Figure 1. ACR20 response rate of Jaki over Placebo

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Psoriatic arthritis - clinical aspects (other than treatment)

AB0566

CONSENSUS-BASED RECOMMENDATIONS FOR THE MANAGEMENT OF PSORIATIC ARTHRITIS IN THE KINGDOM OF SAUDI ARABIA

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Background: Psoriatic arthritis (PsA) is a chronic inflammatory condition associated with psoriasis. The common clinical features of PsA include peripheral arthritis, dactylitis, enthesitis, spondylitis, skin and nail disease¹. Considering the heterogeneous course of disease and the different patient characteristics, there is a need to standardize management of PsA patients. At present, no established guidelines are available on PsA care pathway in Saudi Arabia.

Objectives: To provide consensus-based guidance to all Saudi health care providers (HCPs) on the management of PsA patients including referral pathway, definition of remission and treat-to-target approach.

Methods: A Delphi technique was used to understand PsA patient care pathway. In first step, a targeted literature review was conducted and a survey questionnaire including 16 questions was developed to explore PsA patient journey. In second step, this questionnaire was submitted to 127 HCPs and 33 of them provided their response. In third step, a panel of 12 experts including 10 rheumatologists, 1 dermatologist and 1 general physician reviewed the available evidence along with survey results to align on final recommendations.

Results: The most common management guidelines recommended for PsA were European League against Rheumatism (EULAR, 100% agreed) and American College of Rheumatology (ACR, 100% agreed). Psoriasis Epidemiology Screening Tool (PEST) was recommended by 67% of experts as validated screening tool for PsA in dermatology clinic. The laboratory investigations included were C-reactive protein (CRP, 100%), erythrocyte sedimentation rate (ESR, 100%), complete blood count (92%), urea and creatinine (92%), liver function (92%), rheumatoid factor (56%) and X-ray of affected joints (75%). For patients with additional symptoms of back pain, X-ray of sacroiliac joints and human leukocyte antigen B27 (HLA-B27) test to be included. Only rheumatologists should recommend a magnetic resonance imaging based on the individual clinical picture. The agreement criteria for HCPs for referring patient to a rheumatologist were presence of psoriasis (100%) and one of the following features: dactylitis [100%], joint pain [100%], arthritis [100%], nail dystrophy [91%]. Patient with active arthritis should be referred to

rheumatologist within 4 weeks. The referral pathway agreed by the experts for PsA patients is presented in Figure 1. Majority of experts (57%) defined clinical remission as absence of disease activity in all facets of disease assessed using the disease activity in psoriatic arthritis (DAPSA) or minimal disease activity (MDA) index. For treat-to-target, 71% of experts agreed on EULAR recommendations². For remission and treat-to-target, experts identified a need for more clear definition.

Conclusion: This expert consensus aimed to provide guidance to Saudi HCPs on standardizing diagnosis and care of PsA patients. Most experts recommended PEST as validated screening tool for PsA along with laboratory investigations such as CRP, ESR, X-ray, etc. Referral to a rheumatologist should be considered for patient with presence of psoriasis and one of the other defining features for PsA. There is a need for more clear definition of remission and treat-to-target.

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Figure 1. Referral pathway for psoriatic arthritis patients. CRP: C-reactive protein; ESR: Erythrocyte sedimentation rate; CBC: Complete blood count; HLA-B27: Human leukocyte antigen B27; PEST: Psoriasis Epidemiology Screening Tool

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AB0567

USING Q-RISK SCALE FOR CHECKING CARDIOVASCULAR RISK IN PATIENTS WITH PSORIATIC ARTHRITIS

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Background: Psoriatic arthritis (PsA) is an inflammatory arthritis associated with psoriasis. In addition to skin and joint involvement, there is a growing evidence suggesting that patients with PsA also have increased risk of clinical and subclinical cardiovascular disease (CVD), mostly due to endothelial dysfunction and accelerated atherosclerosis, which are the main causes of elevated mortality rate among patients with PsA. For prevention and monitoring progression of CVD in clinical practice scale SCORE usually used, but it isn't adapted for checking in patients with autoimmune diseases and can be used only for patients after forty years old.

Objectives: To check a cardiovascular risk in patient with PsA using Q-risk scale.

Methods: In total, ninety-four patients with PsA, who fulfilled the disease criteria (CASPAR) were examined using standard diagnostic methods (including C-reactive protein, lipid profile). The QRISK-3 and SCORE scales were used to assess the 10-year risk of CVD.

Results: Intermediate (12.4 ± 0.75 %) risk of adverse cardiovascular events within the next 10 years was estimated for PsA patients and it was 7 to 8 – fold higher than the Q – score of a healthy age, sex, and ethnicity – matched subjects. Using classical SCORE, the risk was estimated as low (1.9 ± 0.24 %). Healthy Heart Age was about 25 % higher than predicted as assessed by QRISK.

Conclusion: The Q-risk Scale considers not only classical of such risk factors as age, sex, smoking, systolic blood pressure, total cholesterol (which used SCORE) but also index of atherogenicity, BMI, family history of coronary artery disease, treatment with antihypertensive drugs and glucocorticosteroids, comorbidity, systemic inflammatory disease and can be used for different age groups and ethnicity.

Q-risk scale appears to be adaptive and informative in patients with chronic inflammatory and autoimmune diseases as compared with SCORE, because it uses mostly all important etiological and trigger factors of CVD especially presence autoimmune inflammatory process in our case.

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AB0568

CORRELATION BETWEEN SKIN AND JOINT INVOLVEMENT IN PATIENTS WITH PSORIATIC ARTHRITIS: EXPERIENCE FROM A THIRD LEVEL HOSPITAL

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Background: Determining the relationship between severity of skin and joint disease is essential for better phenotyping of patients and determine whether clinical features of arthritis can associate with psoriasis.

Objectives: To characterize the relationship between skin and joint activity in patients with psoriatic arthritis (PsA) and psoriasis (PsO) at enrolment.

Methods: We performed a retrospective and descriptive study including patients diagnosed with PsA with a history of PsO. Age, sex, disease onset and duration, pattern of PsA and PsO, sites of skin and joint involvement were collected. PsA patients were evaluated at enrolment for skin activity by Psoriasis Area and Severity Index (PASI), joint activity by Disease Activity Score 28 (DAS28) for peripheral arthritis and Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) for axial involvement. A PASI>10% was used to define moderate-severe psoriasis (MS-P). We compared clinical characteristics of patients with PsA based on PASI score and evaluated the relationship of skin and joint activity with linear regression.

Results: A total of 50 patients were collected, 64% were women with a mean age of 57.4 ± 11.9 years. Patients with MS-P had a long-standing history of PsO (16.6 ± 7.9 vs 14.15 ± 8.2 years, $p = 0.03$) and arthritis (12.2 ± 7.6 vs 10.6 ± 7.6 years, $p = 0.05$). PsO was diagnosed more frequently before arthritis in the group of MS-P (73% vs 42%, $p = 0.03$). Nail (73% vs 34%, OR 4.27 (1.38-20.14), $p = 0.015$) and hairline psoriasis (67% vs 29%, OR 5 (1.36-18.35), $p = 0.03$) were more frequent in the group of MS-P. Polyarthritis was the most common clinical pattern (60% vs 26%, $p = 0.02$) and peripheral arthritis, in shoulder, elbows and wrists was more associated to patients with MS-P. No significant difference regarding sex, age, arthritis onset, dactylitis, enthesitis or HLA-B27 was found. Patients with MS-P had a higher joint activity for peripheral arthritis (4.1 vs 2.44, $p = 0.02$). The correlation between the skin and joint activity was positive and statistically significant $r = 0.568$ ($p = 0.02$), (graph 1).

Conclusion: Patients with PsA with MS-P associate nail and hairline psoriasis, polyarthritis, and peripheral joint involvement more often. Cutaneous disease activity is correlated with joint activity. Collaboration between dermatologists and rheumatologists is recommended for a proper assessment of psoriatic arthritis with skin involvement.

Graph 1. Correlation between skin and joint activity

Table 1. Demographic and clinical characteristics of 50 patients

	PASI <10% N = 35	PASI > 10% N=15	OR 95%IC	P value
Age	54.4 ±10.4	53.9 ±12.9	-	0.86
Female	63%	73%	0.62 (0.16-2.34)	0.53
Duration of psoriasis	14.15 ±8.2	16.6±7.9	-	0.03
Duration of arthritis	10.6 ±7.4	12.2 ±7.6	-	0.05
Psoriasis onset	42%	73%	3.67 (1.97-13.8)	0.03
Arthritis onset	17%	20%	1.21 (0.26-5.64)	1
Nail psoriasis	34%	73%	4.27 (1.38-20.14)	0.015
Hair line	29%	67%	5 (1.36-18.35)	0.03
Enthesitis	14%	13%	1.08 (0.19-6.32)	0.96
Dactylitis	20%	33%	0.5 (0.13-0.96)	0.47
HLA B27	34%	13%	3.39 (0.66-17.56)	0.18
Type of arthritis				
Axial	26%	13%	0.44 (0.08-2.36)	0.47
Peripheral	42.8%	73%	6.88 (1.77-26.76)	0.05
Both	31%	13%	0.34 (0.06-1.75)	0.29
Joint involvement				
Back	14%	20%	0.67 (0.14-3.24)	0.68
Shoulders	17%	53%	5.52 (1.44-21.14)	0.02
Elbows	5.7%	33%	8.25 (1.38-49.21)	0.02
Wrists	31%	73%	6 (1.56-23.11)	0.01
Fingers	54%	60%	1.26 (0.37-4.32)	0.77
Knees	29%	47%	2.19 (0.63-7.65)	0.33
Ankles	40%	60%	2.25 (0.65-7.73)	0.22
Toes	46%	53%	1.36 (0.4-4.56)	0.76
Articular pattern				
Polyarthritis	26%	60%	4.33 (1.2-15.61)	0.02
Asymmetric oligoarthritis	29%	27%	0.91 (0.23-3.54)	1
DIP involvement	14.3%	13.3%	0.92 (0.16-5.39)	1
Spondyloarthritis	11.4%	13.3%	1.19 (0.19-7.33)	1
Arthritis mutilans	-	-	-	-
DAS28	2.44 ±0.95	4.1±1.2	-	0.02

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AB0569

PSORIATIC ARTHRITIS, ALLIED DISEASES AND MORTALITY - A POSTMORTEM CLINICOPATHOLOGIC STUDY OF 12 PATIENTS

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