Background: Psoriatic arthritis (PsA) is an inflammatory joint disease that is traditionally included in the Spondyloarthritides (SpA) spectrum. Prevalence and impact of axial involvement in PsA remains understudied but increasingly affects treatment decisions.

Objectives: The first step, in this multi-purpose radiographic study, is to report on baseline radiographic damage of the sacroiliac joints (SIJ) in PsA patients from a prospective multicentre cohort study in private and academic rheumatology practices.

Methods: Data from the Belgian Epidemiological Psoriatic Arthritis Study (BEPAS), a prospective multicentre cohort involving 17 Belgian rheumatology practices. Recruitment was from December 2012 until July 2014. Patients were included in the study when the local rheumatologist could diagnose an existing or new PsA and when patients fulfilled the Classification criteria for Psoriatic Arthritis (CASPAR). Radiographs of the SIJ were obtained at baseline and after 2 years. Two calibrated readers assessed radiographic damage by grading the SIJ according to the modified New York (mNY) criteria. When assessing the images, readers were blinded for clinical data and information from other obtained images (radiographs of the hands, feet and spine). Individual scores as well as consensus scores are described.

Results: In total 461 patients where included in BEPAS. Mean age was 52.7±9.12±9.2 years and 43.0±18% were female; average disease duration was 8.5±4.3 yrs and approximately 34% of the patients report inflammatory axial pain. From 338 patients SIJ radiographs were obtained. At baseline, the vast majority of patients did not fulfil the mNY criteria (n=325, 96.2%), according to both readers. In 8 cases (2.4%) there was concordance on fulfilment of the mNY criteria. Discordant cases (n=5, 1.4%) were equally distributed. Agreement between the 2 readers was good with 98.5% overall agreement and kappa=0.75. Therefore, with more a sensitive approach (any of the 2 readers scores mNY positive), we see slight differences; 13 patients (3.6%) fulfil the mNY criteria. Table 1 shows radiographic damage by individual readers.

Conclusion: Despite the patient self-identified presence of axial disease in up to 34% in this cohort of PsA patients, there was minimal radiographic damage on SIJ, suggesting that SIJ disease is not a major manifestation of PsA.

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Background: Psoriatic arthritis (PsA) is a chronic, heterogeneous, immune-mediated seronegative arthritis characterized by joint inflammation in people with skin psoriasis (PsO). In recent years several effective biologic treatments such as tumour necrosis factor inhibitors (TNFi), interleukin (IL) 12 and 23 inhibitors (IL-12/23i), and IL 17 inhibitors (IL-17i) have been introduced for PsA. Discontinuation (non-persistence) of therapy is usually a consequence of lack of effect and intolerability.

Objectives: Compare time to discontinuous of TNFi (adalimumab, ADA) IL-17i (secukinumab, SEC) and IL-12/23i (ustekinumab, UST) treatment exposures and the association with previous biologic treatment experience.

Methods: Population-based national health data from the Swedish Patient Registry, Prescribed Drug Registry and Cause of Death Registry were linked at the patient level and used to identify treatment exposures in PsA patients initiating ADA, SEC, or UST between January 2008 and September 2018. Discontinuation was defined as a treatment switch to any other PsA-indicated biologic, or failure to re-dispense treatment within a grace period following end of drug supplied. The grace period, defined as the number of days between end of drug supply and re-dispensation during which a patient is considered to be on active treatment, was set dynamically to the number of days of drug supplied in the primary analysis. As a sensitivity analysis, a fixed 90-day grace period was used. Supply was calculated as total milligrams dispensed divided by maintenance dose policy, where the following assumptions were made due to the limitations of the administrative data used: UST patients’ weight corresponded to the amount of drug dispensed (both 45mg and 90mg dispensations last 84 days), SEC patients with prior TNFi experience consumed 300mg/28 days and all others consumed 150mg/28 days, and ADA patients consumed 40mg/14 days. Adjusted hazard ratios (HR) for time to discontinuation were calculated using a Cox proportional hazards model. Covariates for age, marital status, and previous biologic treatment experience were assessed at the initiation of treatment exposure, while comorbidity including skin PsO was assessed during the two years prior.

Results: 3,620 discontinuation events were observed in the main analysis across 4,649 treatment exposures (ADA: 3,255; SEC: 887; UST: 507) (Figure 1, unadjusted); 3,162 events were observed in the sensitivity analysis. Average age at treatment initiation was 50, 54% were female, 47% were biologic naive, and 38% had history of previous biologic. Thus, UST exhibited lower discontinuation rates vs ADA (HR=0.56, 95% CI: 0.49-0.64) while there...
was no significant difference between SEC and ADA (HR=1.01, 95% CI: 0.88-1.15). In the multivariate sensitivity analysis, both UST (HR=0.81, 95% CI: 0.70-0.94) and SEC (HR=0.82, 95% CI: 0.70-0.95) were associated with significantly lower discontinuation rates ratio relative to ADA. Overall, patients with more biologic treatment experience were statistically significantly (p<0.05) associated with higher risk of treatment discontinuation.

Figure 1. Unadjusted Kaplan-Meier curves of time to treatment discontinuation (main analysis, dynamic grace period)

Conclusion: UST exhibits a favourable treatment persistence profile relative to ADA, regardless of the grace period definition. The relative risk of discontinuing SEC vs ADA is sensitive to the grace period definition. Treatment discontinuation was higher in treatment exposures with more biologic experience.


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All composite indices (CPDAI, DAPSA, GRACE, MDA, Psoriatic Arthritis Disease Activity Score) showed significantly worse results in women at baseline. Women also suffered more frequently from comorbid medical conditions, fatigue and anxiety, and reported more severe limitations in function and worse quality of life.

At 12 months women, despite the improvement they made, reported significantly higher levels of pain compared to men. Although MDA rates increase over time for both sexes, Fig.2, it remained significantly more prevalent among men (19.0% vs 11.1% at inclusion, p<0.05, and 58.1% vs 35.7%, p<0.00, at T12). DAPSA was significantly higher in women at both timepoints and a significantly higher percentage of men presented remission according to DAPSA score at 12 months.

Figure 2. Longitudinal evolution of composite measures for men and women in the first year of PsA.

All composite indices (CPDAI, DAPSA, GRACE, MDA, Psoriatic Arthritis Disease Activity Score) showed significantly worse results in women at baseline. Women also suffered more frequently from comorbid medical conditions, fatigue and anxiety, and reported more severe limitations in function and worse quality of life.

Figure 1. Longitudinal evolution of TJC68, Pain, VAS global, BRAFT for men and women in the first year of PsA.

Conclusion: After 1 year of follow-up women didn’t surpass their baseline disadvantages and despite the improvement, they still present higher disease activity, more pain and lower functional capacity than men. The nature of these findings may advocate a need for sex specific adjustment of treatment strategies and evaluation in psoriatic arthritis as sex-related difference in outcome persisted over time.

References: