Figure 2. Patients achieving HAQ-DI MCID Response up to Week 156 (Observed) and at Week 156 (mNRI) among patients with HAQ-DI ≥ 0.35 at baseline: Intent-to-Treat Population (Patients Randomized to IXE at Baseline)

Conclusion: Improvements in PROs, measuring physical and mental function, quality of life, and work productivity are maintained up to 3 years with IXE treatment in patients with active PsA who have had an inadequate response or intolerance to 1 or 2 TNFs.

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AB0815

CHANGES IN BODY COMPOSITION, BONE MINERAL DENSITY AND BONE REMODELING MARKERS DURING INTERLEUKIN 12/23 INHIBITION IN PSORIATIC ARTHRITIS

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Background: Psoriatic arthritis (PsA) is a chronic inflammatory disease characterized by multiple comorbid conditions including cardiovascular comorbidities, diabetes, obesity and osteoporosis. Little is known about body composition in patients with PsA and no data are available regarding body composition changes under DMARDs.

Objectives: We investigated the effects of ustekinumab (UST), a humanized anti-interleukin 12/23 antibody, on body composition, bone mineral density (BMD) and bone remodeling markers in patients treated for PsA.

Methods: Thirty patients with active PsA treated with UST were included in a 6 months open follow-up study. Body mass index, DAS28-CRP, bone remodeling markers, serum levels of leptin, BMD and body composition (dual-energy X-ray absorptiometry) were measured at baseline and 6 months of treatment. At baseline, PsA patients were compared with 60 non-PsA controls matched for age, sex and body mass index.

Results: Compared with controls, we observed lower total and appendicular lean mass (53.1 ± 13.1 vs. 56.7 ± 11.9 kg, $p=0.013$ and 21.6 ± 6.3 vs. 23.4 ± 5.0 kg,

$p=0.010$ respectively) and greater fat mass in PsA (32.5 ± 10.8 vs. 25.2 ± 8.9 kg, $p<0.001$). Among PsA patients, 30% had a skeletal muscle mass index below the cut-off point for sarcopenia (Baumgartner's criteria: men 7.26 kg/m², women 5.5 kg/m²) whereas no case was observed in the control group. After 6 months of treatment with UST, there was not a significant change of BMI, while there was a tendency for reaching the significant level for fat mass ($+1.75 \pm 3.60$ kg, $p=0.054$), and fat mass index ($+0.59 \pm 1.25$ kg/m², $p=0.061$). In contrast, a decrease in total lean mass was observed (-1.57 ± 3.10 kg, $p=0.046$) without a significant change in appendicular lean mass and skeletal muscle mass index. No changes for bone remodeling markers, leptin and BMD were observed at 6 months.

Conclusion: Patients with active PsA required biologic therapy had increased fat mass and decreased lean mass. Moreover, ustekinumab might worsen the decrease in lean mass with no significant change in fat mass.

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AB0816

CARDIOVASCULAR COMORBIDITIES IN PSORIATIC ARTHRITIS: A CASE CONTROL STUDY.

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Background: Psoriatic Arthritis (PsA) is an inflammatory arthritis associated with psoriasis. It occurs in approximately 8% –30% of patients diagnosed with psoriasis. In addition to joint and skin manifestations, patients with PsA have an increased prevalence of traditional cardiovascular (CV) risk factors that has been associated with a higher severity of PsA and increased cardiovascular disease (CVD). However, this increased risk has been attributed not only to increased traditional risk factors but also to chronic systemic inflammation.

Objectives: To compare the most relevant CV comorbidities in patients with PsA and controls.

Methods: A cross-sectional observational study was designed, 94 patients between 45-75 years who fulfilled the CASPAR classification criteria for PsA and 94 age-matched controls were included. The clinical characteristics compared between groups were: age, BMI, waist/hip index, gender, diabetes mellitus, hypertension, dyslipidemia, overweight, obesity, smoking history and prior cardiovascular event. Student-t test, Mann-Whitney U, Chi² test and Fisher's exact test were used to compare data and odds ratio were calculated. $p \leq 0.05$ was considered statistically significant. Logistic regression analysis was used to test association between significant clinical risk factors for PsA. The data were analyzed using the SPSS version 25 software.

Results: 94 PsA patients and 94 controls were included. The majority of the patients were women (57.4% in the PsA group and 80.9% in the control group) ($p < 0.001$). Body mass index and waist/hip index were higher in PsA group ($p < 0.002$) ($p < 0.001$) respectively.

PsA patients had more hypertension than controls ($p < 0.022$), more overweight ($p < 0.005$), and a higher smoking history ($p < 0.001$) than the control group. There was a trend in higher hyperlipidemia prevalence in PsA patients (Table 1).

Table 1. Clinical comorbidities and risk factors for PsA.

Variable	PsA	Control	p	OR (95% CI)
Age*	53.23 $\pm$ 11.31	53 $\pm$ 10	0.790	
BMI*	29.37 $\pm$ 5.32	27.21 $\pm$ 4.17	0.002	
Waist/Hip Index**	0.94 (0.88-1.03)	0.90 (0.85-0.92)	<0.001	
Gender			0.001	
Female	54 (57.4%)	76 (80.9%)		
Male	40 (42.6%)	18 (19.1%)		
Diabetes	18 (19.1%)	14 (14.9%)	0.438	1.35 (0.62-2.91)
Hypertension	33 (35.1%)	19 (20.2%)	0.022	2.13 (1.10-4.12)
Dyslipidemia	36 (38.3%)	24 (25.5%)	0.06	1.81 (0.97-3.37)
Overweight	77 (81.9%)	60 (63.8%)	0.005	2.56 (1.31-5.03)
Obesity	36 (37.6%)	26 (27.7%)	0.146	1.57 (0.85-2.92)
Smoking history	36 (38.3%)	78 (83%)	<0.001	0.127 (0.06-0.25)
History of CVD	68 (72.3%)	8 (53.3%)	0.137	2.28 (0.75-6.94)

*Data are reported in mean $\pm$ SD

**Data are reported in median (IQR)

We performed a multivariate analysis that showed that being overweight and presenting a waist / hip index above 0.90 cm confers an increased risk of developing PsA (Table 2).

Table 2. Multivariate analysis of significant clinical risk factors for PsA.

Variable	p	OR (95% CI)
Hypertension	0.239	1.69 (0.70-4.05)
Overweight	0.027	2.57 (1.11-5.92)
Waist/hip index >0.90	0.007	2.80 (1.32-5.95)

Conclusion: Several traditional cardiovascular risk factors were found with a higher prevalence in the group with psoriasis. It is critical that physicians known the common comorbidities associated with PsA so that they can provide optimal management and treatment and improve mortality and quality of life.

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AB0817

DOES SMOKING AFFECT SECUKINUMAB TREATMENT OUTCOMES AND SAFETY IN PATIENTS WITH PSORIATIC ARTHRITIS? - REAL WORLD DATA FROM THE GERMAN AQUILA STUDY

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Background: Several studies have shown a negative association between smoking status and psoriatic arthritis (PsA) clinical outcomes.^{1,2} The German non-interventional study AQUILA provides real-world data on the influence of smoking on therapeutic effectiveness and safety issues under secukinumab (SEC), a fully human monoclonal antibody that selectively inhibits interleukin-17A.

Objectives: The aim of this interim analysis is to describe selected baseline (BL) demographics, to evaluate SEC effectiveness on disease activity and depressive mood and to report the safety profile depending on smoking status of PsA patients.

Methods: AQUILA is an ongoing, multi-center study including up to 2700 patients with active PsA or ankylosing spondylitis. Patients were observed from BL up to week (w) 52. Real-world data was assessed prospectively and analyzed as observed. In addition to the assessment of C-reactive protein (CRP), data was collected on patient's disease activity (tender/swollen joint counts, TJC/SJC), skin disease activity (Psoriasis Area and Severity Index, PASI) and depressive mood (Beck's Depression Inventory version II, BDI-II). For calculation of the proportion of patients who experienced (serious) adverse events ((S)AEs), all PsA patients were included who received at least one dose of SEC irrespective of further documentation of any study visit. This interim analysis focuses on subgroups non-smoker (NS) and smoker (S).

Results: At BL, 641 PsA patients were included: 49.8% (n=319) non-smokers (NS) and 24.3% (n=156) smokers (S). 17.5% (n=112) were ex-smoker and 8.4% (n=54) of unknown smoking status. In both, NS and S, the proportion of women was higher (58.0% in NS and 67.3% in S). NS were slightly older than S (mean age: 53.8/49.7 years). There were no significant differences between NS and S in mean CRP within the 52 weeks (Fig. 1A). Both TJC and SJC improved over time and were similar between NS and S (Fig. 1B). Although mean absolute PASI value was worse in S at BL, a similar temporal improvement was seen in both groups (NS: 7.0 at BL to 1.0 at w52; S: 9.2 at BL to 1.0 at w52). BDI-II scores decreased in both groups with overall higher values in S (NS: 10.9 at BL to 9.1 at w52; S: 12.8 at BL and 10.8 at w52). Regarding the occurrence of AEs and SAEs with or without suspected relationship to SEC, NS had percentagewise less events than S (Table 1). In addition, percentage of PsA patients who discontinued SEC treatment due to an AE was lower for NS compared to S.

Table 1. Overview of AEs (and SAEs) under SEC treatment depending on smoking status in PsA patients

Number of patients with	NS (N=333), n (%)	S (N=161), n (%)	P value
AE	233 (70.0)	118 (73.3)	0.11
AE with suspected relationship to SEC	129 (38.7)	72 (44.7)	0.10
SAE	74 (22.2)	45 (28.0)	0.06
SAE with suspected relationship to SEC	29 (8.7)	18 (11.2)	0.37

Figure 1. Disease activity in PsA patients treated with SEC depending on the smoking status*CRP data/ACR joint counts were documented not for all PsA patients at BL and subsequent visits.

Conclusion: In a real-world setting, SEC improved disease activity and depressive mood of PsA patients with no obvious differences between NS and S. Overall, this interim analysis shows that SEC is an effective and reliable treatment, irrespective of the PsA patients' smoking status. Further progress of the AQUILA study as well as long-term data from other real-world observational studies with SEC, such as SERENA, will reveal whether this trend will continue.

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AB0818

SKIN INVOLVEMENT IN PSORIATIC ARTHRITIS (PSA) - THE INCREMENTAL IMPACT OF PSORIASIS ON QUALITY OF LIFE, DISABILITY AND WORK PRODUCTIVITY: REAL-WORLD SURVEY IN US AND EUROPE

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Background: PsA involves joint and skin symptom presentation that varies across patients. Differences in patients outcomes with joint only, and joint and skin involvement have not been extensively studied in a real-world setting.

Objectives: To assess prevalence of joint only, and joint and skin disease in a real-world clinical setting, and to assess incremental impact of skin symptoms on quality of life (QoL), disability and work productivity.

Methods: A cross-sectional survey in patients with PsA recruited by rheumatologists and dermatologists was conducted in France, Germany, Italy, Spain, UK and US. Data were collected Jun-Aug 2018 via physician-completed patient record forms and patient self-completed forms. Patients were compared by joint and skin involvement using parametric and non-parametric tests. Multiple linear regression analyses examined impact of incremental body surface area (BSA) on patient reported outcomes (PROs). Models controlled for gender, age, time