Results: The PsA cohort consisted of 5,275 patients, 53.2% females with mean age of 51.66 ± 15.41. The control group consisted of 21,011 subjects matched for age and sex. In relation to the control group, the PsA cohort had a higher SES (25.1% vs 23.4%, $p < 0.0001$), higher tobacco use (42.2% vs 39.6% $p < 0.0001$) and obesity (33.5% vs 25.8%, $p < 0.0001$). The study group had a statistically significant higher incidence of diabetes (33.8% vs 26.2%, $p < 0.0001$), IHD (10.3% vs 8.6%, $p < 0.0001$), CHF (2.2% vs 1.6%, $p = 0.004$), hypertension (30.1% vs 26.2%, $p < 0.0001$), CVA/TIA (4.6% vs 3.9%, $p = 0.024$) and vascular disease (3.7% vs 3.0%, $p = 0.005$). There were 62 patients (1.2%) diagnosed with VTE in the PsA group as opposed to 176 patients (0.8%) in the control group ($p = 0.023$, HR=1.397, CI 1.05-1.87). The mean age of patients diagnosed with VTE was higher in the PsA group relative to controls (64.90 ± 13.20 vs 51.54 ± 15.41, respectively, $p < 0.0001$), with higher age, BMI > 30, cancer, IHD, vascular disease, and previous VTE found to be associated with VTE in the PsA group relative to controls in both univariate and multivariate analyses. The higher prevalence of VTE in PsA patients relative to controls did not remain statistically significant in multivariate analysis following adjustment for risk factors. Within the PsA group, patients with VTE were more often of older age and with past history of VTE. Both cDMARD and bDMARD were not associated with increased risk of VTE among PsA patients.

Conclusion: The prevalence of VTE was higher in PsA group compared to the general population, but after adjustment for comorbidities and risk factors, it no longer remained statistically significant. Among PsA patients, age and previous history of VTE were associated with increased risk of VTE. Addressing VTE risk in the management of patients with PsA is recommended especially in the era of Janus kinase inhibitors.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.1811

POS0148 MATERNAL AND NEONATAL OUTCOMES IN PREGNANT WOMEN WITH PSORIASIS AND PSORIATIC ARTHRITIS: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Background: Psoriasis and psoriatic arthritis (PsA) are inflammatory diseases that affect women in their reproductive years. The evidence regarding the pregnancy outcomes in psoriasis and PsA is more limited and conflicting, to a large extent, confusing our knowledge on this topic.

Objectives: We aim to investigate whether maternal psoriasis and PsA are associated with adverse pregnancy outcomes.

Methods: We searched multiple electronic databases from inception to 3 August 2020, and reference lists of selected articles. Observational studies reporting at least one pregnancy outcomes in women with psoriasis or PsA with a comparator of general population or healthy subjects were included. Data were pooled by random-effects models (DerSimonian and Laird method) and expressed as odds ratio (OR) and 95% confidence interval (CI).

Results: Overall, 16 studies were included in the meta-analysis. The pooled analyses showed pregnant women with psoriatic diseases have significantly higher risk of adverse maternal outcomes compared with general population (caesarean delivery: 1.33 (1.17-1.52); preterm birth: 1.32 (1.15-1.52); (pre)eclampsia: 1.28 (1.14-1.43); gestational diabetes: 1.19 (1.10-1.30); gestational hypertension: 1.30 (1.18-1.44) (Figure 1). However, no statistically increased risks of fetal complications were observed in women with psoriatic diseases (small for gestational age: 1.02 (0.93-1.11); low birth weight: 1.15 (0.93-1.42); congenital malformations: 1.03 (0.93-1.14); Apgar score < 7: 1.07 (0.81-1.39); neonatal mortality: 1.13 (0.90-1.43); stillbirth: 1.19 (0.95-1.50)). Subgroup analysis found similar results in women with either psoriasis or PsA regarding maternal outcomes, but the magnitude of risk estimates seems to be greater in PsA.

Conclusion: Pregnant women with psoriasis and PsA have excess risk of adverse maternal events, with seemingly higher risk in women with PsA, but not adverse neonatal events. Close monitoring of the mothers' clinical status before and during pregnancy are decidedly required in daily practice.

Figure 1. Forest plots of the odds ratio for the risk of adverse pregnancy outcomes in patients with psoriatic diseases.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.2283

POS0149 MUSCULOSKELETAL PAIN IN PATIENTS WITH PSORIASIS AND THE INFLUENCE ON HEALTH-RELATED QUALITY OF LIFE: RESULTS FROM A DANISH POPULATION-BASED SURVEY

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Background: Psoriasis (PsO) impacts health-related quality of life (HRQoL). The impact of musculoskeletal (MSK) pain in patients without diagnosed psoriatic arthritis (PsA) (1) is poorly understood.

Objectives: To assess the pattern of MSK pain in patients with PsO, and its influence on important patient-reported outcomes.

Methods: A nationwide survey of patients with PsO and PsA, covering skin and MSK symptoms, healthcare contacts, self-assessed disease severity, treatment satisfaction, HRQoL (including Dermatology Life Quality Index (DLQI) and European Quality of life-5 Dimensions (EQ5D)) and disability. Respondents were grouped according to MSK pain as shown in Table 1. 'PsO previous pain' was combined with 'PsO no pain ever' (labeled 'PsO no pain now') for some analyses and with 'PsO pain now' (labeled 'PsO pain ever') for others.

Results: 561 respondents with PsO completed the questionnaire. Population and subgroup demographics, clinical PsA/PsO features and HRQoL measures are shown in Table 1. Patients in 'PsO pain now' had poorer HRQoL (higher DLQI, lower EQ5D) compared to 'PsO no pain now', and similar to patients with PsA. Patients with PsA assessed their PsO severity higher than patients with 'PsO pain ever' and 'PsO no pain ever' (median (interquartile range) 2 (2-3), 2 (1-3) and 2 (1-2) on a five-level scale, respectively). PsO treatment satisfaction (five-level scale) was lower for 'PsO pain ever' (3 (3-4)) than for 'PsO no pain ever' (4 (3-4), $p = 0.03$). Figure 1 shows contacts to dermatologists and rheumatologists, where 72% of patients in 'PsO pain ever' had never been examined by a rheumatologist. Time from symptom debut to diagnosis was 1.5 (1-3) years for PsO and 7.5 (1.5-12.5) for PsA.

Table 1. Population and subgroup characteristics

DEMOGRAPHICS	All	PsO			PsA	p-value*		
		PsO no pain ever	previous pain	PsO pain now				
N	561	178	104	130	108			
Male	212 (38%)	79 (44%)	34 (33%)	36 (28%)	40 (37%)			0.02
Age (years)	58 (43-68)	58 (43-68)	56 (42-63)	53 (43-63)	58 (48-68)			0.05
Body Mass Index	27 (24-32)	26 (23-30)	28 (24-32)	29 (25-33)	28 (24-33)			0.01
No current occupation ¹	119 (21%)	20 (11%)	23 (22%)	34 (26%)	35 (32%)			<0.001
PsO/PsA FEATURES	All	1. PsO no pain ever	2. PsO pain ever	3. PsA	1 vs. 2	1 vs. 3	2 vs. 3	
N	561	178	234	108				
BSA (%)	1 (1-2)	1(1-2)	1 (1-2)	2 (1-2)	0.10	<0.001	0.01	
Nail psoriasis	134 (24%)	27 (15%)	50 (21%)	46 (48%)	0.13	<0.001	<0.001	
'Dactylitis' ^{2a}	80 (14%)	2 (1%)	34 (15%)	40 (42%)	<0.001	<0.001	<0.001	
'Enthesitis' ^{2b}	74 (13%)	4 (2%)	30 (13%)	39 (41%)	<0.001	<0.001	<0.001	
QUALITY OF LIFE AND DISABILITY	All	1. PsO no pain now	2. PsO pain now	3. PsA	1 vs. 2	1 vs. 3	2 vs. 3	
N	561	282	130	108				
DLQI score (0-30)	2 (1-5)	1 (1-4)	2 (1-5)	2 (1-6)	0.001	0.04	0.52	
EQ5D index (0-1)	0.797 (0.691-0.859)	0.859 (0.768-1)	0.732 (0.679-0.859)	0.702 (0.598-0.802)	<0.001	<0.001	0.53	
HAQ score (0-3)	0.63 (0-1.25)		0.50 (0-0.88)	0.88 (0.13-1.38)			0.03	

Numbers are numbers (%) (binary data), median (interquartile range) (continuous data). BSA: Body Surface Area (palm-size areas of the body with psoriasis). DLQI: Dermatology life quality index (higher scores = higher impact of disease). EQ5D: European Quality of life-5 Dimensions -5 Domain (higher scores = better health state). HAQ: Health assessment questionnaire. PsA: Psoriatic arthritis. PsO: Psoriasis.* Multiple groups: Chi-square test/ Kruskal-Wallis test. Pairwise: Fishers exact test/Mann-Whitney U test. 1. e. work/studies/retirement 2. a. "Swollen entire finger or toe" b. "Tender or swollen tendon".