depending on index of assessment. The achieved values maintained throughout the entire analyzed period (Table 2). At Wk 24, mean changes in ASDAS-CRP and BASDAI were -1.57 and -2.83 in NTK arm vs -0.11 and -0.19 in PBO arm respectively ($p < 0.0001$).

Table 1. Baseline demographics and mean composite endpoint scores

Arm	NTK (N=54)	PBO (N=50)
Age (years)	43.5 (12.16)	42.7 (10.76)
Male, n (%)	27 (50)	26 (52)
PsA duration, mo	70.0 (78.78)	79.0 (81.62)
BASDAI score	5.58 (1.80)	5.79 (1.94)
ASDAS-CRP score	3.38 (1.16)	3.38 (1.28)
nocturnal pain	4.2 (2.42)	5.1 (2.29)
spinal pain	4.4 (2.41)	5.3 (2.40)

* mean (standard deviation) BASDAI=Bath Ankylosing Spondylitis Disease Activity Index, ASDAS-CRP=Ankylosing Spondylitis Disease Activity Score with C-reactive protein

Table 2. Changes in BASDAI and ASDAS-CRP vs baseline

	BASDAI		ASDAS-CRP	
	NTK (N=54)	PBO (N=50)	NTK (N=54)	PBO (N=50)
Wk 4	-2.45 (1.94)	-0.51 (1.26)	-1.44 (1.06)	-0.19 (0.60)
Wk 8	-2.77 (2.22)	-0.38 (1.55)	-1.53 (1.07)	-0.21 (0.74)
Wk 16	-2.77 (1.83)	-0.17 (1.67)	-1.52 (0.98)	-0.10 (0.97)
Wk 24	-2.83 (2.15)	-0.19 (1.70)	-1.57 (1.06)	-0.11 (0.95)

mean (standard deviation)

Figure 1. Mean change in BASDAI, ASDAS-CRP, spinal pain, and nocturnal pain at Wk 24

Conclusion: About 50% of subjects, randomized to PATERA study, had IBP at baseline. NTK leads to rapid and sustained improvement in axial disease in patients with active PsA.

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FRI0347 PREVALENCE OF OBESITY AND ITS LINK TO PSORIATIC ARTHRITIS (PSA) ACTIVITY AND RESPONSE TO THERAPY: DATA FROM THE RUSSIAN PSA REGISTRY (RU-PSART)

Y. Korsakova^{1,2}, E. Loginova³, E. Gubar³, E. Vasilenko⁴, A. Vasilenko⁵, N. Kuznetsova⁶, I. Patrikeeva⁷, T. Korotaeva⁸, E. Nasonov⁸ on behalf of RU-PSART Study Group. ¹Nasonova Research Institute of Rheumatology, Department of Spondyloarthritis and Psoriatic Arthritis, Moscow, Russian Federation; ²V.A. Nasonova Research Institute of Rheumatology, Department of Spondyloarthritis and Psoriatic Arthritis, Moscow, Russian Federation; ³V.A. Nasonova Research Institute of Rheumatology, Department of Spondyloarthritis and Psoriatic Arthritis, Moscow, Russian Federation; ⁴Clinical Rheumatological Hospital No 25, St. Petersburg, Russian Federation; ⁵Novgorod Regional Clinical Hospital, Novgorod, Russian Federation; ⁶Municipal Autonomous Institution "City Clinical Hospital No. 40, Ekaterinburg, Russian Federation; ⁷Tyumen Regional Clinical Hospital No 1, Tyumen, Russian Federation; ⁸V.A. Nasonova Research Institute of Rheumatology, Moscow, Russian Federation

Background: Obesity is a common comorbidity of psoriasis and PsA. It is connected to low-grade inflammation and it has a negative impact on the response to therapies. Although a high prevalence of obesity has been shown in a whole number of epidemiology and observational studies, its relationship to PsA activity has been less investigated. In the RU-PSART registry data was collected from 43 rheumatology centers of the Russian Federation

Objectives: to evaluate the prevalence of obesity and its association to PsA activity as well as its impact on therapy response in real clinical practice

Methods: 614 (M/F=331(54%)/283(46%)) PsA pts fulfilling the CASPAR criteria were included from the RU-PSART cohort. Mean age 45.2±0.52 yrs, PsA duration 5.7±0.27 yrs, PsO duration 15.71±0.56 yrs, DAPSA 28.79±0.75. At baseline (BL) and 6 mo/12 mo of observation PsA activity was evaluated by Tender Joint Count (TJC68), Swollen Joint Count (SJC66); PGA, physician global assessment by Visual Analog Scale (VAS); PtGA VAS; PtPain VAS; DAPSA and body mass index (BMI, kg/m²) were calculated. Pts were treated with conventional/target synthetic disease-modifying antirheumatic drugs csDMARDs (55%)/tsDMARDs (5%), biological DMARDs (23%), NSAID (17%) according to physician's decision. At BL/6/12 mo all pts were categorized according to DAPSA as high activity (DAPSA>28) and Moderate (Mo≤28)/Low Activity (LA≤14)/Remission DAPSA (REM≤4). All pts were divided into three groups according to BMI (kg/m²): normal<25, overweight >25-30, obese>30. M±m, %, multivariate analysis of variance (MANOVA), ANOVA, OR 95% (CI) were performed. All p<0.05, were considered to indicate statistical significance

Results: The baseline BMI was 27.7±0.23 kg/m² with the following BMI categories: normal - 212 pts (34.6%), overweight - 214 pts (34.8%) and obese - 187 (30.45%). In all pts DAPSA significantly improved to 16.11±0.82/14.71±1.17 at 6/12 mo accordingly. At BL and 6/12 mo of therapy DAPSA was significantly higher in the obese pts compared to the normal and the overweight pts despite of improvements seen in all groups (table 1). By the last visit significant differences were found in DAPSA depending on BMI at BL (ANOVA, p<0.031). BMI>30 at BL was associated with lower probability of DAPSA improvement from high activity to Mo/LA/REM state compared to normal BMI pts and the overweight pts: OR 2.484 (95% CI 1.135-5.439) and OR 2.346 (95% CI 1.07-5.143) accordingly (Fig 1)

Table 1. Dynamics of DAPSA from BL to 6/12 mo depending on BMI categories.

BMI (kg/m ²)	DAPSA BL	DAPSA 6 mo	DAPSA 12 mo
<25	27.20 ± 1.15	13.84 ± 1.01	13.33 ± 1.53
25-30	26.93 ± 1.17	14.48 ± 1.43	13.83 ± 2.36
>30	32.86 ± 1.57	21.19 ± 1.84	18.92 ± 2.54

Fig. 1. OR analysis of relationship between BMI at BL and treatment response.

Conclusion: The high prevalence of overweight/obesity PsA pts was associated with higher PsA activity and lower response to therapy in our cohort

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FRI0348

PERSISTENCE OF SECUKINUMAB AND USTEKINUMAB IN PSORIATIC ARTHRITIS: A REAL-WORLD MULTICENTRIC COHORT OF 409 PATIENTS

J. G. Letarouilly¹, B. Flachaire², C. Labadie³, N. Cohen², M. Kyheng¹, J. Sellam⁴, P. Richette⁵, P. Dieudé⁶, P. Claudepierre⁷, B. Fautrel⁸, E. Houvenagel⁹, C. D. Nguyen¹⁰, M. H. Guyot¹¹, N. Segaud¹², F. Maury¹³, L. Marguerie¹⁴, X. Deprez¹⁵, J. H. Salmon¹⁶, G. Baudens¹⁷, C. Miceli Richard¹⁸, E. Gervais¹⁹, I. Chary Valckenaere²⁰, P. Lafforgue², D. Loeuille²⁰, C. Richez³, T. Pham², R. M. Flipo²¹. ¹CHU Lille, Lille, France; ²Aix Marseille Univ, APHM, Marseille, France; ³CHU Bordeaux, Bordeaux, France; ⁴CHU Saint-Antoine, Paris, France; ⁵CHU Lariboisière, Paris, France; ⁶CHU Bichat, Paris, France; ⁷CHU Henri Mondor, Paris, France; ⁸CHU Pitié, Paris, France; ⁹GHICL, Lomme, France; ¹⁰CH. Béthune, Béthune, France; ¹¹CH. Roubaix, Roubaix, France; ¹²CH. Armentières, Armentières, France; ¹³Private Practice, Beuvry, France; ¹⁴Institut Calot, Berck-sur-mer, France; ¹⁵CH. Valenciennes, Rhumatologie, France; ¹⁶CHU Reims, Reims, France; ¹⁷Private practice, Valenciennes, France; ¹⁸CHU Cochin, Paris, France; ¹⁹CHU Poitiers, Poitiers, France; ²⁰CHU Nancy, Nancy, France; ²¹CHU Lille, Lille, France

Background: Real-world data are missing for Ustekinumab (UST) and secukinumab (SEK) in psoriatic arthritis (PsA).

Objectives: To evaluate the characteristics of the patients (pts) with PsA treated by UST or SEK and to assess real world persistence of UST and SEK in PsA.

Methods: This is a retrospective, multicenter study of pts with PsA (CASPAR criteria or diagnosis confirmed by a rheumatologist) initiating UST or SEK with a follow-up ≥ 6 months from January 2011 to April 2019. The comparison of persistence between UST and SEK was analysed using a Cox model with an inverse probability of treatment weighting propensity score including 11 confounding factors. Subgroup analyses (age >65 years, gender, Body Mass Index (BMI), Charlson score >2 , psoriasis, CRP >5 mg/L, number (nb) of prior biotherapies, proportion of pts on maximum dose of UST or SEK, combination with methotrexate (MTX), enthesitis and axial forms of PsA) were also performed to test the heterogeneity of UST and SEK persistence. Finally, 2 sensitivity analyses were performed, first excluding the pts treated before the marketing authorization of SEK, and then excluding the pts that underwent a molecule switch. Causes of discontinuation were also collected.

Results: 406 pts were included: 245 with UST and 161 with SEK. At baseline before propensity score-matching, the UST group has a higher BMI (28.9 ± 6.4 kg/m² vs. 27.4 ± 6.0 kg/m²), more peripheral forms (98% vs. 90.8%), a higher nb of active smokers (27.1% vs. 19.9%), a higher frequency of psoriasis (96.3% vs. 83.2%), less MTX users (38.9% vs. 44.2%), a higher nb of pts with CRP >5 mg/L (54.3% vs. 47%), a higher nb of pts naïve to biotherapies (22% vs. 13%) and a higher nb of pts with recommended dosing (97.3% vs. 50.9%). The median persistence was 9.4 months and 14.7 months for UST and SEK, respectively. The persistence rate was lower in the UST group compared to the SEK group (40.9% vs. 59.1% at 1 year; 26.4% vs. 38.0% at 2 years; weighted HR=1.42; 95% CI 1.07 to 1.92; p=0.015) (Fig 1). In subgroup analysis, combination with MTX was associated with a higher persistence rate in the patients with SEK compared to those receiving UST: 43.6% vs. 23.2% (HR=2.20; 95% CI 1.30 to 3.51; p=0.001), whereas no difference was observed in SEK and UST monotherapy: 33.8% vs. 28.4%, respectively (HR=1.06; 95% CI 0.74 to 1.53; p=0.75) (Fig 2). A similar difference was found in the sensitivity analyses, with however a difference at the limit of significance for the analysis excluding pts with a molecule switch (adjusted HR=1.35; IC95% 0.96 to 1.92; p=0.085). The causes of discontinuation were due to inefficacy in 85% of cases and an adverse event in 12% of cases (19% in the SEK group and 9% in the UST group).

Conclusion: In this first real-world study comparing UST and SEK persistence in PsA, the persistence of SEK was longer than that of UST. Subgroup analysis revealed this difference of persistence was restricted to patients treated in combination with MTX.

Figure 1. Persistence with Ustekinumab (UST) and Secukinumab (SEK) in IPTW cohort

Figure 2. Follow-up 2-year persistence of molecules according to different subgroups in IPTW Cohorts

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FRI0349

PSORIATIC ARTHRITIS AND CENTRAL OBESITY: STRONG ASSOCIATION WITH FUNCTIONAL DISABILITY AND A WORSE QUALITY OF LIFE

M. Lo Monaco^{1,2,3}, G. Pistone¹, G. Natoli^{1,3}, R. Daita¹, C. Argano¹, L. Calvo¹, R. Mallaci Bocchio^{1,3,4}, R. Scondotto^{1,5}, S. Corrao^{1,3,4}. ¹National Relevance and High Specialization Hospital Trust ARNAS Civico, Di Cristina, Benfratelli, Internal Medicine with Rheumatology and Dermatology, Palermo, Italy; ²School of Medicine University of Palermo, Biomedicine and Neuroscience (BIND), Palermo, Italy; ³I.E.M.E.S.T., Organizational, Clinical, and Translational Research, Palermo, Italy; ⁴School of Medicine University of Palermo, Promozione della Salute, Materno-Infantile, Medicina Interna e Specialistica di Eccellenza "G. D'Alessandro" (PROMISE), Palermo, Italy; ⁵School of Medicine University of Palermo, Internal Medicine, Palermo, Italy