAMAGE PROGRESSION IN PATIENTS WITH PSORIATIC ARTHRITIS

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Background: Psoriatic Arthritis (PsA) is associated with insufficient levels of vitamin D (25OHD) and an increased cardiovascular risk. Several studies have shown a vascular damage progression between PsA and vascular damage. Objectives: To study the relationship between 25OHD and vascular damage, as well as its possible influence on its progression, in patients with PsA.

Methods: Pre-post longitudinal study with analytical components. PsA patients with peripheral joint involvement were included. Demographic (sex, age), clinical [follow-up time, DAPSA, current treatment, body mass index (BMI), classic vascular risk factors, vascular events] and analytical variables [atherogenic index, glomerular filtration (GF-MDRD), glycated hemoglobin (HbA1c)] were collected. We considered deficient level of 25OHD <20ng/ml and insufficient <30ng/ml. Basal vascular risk was estimated through SCORE tool. Extracranial carotid artery was explored with an Esaote MyLab70XVG ultrasound with linear probe (7-12mHz) and an automated program that measures intima media thickness (IMT) by radiofrequency. The presence of atheroma plaques was evaluated following Mannheim consensus. Pulse wave velocity (PWV) was measured through Mobilograph device. IMT<0.90 mm and PWV>10 m/s were considered as pathological values. We repeat vascular study 3 years later. Vascular damage progression was defined as the appearance of atheroma plaques during the follow-up and/or an increase in their number. Statistical analysis was performed using SPSS 22.0 program.

Results: 78 patients were included. Eighteen patients were excluded due to high vascular risk [previous event, diabetes type II or type I with target organ injury and/or GF-MDRD< 0.60/m], 57.5% were women with a mean age of 54.2 (SD 10.9) years. The mean follow-up time was 96.8 (SD 163.6) months and mean DAPSA was 10.2 (SD 8.3), 96.2% of patients had received DMARDs and 42.3% biologicals, and 42.3% took calcium and 25OHD supplements. Mean BMI was 25.3 (SD 4.7) kg/m²; 42.3% had tobacco exposure. 29.8% were hypertensive and 32% dyslipidemic. Mean SCORE was 16 (SD 1.8) and mean 25OHD was 276 (SD 116) ng/ml. 28.2% patients had 25OHD deficit and 60.3% insufficiency. As can be seen in our sample, low values of 25OHD are related to the other hand, patients with hypovitaminosis D presented a tendency to get higher scores in DAPSA index (P=0.07). We do not observe any relationship between 25OHD and TJC.

Conclusion: As can be seen in our sample, low values of 25OHD are related to increased disease activity in patients with PsA.

Disclosure of Interests: None declared.

 insistence that adopting a ‘treat-to-target’ approach aiming for Minimal Disease Activity (MDA) could result in better clinical outcomes.

Objectives: To improve assessment of all the core domains of PsA during clinic appointments and aim to treat these patients using a ‘treat-to-target’ approach to improve clinical outcomes.

Methods: We were able to confirm through a retrospective baseline audit that all core domains of PsA were not being fully addressed in our general rheumatology clinics. A dedicated weekly PsA clinic was then set up at our district general hospital. Subsequently, iPads incorporated with GRAPPA App were implemented in these clinics to facilitate multi-domain assessments aiming for MDA. This was supported by a Health Education England (Wessex) Quality Improvement Fellowship that involved rheumatology and dermatology team members working in close collaboration. We then carried out a re-audit to assess our performance. Additionally we set up quarterly combined Rheumatology and Dermatology clinics for patients with severe joint and skin involvement. We also conducted a baseline survey by asking patients for their opinion about the ‘setting up of the dedicated PsA service’ , the ‘quarterly combined clinics’ and the ‘use of iPad-based assessments;’ we asked them to score each of these on a scale of 0 to 10, with 0 being ‘very negative’ and 10 ‘very positive’.

Results: We had pragmatically set a standard of 75% for our baseline audit but we found an overall compliance of only 27.4%. There was also a wide variation between different domains with a compliance of even 0% for some. Domains that are not assessed are unlikely to be fully taken into account when deciding about treatment. The re-audit following the implementation of iPad-based assessments in dedicated PsA clinics showed a significant improvement in each of the domains and the overall compliance went up to 97.9% (Table 1). The patient survey findings were also excellent with mean scores of 9.5, 9.0 and 9.5 respectively for the three items (Figure 1).