Conclusion: Regardless of previous biologic DMARD failure, pts treated with UPA15 or UPA30 achieved a higher rate of remission or LDA measured by various disease activity measures vs PBO at Wk 24; higher rates of response were observed in most of the remission and LDA measures with UPA30 vs ADA in non-biologic DMARD-IR pts. Among pts who did or did not achieve MDA criteria at Wk 24, a greater proportion of UPA-treated pts achieved physician derived measures such as SJC ≤ 1 , PASI ≤ 1 or BSA-Ps $\leq 3\%$, and LEI ≤ 1 .

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Table 1. Proportion of Patients Achieving Remission and LDA Measures at Week 24

Endpoint, n (%)	SELECT-PsA 1				SELECT-PsA 2			
	PBO N=423	ADA 40mg EOW N=429	UPA 15mg QD N=429	UPA 30mg QD N=423	PBO N=212	UPA 15mg QD N=211	UPA 30mg QD N=218	
MDA	52 (12.3)	143 (33.3)	157 (36.6) *,#	192 (45.4) *,#	6 (2.8)	53 (25.1) *,#	63 (28.9) *,#	
≥ 6 VLDA components	25 (5.9)	90 (21.0)	105 (24.5) *	134 (31.7) *,†	3 (1.4)	26 (12.3) *	44 (20.2) *	
VLDA	11 (2.6)	62 (14.5)	55 (12.8) *	72 (17.0) *	3 (1.4)	16 (7.6) *	21 (9.6) *	
DAPSA REM	9 (2.1)	43 (10.0)	47 (11.0) *	79 (18.7) *,†	1 (0.5)	15 (7.1) *	28 (12.8) *	
DAPSA LDA	70 (16.5)	198 (46.2)	204 (47.6) *	235 (55.6) *,†	14 (6.6)	73 (34.6) *	91 (41.7) *	
PASDAS REM	12 (2.8)	51 (11.9)	60 (14.0) *	91 (21.5) *,†	4 (1.9)	20 (9.5) *	31 (14.2) *	
PASDAS LDA	63 (14.9)	168 (39.2)	195 (45.5) *	211 (49.9) *,†	9 (4.2)	69 (32.7) *	82 (37.6) *	

*P ≤ 0.05 for UPA15 and UPA30 vs PBO; †P ≤ 0.05 for UPA30 vs ADA; #Statistically significant in the multiplicity-controlled analysis. MDA (5/7) and VLDA (7/7): TJC ≤ 1 ; SJC ≤ 1 ; PASI ≤ 1 or BSA-Psoriasis $\leq 3\%$; Patient's Assessment of Pain NRS ≤ 1.5 ; PtGA-Disease Activity NRS ≤ 2.0 ; HAQ-DI score ≤ 0.5 ; and tender entheseal points ≤ 1 . DAPSA REM ≤ 4 ; DAPSA LDA ≤ 14 . PASDAS REM ≤ 1.9 ; PASDAS LDA ≤ 3.2 .

Figure 1

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AB0530 EFFECT OF SKIN SYMPTOMS ON DISEASE IMPACT IN PATIENTS WITH PSORIATIC ARTHRITIS RECEIVING THE IL-17/23 INHIBITOR USTEKINUMAB OR TNF INHIBITORS IN THE REAL-WORLD PSABIO STUDY

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Background: Psoriatic arthritis (PsA) is characterised by musculoskeletal symptoms, and patients (pts) with PsA usually experience psoriasis concurrently. Real-world data reflecting impact of skin symptoms on PsA disease burden are limited.

Objectives: Analyse effectiveness of ustekinumab (UST) and tumour necrosis factor inhibitor (TNFi) therapy on extent of skin involvement, and the impact this has on PsA disease burden and drug persistence.

Methods: PsABio (NCT02627768) is a prospective, observational study of 1st/2nd/3rd-line UST or TNFi treatment in PsA in 8 European countries. Extent of skin involvement was categorised as body surface area (BSA): clear/almost clear; <3% but not clear/almost clear; 3–10%; or >10%. Pt-reported disease impact was evaluated by PsAID-12, including assessment of two skin-related domains (D): D3 (skin problems, including itching) and D10 (embarrassment and/or shame because of appearance). Estimated persistence at 1 year was assessed against baseline (BL) BSA categories.

Results: At BL, significantly more pts receiving UST than TNFi had BSA >10% (Figure 1). BL disease impact (PsAID-12) was worse in pts with BSA >10% than <3% in D3, D10 and total (non-overlapping 95% CIs suggest significance) (Table 1). BSA improved from BL to 1 year with both treatments. At 1 year, 64% of pts in both groups had clear/almost clear skin and only 3% had BSA >10% (Figure 1). At 1 year, both treatments significantly reduced disease impact (PsAID-12 total), and D3 and D10 scores, irrespective of BL BSA category, but most markedly in pts with higher BL BSA (Table 1). Worse BL psoriasis was generally associated with longer persistence for both treatments; however, at 1 year, pts

with BSA >10% had significantly shorter persistence with TNFi (mean [95% CI]: 361 [336; 387] days) than with UST (410 [394; 426] days).

Conclusion: In PsA, interleukin-12/23 inhibition (UST) and TNFi therapy in routine care rapidly and substantially reduced extent of skin involvement and related disease impact. Pts with highest BL skin involvement had significantly longer drug persistence with UST than with TNFi. Together, PsABio data suggest that successful treatment of skin involvement in PsA with biologics reduces disease burden and may improve persistence, especially in pts with worse BL psoriasis.

Figure 1

Table 1. PsAID-12 scores at BL and change from BL scores at 6 months and 1 year, by BL BSA category

Mean (95% CI)	Domain 3 (skin problems, including itching)		Domain 10 (embarrassment and/or shame because of appearance)		Total PsAID-12	
	UST	TNFi	UST	TNFi	UST	TNFi
PsAID-12 score at BL by BL BSA						
<3%	4.2 (3.7; 4.8)	3.1 (2.7; 3.6)	3.9 (3.3; 4.4)	3.1 (2.6; 3.6)	5.7 (5.3; 6.0)	5.0 (4.6; 5.3)
3-10%	6.4 (5.9; 6.8)	5.8 (5.3; 6.3)	4.1 (3.5; 4.7)	4.5 (3.9; 5.1)	5.4 (5.1; 5.8)	5.8 (5.4; 6.1)
>10%	7.9 (7.5; 8.3)	6.7 (6.0; 7.5)	6.1 (5.4; 6.8)	5.8 (4.8; 6.8)	6.2 (5.7; 6.6)	6.1 (5.6; 6.7)
Change from BL in PsAID-12 score at 6 months by BL BSA						
<3%	-1.5 (-2.1; -0.9)	-0.8 (-1.3; -0.3)	-1.5 (-2.0; -0.9)	-1.2 (-1.6; -0.7)	-1.6 (-2.0; -1.2)	-1.9 (-2.2; -1.5)
3-10%	-3.2 (-3.8; -2.7)	-2.4 (-3.0; -1.9)	-1.9 (-2.5; -1.3)	-2.0 (-2.5; -1.5)	-2.0 (-2.4; -1.6)	-2.4 (-2.8; -2.0)
>10%	-4.2 (-4.9; -3.6)	-2.5 (-3.2; -1.9)	-2.9 (-3.5; -2.2)	-1.6 (-2.4; -0.8)	-2.4 (-2.8; -2.0)	-2.2 (-2.7; -1.7)
Change from BL in PsAID-12 score at 1 year (LOCF) by BL BSA						
<3%	-1.5 (-2.1; -0.9)	-0.8 (-1.3; -0.3)	-1.6 (-2.2; -1.1)	-1.2 (-1.7; -0.7)	-1.6 (-2.0; -1.2)	-1.9 (-2.3; -1.5)
3-10%	-3.5 (-4.0; -2.9)	-3.2 (-3.7; -2.7)	-2.0 (-2.6; -1.4)	-2.5 (-3.0; -2.0)	-2.2 (-2.6; -1.7)	-3.0 (-3.4; -2.6)
>10%	-4.9 (-5.5; -4.3)	-3.1 (-4.0; -2.3)	-3.5 (-4.2; -2.8)	-2.7 (-3.7; -1.8)	-2.9 (-3.4; -2.4)	-2.9 (-3.5; -2.2)

PsAID-12 total score ≤4 is considered a patient-acceptable symptom state. BL, baseline; BSA, body surface area; CI, confidence interval; LOCF, last observation carried forward; PsAID-12, 12-item Psoriatic Arthritis Impact of Disease questionnaire; TNFi, tumour necrosis factor inhibitor; UST, ustekinumab

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AB0531 THERAPIES FOR PERIPHERAL JOINT INVOLVEMENT IN PSORIATIC ARTHRITIS: A SYSTEMATIC LITERATURE REVIEW

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Background: Much new information has been reported since the last evidence-based GRAPPA recommendations for the treatment of psoriasis and psoriatic arthritis (PsA).

Objectives: We aimed to compile the evidence for the efficacy and safety of established and newly developed drugs targeting the peripheral arthritis domain in PsA so as to provide information for the revised GRAPPA treatment recommendations.

Methods: A working group consisting of clinicians and patient research partners (PRPs) was convened. We performed an updated systematic literature review (SLR) of randomized controlled trials (RCTs) for the treatment of PsA, including peripheral arthritis, from the date of the last GRAPPA SLR, from February 19, 2013 to August 28, 2020. The working group reviewed the evidence supporting the efficacy on peripheral arthritis for each class of drug, according to the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach, for three patients groups: 1) naïve to treatment; 2) refractory to conventional (-c) DMARDs; and 3) with prior biological (-b)DMARD experience. We also evaluated the evidence for non-pharmacological treatments. A set of important outcomes for the peripheral arthritis domain was assessed for each class of medication. The certainty of evidence supporting each class of drugs for each patient group was evaluated. Recommendations were derived through consensus meetings.

Results: 87 articles from 52 RCTs were included. For patients with mild disease who are naïve to treatment, the working group strongly recommends csDMARDs (methotrexate, sulfasalazine, leflunomide) and PDE4i, and weakly recommends them for severe disease, where TNFi are preferred over csDMARDs. Other bDMARDs (IL-17i, IL-12/23i, IL-23i) and JAKi are strongly recommended to treat peripheral arthritis for treatment naïve patients. For patients with inadequate response to csDMARDs, we strongly recommend TNFi, IL-17i, IL-12/23i, IL-23i and JAKi. For those who had prior experience with bDMARDs,