Conclusion: The SLE-DAS is an accurate and easy to use tool for defining clinical remission state and SLE disease activity categories, validated with both the expert assessment and BILAG.

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Difficult to treat RA: definitions and mechanisms_____

OP0298

ARE PATIENTS WITH PSORIATIC ARTHRITIS BEING TREATED OPTIMALLY ACROSS THE WORLD? DISPARITIES IN HEALTH CARE FOR PATIENTS WITH PSORIATIC ARTHRITIS ACROSS COUNTRIES WITH DIFFERENT GDP'S, AN ANALYSIS OF 429 PATIENTS FROM 13 COUNTRIES

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Background: In psoriatic arthritis (PsA), EULAR recommendations are to aim for remission or low disease activity(1). Many treatments are now available, though some are costly and not widely available in all countries. Country of patient care, and in particular Gross Domestic Product (GDP) may be linked to PsA outcomes(2). Although patients with high disease activity are eligible for targeted therapies such as biologic disease-modifying anti-rheumatic drugs (bDMARDs), they may not be able to get the benefits from these efficacious treatments in all countries equally.

Objectives: The objective was to explore the rate of PsA patients with high to moderate disease activity, not receiving bDMARDs across countries, and to assess the consequences on functional incapacity.

Methods: This was a cross-sectional analysis of an observational study (ReFlap, NCT03119805)(3), which included adult patients with PsA with ≥ 2 years disease duration from 14 countries. One country was excluded from this analysis since only 7 patients were included. We explored the rate of patients with significant disease activity (i.e based on DAPSA > 14) and no ongoing bDMARD prescription. Countries of inclusion were analysed separately, and classified into tertiles by GDP/capita (lowest tertile: Brazil, Turkey, Russia, Romania, Estonia; middle tertile: Spain, Italy, UK, France; highest tertile: Canada, Germany, USA and Singapore). The rate of no bDMARDs - DAPSA > 14 patients was analysed by country and compared between the 3 tertiles of GDP/capita by parametric tests. Functional capacity (HAQ) was compared between no bDMARDs - DAPSA > 14 patients and the other patients (pooling patients with moderate or high disease activity with bDMARD, low disease activity and remission with or without bDMARD). There was no imputation of missing data.

Results: Of the 459 patients, 429 had complete data available and were analysed: mean age 52.3 (SD 12.6) years, mean disease duration 10.2 (SD 8.2) years, 215 (50.1%) males. The rate of no bDMARDs - DAPSA > 14 patients was 18.4% (76/414). The rate ranged from 7.4% (UK and Spain) to 40% (Russia): Figure 1. A link was seen with the country and the tertiles of countries according to GDP/capita, with higher rate of no bDMARDs - DAPSA > 14 patients in the lowest GDP/capita countries (28.8%, 15.3% and 14.3% in the 3 GDP/capita tertiles, respectively, p=0.005; Figure 1). Of note, 40/76 no bDMARDs - DAPSA > 14 patients received a treatment intensification during the visit. Among no bDMARDs - DAPSA > 14 patients, functional incapacity was higher than in the other patients, as expected (mean HAQ 0.96 (SD 0.64) vs 0.57 (SD 0.63), p<0.001).

Figure 1. The size of the bubbles represent the number of patients per country (range, 13 to 89). The horizontal lines represent the mean proportion of patients with no bDMARDs - DAPSA > 14 for each tertiles of countries by GDP/capita.

Conclusion: In this exploratory comparison of disease patterns and treatments choices in 13 countries, we observed that more PsA patients with high or moderate disease activity and living in low GDP/capita countries were less likely to be treated with bDMARDs. As a consequence, no bDMARDs - DAPSA > 14 patients had worse functional incapacity. Equitable access to bDMARDs should be aimed for all patients regardless of their country of origin.

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