Figure 1. a) ACR20, b) ACR50, c) ACR70 and d) HAQ-DI responses, e) dactylitis resolution rates, f) enthesitis resolution rates and g) LS mean change from baseline in BMI at M3 by baseline BMI and treatment group (pooled data from OPAL Broaden and OPAL Beyond)

*ACR20/50/70 are calculated as a ≥50%/70% improvement from baseline in tender and swollen joint counts and ≥50%/70% improvement from baseline in 3 of the 5 remaining ACR core measures.
 †HAQ-DI response was defined as the number of patients achieving a reduction from baseline ≥0.25 in HAQ-DI, considered the minimal clinically important difference.
 ‡Dactylitis resolution rates, defined as the absence of dactylitis in all of the 20 assessed digits, and enthesitis resolution rates, defined as the absence of enthesitis in all of the 6 assessed sites, were only assessed in patients who reported a baseline value of DSI or LEI <0, respectively.
 §Δ change from baseline: ACR, American College of Rheumatology; BID, twice daily; BMI, Body Mass Index; DSI, dactylitis severity score; HAQ-DI, Health Assessment Questionnaire Disability Index; LEI, Leeds Enthesitis Index; LS mean, least squares mean; M3, Month 3; N, number of patients with a non-missing BMI available at M3; n, number of patients in each category; PBO, placebo; SE, standard error.

Figure 2. LS mean (SE) changes from baseline in a) SF-36v2 PCS, b) SF-36v2 MCS and c) FACIT-F at M3 by baseline BMI and treatment groups (pooled data from OPAL Broaden and OPAL Beyond)

Δ, change from baseline; BID, twice daily; BMI, Body Mass Index; FACIT-F, Functional Assessment of Chronic Illness Therapy-Fatigue; LS, least squares; M, month; MCS, Mental Component Summary; N, total number of unique patients; PBO, placebo; PCS, Physical Component Summary; SE, standard error; SF-36v2, Short-Form 36 Version 2.

Acknowledgments: Medical writing support was provided by Mark Bennett of CMC Connect, McCann Health Medical Communications, and funded by Pfizer Inc.

Disclosure of Interests: Christopher T. Ritchlin Grant/research support from: UCB Pharma, AbbVie, Amgen, Consultant of: UCB Pharma, Amgen, AbbVie, Lilly,

Pfizer, Novartis, Gilead, Janssen, Alexis Ogdie Shareholder of: Amgen, Novartis, Pfizer Inc, Grant/research support from: Novartis, Consultant of: AbbVie, Amgen, Bristol-Myers Squibb, Celgene, Corrona, Eli Lilly, Novartis, Pfizer Inc, Jon T Giles Grant/research support from: Pfizer Inc, Juan Jesus Gomez-Reino Grant/research support from: AbbVie, Novartis, Pfizer Inc, Roche, UCB, Consultant of: Pfizer Inc, Speakers bureau: AbbVie, Bristol-Myers Squibb, Janssen, MSD, Pfizer Inc, Roche, UCB, Philip Helliwell: None declared, Lori Stockert Shareholder of: Pfizer Inc, Employee of: Pfizer Inc, Pamela Young Shareholder of: Pfizer Inc, Employee of: Pfizer Inc, Wael Joseph Shareholder of: Pfizer Inc, Employee of: Pfizer Inc, Rajiv Mundayat Shareholder of: Pfizer Inc, Employee of: Pfizer Inc, Daniela Graham Shareholder of: Pfizer Inc, Employee of: Pfizer Inc, John Woolcott Shareholder of: Pfizer Inc, Employee of: Pfizer Inc, Ana Belen Romero Shareholder of: Pfizer Inc, Employee of: Pfizer Inc

DOI: 10.1136/annrheumdis-2020-eular.993

AB0828 IS PSORIATIC ARTHROPATHY DIFFERENT WHEN IS ACCOMPANIED BY AXIAL INVOLVEMENT?

S. M. Rojas Herrera¹, J. Malave Calzada¹, I. Braña Abascal¹, M. Priego Fernandez-Martos¹, D. Fernandez Lozano¹, R. Veroz Gonzalez¹, J. J. Aznar Sanchez¹, L. M. Chaves Chaparro¹, E. Chamizo Carmona¹. ¹Rheumatology, Hospital of Mérida, Mérida, Spain

Background: Axial involvement in patients diagnosed of Psoriatic arthritis (PsA) in variable in previous studies. Axial involvement (according GRAPPA criteria) is based upon inflammatory spinal symptoms pain with loss of lumbar mobility and the presence of radiological sacroiliitis and other radiographic signs of spondylitis in patients with PsA.

Objectives: Evaluate the prevalence of axial involvement in PsA an their clinical features.

Methods: All patients included in the monographic PsA consultation database of our second level hospital were analyzed. Demographic, clinical and analytical variables were collected. Statistical analysis was performed using SPSS v.25

Results: We included 145 patients with PsA (fulfilling CASPAR criteria) with a mean age at diagnosis of 45,4 (±13) years and time of evolution of the disease 9,3 (±6,2) years. The proportion of the affection types were: peripheral 94 (64,8%), mixta 31 (21,4%) and axial 20 (13,8%). Therefore, 51 (35,2%) patients meet criteria for axial involvement, of with 31 (21,4%) also had associated peripheral involvement. Table 1 shows the differences between patients with and without axial disease. Axial involvement was higher in males than women [OR=2,3 (1,1-4,7), p=0,023]. HLAB27, determined in 106 patients, was more prevalent in axial PsA than in exclusive peripheral patients, 35% and 4,5% respectively [OR=11,3 (3,0-42,7), p<0,0001]. We didn't find any differences in other domains of psoriatic disease or gender. Age at diagnosis was lower in patients with HLA B27 positive [35,6 (±12,3) vs 46,2 (±12,1) years, p=0,0001] and in the patients with dactylitis [40,2 (11,8) vs 46,7 (13) años, p=0,018] or uveitis [28,7 (8,5) vs 45,8 (12,8) years, p=0,02], respect patients who did not present them, regardless of HLAB27. No differences were found in age between patients with axial o peripheral disease [44,6 (±13,3) vs 45,9 (±12,8) years, p=0,56], neither other domains like skin psoriasis, onicopathy or enthesitis. Patients with axial involvement had overweight (BMI >25) less frequently than peripheral disease [OR=0,4 (0,2-0,8), p=0,01]. We didn't find any differences in other comorbidities (arterial hypertension, diabetes, hyperlipemia, hyperuricemia, ischemic heart disease, depression) between patines with axial or peripheral disease.

Table 1. Differences between axial and peripheral patterns

	With axial involve- ment, n=51	Without axial involvement, n=94	OR (IC 95%)	p value
Age at diagnosis, years (SD)	44,6 (±13,3)	45,9 (±12,8)		0,6
Time of evolution, years (SD)	10 (±6,8)	8,9 (±5,8)		0,3
Men, n (%)	36 (42,9%)	48 (57,1%)	2,3 (1,1-4,7)	0,02
HLAB27, n (%)	14 (82,4%)	3 (17,6%)	11,3 (3,0-42,7)	<0,0001
Skin Psoriasis, n (%)	47 (36,4%)	82 (63,6%)	1,7 (0,5-5,6)	0,4
Onicopathy, n (%)	11 (26,2%)	31 (73,8%)	0,6 (0,2-1,2)	0,1
Dactylitis, n (%)	9 (32,1%)	19 (67,9%)	0,8 (0,3-2,0)	0,7
Enthesitis, n (%)	13 (44,8%)	16 (55,2%)	1,7 (0,7-3,8)	0,2
Uveitis, n (%)	2 (66,7%)	1 (33,3%)	3,8 (0,3-42,9)	0,2
Inflammatory bowel disease, n (%)	2 (66,7%)	1 (33,3%)	3,8 (0,3-42,9)	0,2
Hyperlipemia, n (%)	27 (31%)	60 (69%)	0,6 (0,3-1,3)	0,2
BMI >25, n (%)	22 (26,5%)	61 (73,5%)	0,4 (0,2-0,8)	0,01
Hypertension, n (%)	18 (39,1%)	28 (60,9%)	1,3 (0,6-2,6)	0,5
Hyperuricemia, n (%)	16 (39%)	25 (61%)	1,3 (0,6-2,7)	0,5
Smokers, n (%)	13 (50%)	13 (50%)	2,1 (0,9-5,0)	0,08
Ischemic heart disease, n (%)	8 (53,3%)	7 (46,7%)	2,3 (0,8-6,8)	0,1
Depression, n (%)	7 (30,4%)	16 (69,6%)	0,8 (0,3-2,0)	0,6
Diabetes, n (%)	7 (30,4%)	20 (74,1%)	0,6 (0,2-1,5)	0,3

Conclusion: Prevalence of axial involvement in our cohort (35,2%) is found within the data reported in other studies (25-70%). Nevertheless, we found less prevalence of HLAB27 positive than other reports. Patients with HLAB27 positive, dactylitis or uveitis are diagnosed at earlier ages.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.6270

AB0829

INFLAMMATORY BOWEL DISEASE IN PSORIATIC ARTHRITIS. STUDY OF 306 PATIENTS FROM A SINGLE UNIVERSITY CENTER. PREVALENCE, CLINICAL FEATURES AND RELATIONSHIP TO BIOLOGIC THERAPY.

L. Sanchez-Bilbao¹, D. Martinez-Lopez¹, N. Palmou-Fontana¹, S. Armesto², M. A. González-Gay¹, R. Blanco¹. ¹H.U. Marqués de Valdecilla, Rheumatology, Santander, Spain; ²H.U. Marqués de Valdecilla, Dermatology, Santander, Spain

Background: Inflammatory bowel disease (IBD), which includes Crohn's disease (CD), Ulcerative colitis (UC), and undetermined colitis may be related to psoriasis and psoriatic arthritis (PsA). Biologic therapy (BT) is useful in PsA and IBD but paradoxically has been related to IBD.

Objectives: In a wide series of PsA, our aim was to assess **a)** the epidemiological and clinical features of associated IBD and **b)** its relationship with BT.

Methods: All unselected consecutive patients studied in a single reference University Hospital with: **a)** PsA (CASPAR criteria) and **b)** IBD: CD, UC and undetermined colitis diagnosed by endoscopic patterns, clinical criteria and laboratory tests. A comparative study between patients with and without IBD was performed

Results: We studied 306 (165 women/141 men) patients with PsA; mean age at PsA diagnosis of 41.7±15.79 years; delay of diagnosis from the onset of symptoms of 2.6±2.01 years. IBD (CD=6; UC=1 and undetermined colitis=3) was observed in 10 of 306 (3.3%, 8 women/2 men). A significant more frequency of enthesitis, positive HLA-B27 and non-significant more severe PsA (axial, and hip involvement, and a higher BASDAI, BASFI, DAPSA, PASI) was observed in patients with associated-IBD (**TABLE**).

IBD was present before PsA in 5 patients and in the other 5, after 9.6±15.3 years of evolution of PsA. BT for PsA has been used in 1 (20%) (etanercept) of these 5 patients which developed IBD and in 67 of 296 (22.6%) without IBD (Adalimumab 45; Certolizumab 8; Infliximab 6; Golimumab 4; Etanercept 4).

Conclusion: IBD in PsA was uncommon (3.3%), may be associated to a more severe PsA, and no relationship to BT was found.

TABLE 1.

	Patients with IBD (n=10)	Patients without IBD (n=296)	p
DEMOGRAPHIC PARAMETERS			
Sex, n (%)	2 ♂/8 ♀ (20.0/80.0)	139 ♂/157 ♀ (46.9/53.1)	p = 0.11
Age at PsA symptoms onset (years), mean± SD	39.0±15.1	44.2±11.4	p = 0.17
Age at PsA diagnosis, mean±SD	41.7±15.7	46.4±15.8	p = 0.22
PSA RELATED DATA			
PsA type			
Asymmetric Oligoarthritis, n (%)	4.0 (40.0)	159 (53.7)	p = 0.59
Symmetrical Polyarthritits, n (%)	0.0 (0.0)	46 (15.5)	p = 0.37
Axial, n (%)	3.0 (30.0)	40 (13.5)	p = 0.31
Mixed, n (%)	3.0 (30.0)	51 (17.2)	p = 0.54
Enthesitis, n (%)	7.0 (70.0)	111 (37.5)	p = 0.03*
Dactylitis, n (%)	0.0 (0.0)	79 (26.7)	p = 0.70
Hip involvement n (%)	4.0 (40.0)	55 (18.5)	p = 0.57
Scores			
BASDAI, median [ICR]	3.1 [0.0-4.4]	2.2 [0.0-4.5]	p = 0.64
BASFI, median [ICR]	6.0[0.0-6.9]	0.0 [0.0-3.3]	p = 0.69
DAPSA, median [ICR]	10.7 [0.0-14.62]	4.3 [0.0-13.0]	p = 0.31
PASI, median [ICR]	2.3 [0.0-6.7]	0.6 [0.0-2.38]	p = 0.70
Laboratory tests: HLA-B27, n (%)	6.0 (60.0)	23 (7.8)	p = 0.001*

Disclosure of Interests: Lara Sanchez-Bilbao Grant/research support from: Pfizer, David Martinez-Lopez: None declared, Natalia Palmou-Fontana: None declared, Susana Armesto: None declared, Miguel A González-Gay Grant/research support from: Pfizer, Abbvie, MSD, Speakers bureau: Pfizer, Abbvie, MSD, Ricardo Blanco Grant/research support from: AbbVie, MSD, and Roche, Speakers bureau: AbbVie, Pfizer, Roche, Bristol-Myers, Janssen, and MSD

DOI: 10.1136/annrheumdis-2020-eular.4806

AB0830

LIPID PROFILE IN PSORIATIC ARTHRITIS. FREQUENCY AND ASSOCIATION WITH DISEASE ACTIVITY.

V. Savio^{1,2}, Y. Tissera¹, M. I. Quaglia¹, J. A. Albiero¹, C. G. Alonso¹, M. Demarchi¹, C. Maldini², C. Gobbi^{1,2}, M. Yorio^{1,2}, A. C. Martini², M. E. Castrillon³, P. Alba^{1,2}. ¹Hospital Córdoba, Córdoba, Argentina; ²Universidad Nacional de Córdoba, Córdoba, Argentina; ³Hospital Italiano de Córdoba, Córdoba, Argentina

Background: Psoriatic arthritis (PsA) is a chronic inflammatory disease associated with higher risk of cardiovascular events and metabolic syndrome. The inflammation not only accelerates atherosclerosis, but also may influence cardiovascular (CV) risk factors such as lipid profile, blood pressure and insulin resistance. Lipid profile has previously been studied in PsA, however this association is still controversial.

Objectives: To study the frequency of altered lipid profile in patients with PsA and its association with disease activity.

Methods: We studied all the patients with diagnosis of PsA who consecutively attended to Rheumatology Unit at Córdoba Hospital from July 2018 to December 2019. PsA was diagnosed according CASPAR criteria. Clinical and laboratory data were collected. The activity of the disease was evaluated by PASI, MDA and DAPSA. Quantitative variables will be expressed in median and 1st and 3rd interquartile; qualitative variables expressed in frequency and percentage. Correlation analysis was calculated using Spearman's rank correlation coefficient. P<0.05 was considered statistically significant.

Results: 42 PsA patients were included. Mean age was 56 years old (47.25-62.75) and 54.76% were female (n=23). 92.86% (n=39) of the patients had plaque Psoriasis and 87.8% (n=36) had peripheral joint involvement.

Frequency of comorbidities in PsA are shown in Graphic 1. 31 (73.8%) of the patients were treated with topical therapy, 3 (7.14%) with phototherapy, 31 (73.8%) with Methotrexate and 17 (41.46%) with biologics and JAK inhibitor. Activity Disease Index and Lipid profile are shown in Table 1 and 2.

There was not association between Apo B/Apo A coefficient with DAPSA (rho=0.013; p=0.940) and MDA (rho=-0.029; p=0.867).

Conclusion: In spite of the presence of cardiovascular factors in the majority of PsA patients, lipid profile is not correlated with disease activity in this population.

References:

- Ahlehoff O, Gislason GH, Charlott M, et al. Psoriasis is associated with clinically significant cardiovascular risk: A Danish nationwide cohort study. *J Intern Med* 2011;270:147-57.
- Mallbris, L., Ritchlin, C.T., Ståhle, M. "Metabolic disorders in patients with psoriasis and psoriatic arthritis." *Curr Rheumatol Rep.*8(5): 355-363. 2006
- Ng CY, Tzeng I-S, Liu S-H, Chang Y-C, Huang Y-H. Metabolic parameters in psoriatic patients treated with interleukin-12/23 blockade (Ustekinumab). *J Dermatol* 2018; 45:309-313
- Kaur S, Kingo K, Zilmer M. Psoriasis and cardiovascular risk – do promising new biomarkers have clinical impact? *Mediators Inflamm* 2017; 2017: 7279818
- Gentile M, Peluso R, Di Minno MN, et al. Association between small dense LDL and sub-clinical atherosclerosis in patients with psoriatic arthritis. *Clin Rheumatol* 2016; 35: 2023-9.

Graphic 1. Comorbidities in PsA