Table 1.

	Audit (n = 25)	Re-audit (n = 29)
Compliance		
Q1. Documented evidence of joint count being performed?	84.0%	100.0%
Q2. If yes, then was it a 66/68 count for swollen and tender joints?	4.7%	100.0%
Q3. Documented evidence of dactylitis being assessed?	8.0%	100.0%
Q4. Documented evidence of enthesitis being assessed?	4.0%	100%
Q5. Documented evidence of assessment of spinal involvement?	8.0%	100.0%
Q6. Documented evidence of assessment of skin involvement?	36.0%	100.0%
Q7. Documented evidence of assessment of nail involvement?	4.0%	93.1%
Q8. Documented evidence of assessment of fatigue?	8.0%	96.6%
Q9. Documented evidence of assessment of degree of pain?	60.0%	100.0%
Q10. Documented evidence of patient's global assessment?	68.0%	96.6%
Q11. Documented evidence of assessment of physical function?	0.0%	96.6%
Q12. Documented evidence of assessment of health-related quality of life?	0.0%	93.1%
Q13. Documented evidence of assessment of systemic inflammation?	72.0%	96.6%
Overall Compliance	27.4%	97.9%

Conclusion: Dedicated PsA clinics using the GRAPPA App on iPads could facilitate comprehensive multi-domain assessments of patients with PsA and potentially lead to better outcomes as well as greater patient satisfaction.

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- Coates LC *et al.*, Effect of tight control of inflammation in early psoriatic arthritis (TICOPA): a UK multicentre, open-label, randomised controlled trial. *Lancet*. 2015; 386(10012):2489–2498

Figure 1. Patient survey (n=26)

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AB0809 HOW WELL ARE BIOLOGICS RETAINED IN PSORIATIC ARTHRITIS - A REAL WORLD STUDY

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Background: Biologics have led to a sea change in the management of psoriatic arthritis (PsA) with unprecedented improvement in the signs, symptoms and radiographic damage, resulting in improvement in functionality and quality of life. However longitudinal data for their retention and tolerability is sparse.

Objectives: Our objective was to evaluate real-world biologic therapy duration and reasons for discontinuing treatment.

Methods: We conducted a retrospective analysis of our PsA electronic register from 1994 up to and including April 2019 at our university teaching hospital. We had access to full patient records including details on co-morbidities, drugs and disease management.

Results: 335 patients were identified with PsA. 58% of them were female with mean age of 46 yr (13-81). 113 (33.7%) patients had been treated with a biologic with 105 (93%) continuing at the time of analysis. 60 individuals were prescribed combination therapy with DMARDs. Mean age was 43.3 years (13-81) with 56% women. The biologics sample was ethnically diverse including 80% White Caucasian patients, 17% Asian and others (3%). Significant

co-morbidities included cardiovascular disease (18.6%) and diabetes (4.4%). Eight different biologics were in use with adalimumab being the most prescribed (67%).

35 (30.9%) patients had stopped biologics at some point with 76 episodes of cessation. 6% of our sample had discontinued two or more biologic treatments. The mean duration before biologic therapy was discontinued was 18.2 months (8 days to 9.5 years), which was almost twice as long as the average period before discontinuing a DMARD (9.9 months). Main reasons for stopping treatment included 23% each due to GI symptoms, neurological causes, cutaneous symptoms and other side effects. The remaining 8% reported fatigue as the reason for stopping therapy.

Conclusion: To our knowledge this is the first dedicated retrospective review of a large real world PsA cohort comparing drug survival and tolerability of biologics against DMARDs. Biologic therapies are well tolerated in psoriatic arthritis. There is no significant difference amongst various modes of action. Over a quarter of the patients discontinue the drug owing to intolerance with mean drug survival of 18 months. In contrast nearly two-thirds were intolerant of DMARDs and stopped within ten months. Thus both the rate and duration of biologic retention is significantly better than conventional DMARDs. This has significant economic impact as NICE guidelines require an adequate trial of two DMARDs for six months prior to advanced therapy. However, this approach is unlikely to be cost effective as the disease progresses whilst patients struggle with DMARDs prescription and thus delay biologics which are more likely to be tolerated and retained longer. Hence there is an urgent need to review NICE guidelines to allow earlier employment of biologics in the treatment paradigm with significant benefits to both patients and the health economy.

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AB0810 IMPACT OF TOLERABILITY ON RETENTION OF CDMDARDS IN PSORIATIC ARTHRITIS - IS IT A CONCERN?

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Background: Most guidelines recommend the first line use of DMARDs in Psoriatic Arthritis (PsA). However, studies show that many conventional treatments like methotrexate are poorly tolerated. There is hitherto no published real-world data addressing the tolerability of DMARDs in PsA.

Objectives: Our objective was therefore to assess the drug management in PsA with focus on tolerability and the reasons for therapy cessation.

Methods: We conducted a retrospective analysis of all PsA patients enrolled in electronic database up to April 2019 at our university teaching hospital. We had access to full patient records including details on co-morbidities, drugs and disease management

Results: 335 patients were identified with a formal diagnosis of PsA. Mean age of the cohort was 46 years (13-81) and 58% were female. 48% of the group had clinically active disease. Same percentage were taking a single DMARD. 10% had trialled 3 or more drugs. 62% of patients had discontinued one or more DMARDs prior. The mean duration before discontinuing a DMARD was 9.9 months. Methotrexate was the best tolerated and on average discontinued after 13.4 months (range: 4 days to 10.9 years). Sulfasalazine and Hydroxychloroquine were discontinued after an average of 8.4 (11 days to 4.27 years) and 12.5 months (1.3 months to 2.88 years) respectively. Leflunomide was the least tolerated DMARD and stopped after an average of 5.5 months (7 days to 2.53 years). The main reason for stopping a medication was gastro-intestinal symptoms which accounted for 42% of all the reported side effects. This applied to both methotrexate (43%) and sulfasalazine (46%) discontinuation. The leading reasons for discontinuing Hydroxychloroquine were jointly GI symptoms and other side effects at 43% each. Leflunomide was stopped in 50% of cases due to neurological symptoms.

Conclusion: To our knowledge, this is the first report confirming poor retention rate of oral DMARDs in a real world PsA cohort managed over 20 years.

In the context of chronic disease, the median duration of treatment is short. Our analysis did not include patients who suffer from side effects but continue therapy thereby impacting treatment adherence and hence the true scale of the issue is likely higher. Though NICE guidelines stipulate the need of an adequate trial of minimum two DMARDs prior to therapy escalation, in reality these drugs are not well tolerated and thus pose a challenge to clinicians. One potential solution is earlier adoption of biological therapies, which are increasingly cost effective and have been shown to be better tolerated.

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AB0811

DEMOGRAPHIC, TREATMENT AND DISEASE CHARACTERISTICS OF PATIENTS WITH PSORIATIC ARTHRITIS RECEIVING TOFACITINIB IN THE UNITED STATES, FRANCE, GERMANY, ITALY, SPAIN AND THE UNITED KINGDOM

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Background: Tofacitinib is an oral JAK inhibitor for the treatment of psoriatic arthritis (PsA). The efficacy and safety of tofacitinib for PsA have been demonstrated in Phase 3 trials of up to 12 months' (mos) duration.^{1,2}

Objectives: To describe demographic, treatment and disease characteristics of a sample of patients (pts) at initiation of tofacitinib for PsA in the United States (US), France, Germany, Italy, Spain and the United Kingdom (European Union Five; EU5).

Methods: An online, retrospective medical chart review of de-identified pts treated with tofacitinib for PsA from the US and the EU5 was conducted by Ipsos Rheumatology Monitor between Sept and Dec 2019, after product approval for PsA (US, 5 mg twice daily [BID] and 11 mg once daily [QD]; Dec 2017; EU, 5 mg BID; June 2018). Rheumatology healthcare professionals (HCPs), recruited from a large panel, selected a sample of charts of pts ≥18 years of age who had a HCP-reported diagnosis of PsA and were prescribed tofacitinib. Extracted data included pt demographics, treatment characteristics (including treatments prior to tofacitinib) and disease characteristics at tofacitinib initiation (including HCP-reported disease severity).

Results: Of 1564 pts (US n=436; EU5 n=1128, respectively) sampled by 391 HCPs, the majority were White (75%; 91%), female (both 52%) and 45–64 years of age (53%; 57%). At time of chart review, US pts had received tofacitinib for median (interquartile range [IQR]) 9 (7–11) mos, and EU5 pts for 7 (6–9) mos; 52% of US pts received 11 mg QD, and 84% of EU5 pts received 5 mg BID. Median (IQR) time from PsA diagnosis to tofacitinib initiation was 34 (12–68) mos for all pts with data available (n=1237), and was shorter for US (11 [3–33] mos) vs EU5 (40 [19–79] mos) pts. Most pts had received ≥1 prior targeted therapy (59%; biologic or targeted synthetic disease-modifying antirheumatic drugs) for median (IQR) 12 (7–22) mos. The most common HCP-reported reason for switching from prior targeted therapy was efficacy failure (US and EU5 both 59%); either initial failure (US 28%; EU5 13%) or long-term failure (US 34%; EU5 48%) (Figure 1A). Mechanism of action and mode of administration were the most common HCP-reported reasons for switching to tofacitinib in both the US and EU5 (Figure 1B). HCP-reported disease severity at tofacitinib initiation was higher in the EU5 than US (Figure 2).

Conclusion: Characteristics of pts treated with tofacitinib for PsA were generally similar in the US and EU5. However, time from PsA diagnosis to tofacitinib initiation was shorter in the US vs EU5. It was of clinical interest to note that switching to tofacitinib appeared to be more commonly influenced by mechanism of action and mode of administration vs pt preference and access, as reported by HCPs. A key limitation of this study was the retrospective chart review design, which may introduce recall bias.

References:

- [1] Mease et al. NEJM 2017;377:1537-50.
- [2] Gladman et al. NEJM 2017;377:1525-36.

Figure 1. HCP-reported reason for patients A) switching from prior targeted therapy* and B) switching to tofacitinib†

*HCPs were able to select more than one reason for switching.
†HCPs were asked, "Why was this patient switched from this prior targeted therapy?"
HCPs were asked, "Why did you choose tofacitinib to treat this patient's PsA?"
*Efficacy failure includes only initial failure of efficacy or long-term failure of efficacy (DMARD, disease-modifying antirheumatic drug; EAM, extra-articular manifestation; EU5, European Union Five; HCP, healthcare professional; PsA, psoriatic arthritis; US, United States.

Figure 2. Proportion of patients with PsA categorised within each HCP-reported disease severity category*

*HCPs were asked to assess the patient's disease severity at tofacitinib initiation and were given the options of "Severe", "Moderate", and "Mild".
EU5, European Union Five; HCP, healthcare professional; PsA, psoriatic arthritis; US, United States.

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