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

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AB0829 INFLAMMATORY BOWEL DISEASE IN PSORIATIC ARTHRITIS. STUDY OF 306 PATIENTS FROM A SINGLE UNIVERSITARY CENTER. PREVALENCE, CLINICAL FEATURES AND RELATIONSHIP TO BIOLOGIC THERAPY.

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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 Oligoarticular, n (%)	4.0 (40.0)	159 (53.7)	p = 0.59
Symmetrical Polyarthritis, 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***

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AB0830 LIPID PROFILE IN PSORIATIC ARTHRITIS. FREQUENCY AND ASSOCIATION WITH DISEASE ACTIVITY.

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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 Cordoba 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.

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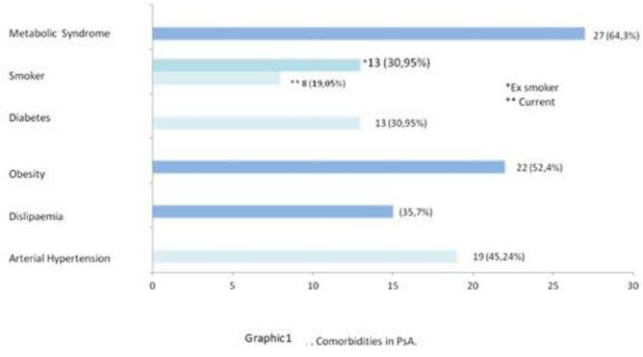

Graphic 1. Comorbidities in PsA

Table. 1. Activity Disease Index in PsA

ACTIVITY INDEX	n=42
DAPSA	14.45 (9.72-23.92)
DAPSA	
≤4 REMISSION	3
>4 y ≤14 low disease activity	16
>14 y ≤28 moderate disease activity	17
>28 high disease activity	3
cDAPSA	14.00 (8.00-23.00)/41*
MDA	9 (25)/36
PASI	2.20 (0.20-6.80)/41*

*Expressed in median and interquartiles.Qualitative variables expressed in frequency and percentage.

Table. 2. Lipid Profile in PsA patients.

Cholesterol (mg/dl)	194.5 (164.8-218.2)
HDL (mg/dl)	48.00 (37.00-57.00)
LDL (mg/dl)	114.5 (78.5-140.8)
TG (mg/dl)	139.50 (89.25-191.20)

Expressed in median and interquartiles.

Disclosure of Interests: None declared

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AB0831

COMPARISON OF DIFFERENT REMISSION INDICES IN PATIENTS WITH PSORIATIC ARTHRITIS: A POST HOC ANALYSIS OF DATA FROM PHASE 3 TOFACITINIB STUDIES

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Background: An international task force has agreed that remission and low disease activity (LDA) are treatment targets for patients (pts) with PsA, and recommends the Disease Activity Index in Psoriatic Arthritis (DAPSA) and minimal disease activity (MDA) to assess disease activity states.[1] Tofacitinib is an oral Janus kinase inhibitor for the treatment of PsA.

Objectives: In this post hoc analysis, we compared DAPSA LDA with MDA, and DAPSA remission with very low disease activity (VLDA) and DAS28-3(CRP) remission, in pts with PsA receiving tofacitinib.

Methods: Data were pooled from 2 Phase 3 studies (OPAL Broaden [12 months; NCT01877668]; OPAL Beyond [6 months; NCT01882439]) for pts receiving tofacitinib 5 or 10 mg twice daily (BID) or placebo (PBO). DAPSA was determined by summing: swollen joint count (SJC66); tender/painful joint count (TJC68); Patient's Global Assessment of Arthritis (PtGA; visual analogue scale [VAS]); pain (VAS); and CRP. Pts were classified as achieving MDA or VLDA when meeting ≥5 (MDA) or 7 (VLDA) of the following criteria: TJC68 ≤1; SJC66 ≤1; Psoriasis Activity and Severity Index ≤1 or body surface area ≤3%; pain (VAS) ≤15; PtGA (VAS) ≤20; HAQ-DI ≤0.5; tender entheseal points (using Leeds Enthesitis Index [LEI]) ≤1. A logistic regression model was used to assess demographic and baseline characteristics as predictors of a trend in DAPSA scores at Month (M)3. DAPSA LDA (≤14), MDA, DAPSA remission (DAPSA ≤4), VLDA and DAS28-3(CRP) remission (DAS28-3[CRP]<2.6) rates were compared at M1, M3 and M6 for pts receiving tofacitinib 5 mg BID and at M6 for pts receiving tofacitinib 5 or 10 mg BID. Agreement between disease activity indices at M6 was evaluated using a kappa test. The percentage of tofacitinib-treated pts who achieved MDA, VLDA and non-response was reported at M6, stratified by achievement of DAPSA LDA, remission or non-response.

Results: This analysis included 709 pts: tofacitinib 5 mg BID, n=237; tofacitinib 10 mg BID, n=236; PBO, n=236. At M3, older patients treated with tofacitinib, and tofacitinib- or PBO-treated pts with higher baseline SJC66, TJC68, PtGA VAS, HAQ-DI, LEI and Pain VAS, were significantly (p<0.05) more likely to have higher DAPSA. DAPSA LDA, MDA, remission (DAPSA and DAS28-3[CRP]) and VLDA rates generally increased from M1 to M6 for patients receiving tofacitinib 5 mg BID (Figure a). At M6, most tofacitinib-treated pts who achieved MDA, and all who achieved VLDA, were also in DAPSA remission or LDA (Figure b). At least moderate agreement (defined by kappa values 0.41–0.60) was observed between DAPSA LDA and MDA, and between DAPSA remission and VLDA, with both doses of tofacitinib at M6 (Figure c).

Conclusion: Remission and LDA rates generally increased over time in pts with PsA receiving tofacitinib. DAPSA LDA showed moderate agreement with MDA, and DAPSA remission showed at least moderate agreement with VLDA, confirming that DAPSA and MDA are useful measurement tools to assess disease activity in pts with PsA treated with tofacitinib.

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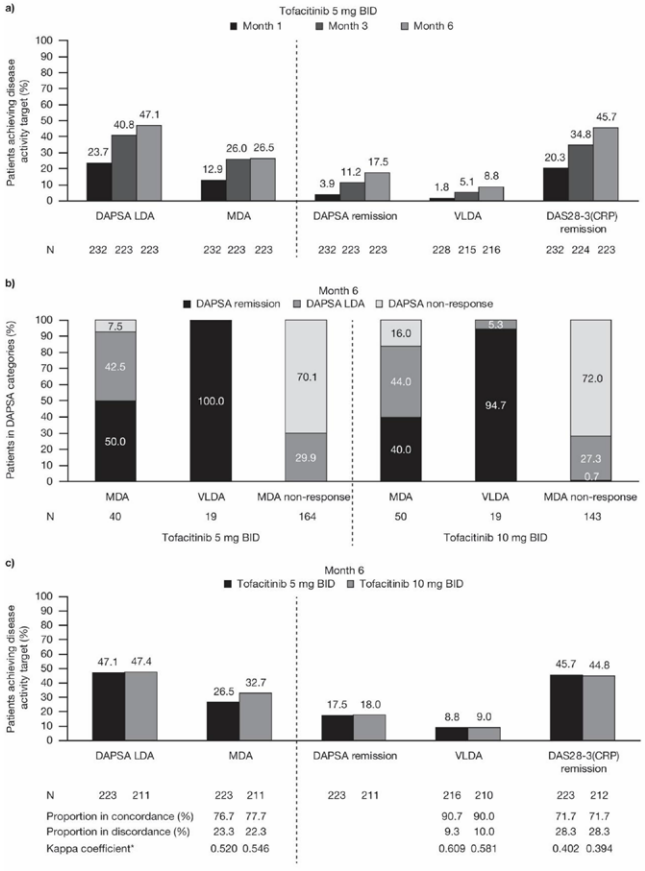
Figure. Percentage of patients receiving a) tofacitinib 5 mg BID achieving DAPSA LDA, MDA, DAPSA remission, VLDA or DAS28-3(CRP) remission at Month 1, 3 or 6; b) tofacitinib 5 or 10 mg BID achieving MDA or VLDA, by DAPSA categories at Month 6; c) tofacitinib 5 or 10 mg BID achieving DAPSA LDA, MDA, DAPSA remission, VLDA or DAS28-3(CRP) remission at Month 6



*Kappa test of agreement between: DAPSA LDA and MDA; DAPSA remission and VLDA or DAS28-3(CRP) remission
BID, twice daily; DAPSA; Disease Activity Index for Psoriatic Arthritis; DAS28-3(CRP), Disease Activity Score in 28 joints, CRP; LDA, low disease activity; MDA, minimal disease activity; N, number of evaluable patients; VLDA, very low disease activity

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