Table 1. Factors associated with discordance: Univariate analysis

	Discordant group n=24	Concordant group n=38	OR (95%CI)	P
History of depression, n (%)	9 (37.5)	1 (2.6)	22 (2.58-190.84)	<0.001
Fibromyalgia (ACR criteria), n (%)	5 (20.8)	1 (2.6)	9.74 (1.06-89.4)	0.028
At least one enthesitis on the Leeds Enthesitis Index, n (%)	14 (58.3)	34 (89.5)	0.17 (0.04-0.61)	0.006
Treatments				
Previous corticosteroid use, n (%)	8 (33.3%)	26 (68.4%)	0.23 (0.08-0.69)	0.007
Disease activity scores et Patients Reported Outcomes				
PROs				
DAS28-CRP > median (2.3), n (%)	19 (79.2)	12 (31.6)	8.23 (2.48-27.32)	<0.001
SDAI > median (5.09), n (%)	21 (87.5)	10 (26.3)	19.6 (4.79-80.18)	<0.001
DAPSA > median (7.97), n (%)	22 (91.7)	9 (23.7)	35.4 (6.9-180.8)	<0.001
BDI > median (3), n (%)	14 (58.3)	10 (26.3)	3.92 (1.32-11.62)	0.012
FIRST > median (2), n (%)	17 (70.8)	11 (28.9)	5.95 (1.94-18.37)	0.001
BASDAI > median (2.45), n (%)	19 (79.2)	12 (31.6)	8.23 (2.48-27.32)	<0.001
HAQ > median (0.1), n (%)	16 (66.7)	11 (28.9)	4.91 (1.63-14.76)	0.004
PCS > median (9), n (%)	18 (75)	11 (28.9)	7.36 (2.3-23.5)	<0.001
PsAID > median (2.1), n (%)	18 (75)	13 (34.2)	5.77 (1.84-18.06)	0.002

FRI0354 FACTORS AFFECTING SELF-REPORTED PHYSICAL ACTIVITY IN PATIENTS WITH PSORIATIC ARTHRITIS

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Background: Despite the known benefits of exercise¹, patients with osteoarthritis (OA) and rheumatoid arthritis (RA) are reported to have low levels of physical activity². Exercise participation is not well studied in psoriatic arthritis (PsA) cohorts. This study aims to explore which factors predict exercise participation across cohorts and specifically in the PsA cohort.

Objectives: The primary aim of this study was to determine which clinical factors were predictive of self-reported physical activity levels in patients with PsA. A secondary aim was to explore differences in self-reported physical activity levels amongst patients with PsA, OA and RA.

Methods: Patients with the diagnosis of PsA, RA or OA are recruited prospectively at two tertiary hospital rheumatology clinics over 12 months. Demographic data is captured by the multi-dimensional health assessment questionnaire, the international physical activity questionnaire short form captures self-reported physical activity and self-efficacy for exercise (SEE) is assessed using the SEE scale. Clinical data including joint count, body mass index and co-morbidities including fibromyalgia are collected for all patients, in addition to PsA specific data including skin and enthesitis indices.

Results: 205 patients (PsA n=62, RA n=83, OA n=60) were recruited across two sites. There was no significant difference in self-reported physical activity between OA, RA and PsA cohorts. Fibromyalgia was present in 30% of each cohort. In patients with PsA, univariate analysis showed that co-existent fibromyalgia, age and self-efficacy for exercise were predictors of physical activity levels. Skin disease and enthesitis were not predictors of physical activity in the PsA cohort.

Table 1. Univariate Analyses of effect of Clinical Features on Physical Activity levels in PsA

	Non-exercisers versus Exercisers	
	OR (95% CI)	P-value
LEI	1.35 (0.92-1.97)	0.127
PASI	0.8 (0.6-1.07)	0.133
DLQI	1.03 (0.92-1.16)	0.589
BMI	0.97 (0.91-1.04)	0.415
DAS28	0.79 (0.55-1.14)	0.205
Concurrent Fibromyalgia	4.46 (1.37-14.49)	0.012
Age	1.05 (1.00-1.10)	0.013
Self-efficacy for exercise	0.97 (0.95-0.99)	0.019
Pain	1.17 (0.99-1.37)	0.061
Function	1.3 (1.02-1.65)	0.031
Patient global	1.14 (0.96-1.34)	0.128
Depression	0.97 (0.51-1.84)	0.930

Table 2. Multivariable Analysis on Physical Activity in PsA

	Non-exercisers vs Exercisers	
	OR (95% CI)	P-value
Concurrent fibromyalgia	5.1 (1.44-18.08)	0.0117
Age	1.05 (1.00-1.11)	0.0342

Conclusion: In the PsA cohort, fibromyalgia and age were associated with lower levels of physical activity. DLQI, PASI, LEI did not predict physical activity in PsA. Multivariate analysis showed higher pain levels and lower self-efficacy scores were associated with lower physical activity across arthritis groups.

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None declared

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FRI0355 IMPACT OF BIOLOGIC THERAPY ON THE INCIDENCE OF PSA AMONG PATIENTS WITH PSORIASIS

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Background: One of the strongest known risk factors for the development of psoriatic arthritis (PsA) is psoriasis. A key question is whether treatment of psoriasis may prevent or delay onset of PsA.

Objectives: To compare the incidence of PsA among patients with psoriasis treated with a biologic compared to those treated with a non-biologic therapy for psoriasis

Methods: We performed a retrospective cohort study in the Optum de-identified Electronic Health Record dataset between 2006-2017. Patients with two or more ICD codes for psoriasis between the ages of 16 and 90, who were initiating an oral medication, a biologic therapy, or phototherapy (defined as no preceding codes for the therapy in the prior 12 months) were identified. Covariates at baseline were determined in the 12 months prior to therapy initiation. The outcome of interest was PsA as defined by one ICD code. The incidence of PsA was described overall and within each therapy group. We analyzed the data in two ways: a) a multivariable Cox model using a time varying exposure (once the patient was exposed to a biologic, they were considered always exposed) derived from automated stepwise regression and b) propensity score matching (greedy matching, caliper 0.1) between biologic-exposed patients and oral/phototherapy exposed patients.

Results: Among 215,386 patients with psoriasis without PsA at baseline, 9,848 were excluded for prior biologic exposure, and among the remaining, 60,258 initiated phototherapy, oral or biologic therapy during follow up. Among 22,461 new biologic initiations, 29,121 oral therapy and 8,676 phototherapy initiations, the mean age was lower in the biologics group compared to the non-biologic groups (46.9 vs 50.8), with a similar proportion of females and Caucasians. Observational time was also similar. A total of 1,643, 1,813, and 122 new PsA cases occurred over 60,739, 85,670, and 28,528 person-years (PY) of follow up, respectively (incidence 27.1, 21.2 and 4.2 per 1,000 person years respectively). Using a traditional multivariable adjustment approach with time varying exposure, the age and sex adjusted and fully adjusted HR (95% CI) for biologic users were 1.01 (0.99-1.04) and 0.93 (0.91-0.95), respectively. However, after propensity score matching, the HR (95% CI) was 1.64 (1.51-1.77). Survival curves cross, however, at approximately 8 years (Figure 1) and most of the new diagnoses of PsA occurred shortly after therapy initiation (Figure 2).