Retention rates of biologic therapy. Differences between axSpA(+) and axSpA(-) pts are statistically significant ($p=0.00265$, log rank test).

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POS0977

CARDIOVASCULAR AND DISEASE RELATED FEATURES IN AXIAL SPONDYLITIS WITH AND WITHOUT CONCOMITANT PSORIASIS. A MULTICENTER STUDY WITH 882 PATIENTS

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Background: Patients with axial spondyloarthritis (axSpA) may present with concomitant psoriasis (Ps) in approximately 10% of cases. As with axSpA, Ps is also associated with an accelerated atherosclerosis process¹. However, it is unknown whether the presence of Ps confers an increased cardiovascular (CV) risk in patients with axSpA.

Objectives: To compare factors related to the disease, CV risk factors, atherosclerotic burden, and CV events in patients with axSpA with and without Ps.

Methods: Cross-sectional analysis of the AthespAin cohort, a Spanish multicenter cohort designed for the study of atherosclerosis in axSpA. We compared axSpA patients with and without concomitant psoriasis, focusing mainly on CV risk characteristics. Background information on CV risk factors, CV events, and disease-related factors was reviewed, and data on maximum body index, blood pressure, lipid profile, and disease status at the time of the study were also obtained. Carotid ultrasound (US) was performed in all patients at the time of the study, including measurement of carotid intima-media wall thickness (cIMT) and plaque detection according to the Mannheim consensus criteria.

Results: A set of 882 axSpA patients were included. 786 (89.1%) of them had no concomitant Ps, which was present in 96 (10.9%) patients. Although the mean age was similar, male sex was more prevalent in axSpA patients with Ps (79.1% Vs 66.5%, $p=0.01$) (Table 1).

Furthermore, it was found that axSpA with Ps had a more frequent history of synovitis (50% vs 33%, $p=0.001$), dactylitis (13% vs 6%, $p=0.011$) and concomitant inflammatory bowel disease (13% vs 6%, $p=0.01$). AxSpA patients with Ps had a non-significant trend towards a higher prevalence of asymmetric sacroiliitis (23 vs 16%, $p=0.064$) and had a lower frequency of

positive HLA-B27 status (56% vs 72%, $p=0.003$). Regarding the management of the disease, prednisone (23% vs 12%, $p=0.02$), methotrexate (30% vs 15%, $p=0.000$) and anti-TNF α therapy (50% vs 34%, $p=0.002$) were more commonly used in the group with Ps.

Regarding CV risk characteristics, no differences were observed either in the prevalence of traditional CV risk factors (Table 1), nor in the total serum level, HDL and LDL, blood pressure and body mass index at that time of the study. However, axSpA patients with Ps showed a higher prevalence of CV events (9% vs 4%, $p=0.05$), including ischemic heart disease (6% vs 3%, $p=0.042$) and ischemic stroke (4% vs 1%, $p=0.016$) (Table 1). The subclinical atherosclerotic burden was also more severe in the group with Ps, with a higher prevalence of carotid plaques (39% vs 31%, $p=0.098$), and higher values of cIMT (0.664 ± 0.170 mm vs 0.642 ± 0.142 mm, $p=0.16$), although the differences did not reach statistical significance.

Table 1. Main sociodemographic and cardiovascular differences among axSpA patients with and without psoriasis.

	axSpA without psoriasis (n=786)	axSpA with psoriasis (n=96)	p
Men/Women, n	523/268	76/20	0.010
Mean age (years) $\pm$ SD at the time of study	49 $\pm$ 13	49 $\pm$ 13	0.81
AS/Nr-AxSpA	625/166	77/19	0.79
History of CV risk factors			
Current smokers	267 (34)	30 (31)	0.60
Obesity	174 (22)	26 (27)	0.29
Dyslipidemia	262 (33)	35 (36)	0.48
Hypertension	211 (27)	28 (29)	0.57
Diabetes Mellitus	56 (7)	8 (8)	0.65
Chronic Kidney Disease	19 (2)	3 (3)	0.72
History of cardiovascular events, n (%)			
Ischemic heart disease	33 (4)	9 (9)	0.023
Congestive heart failure	20 (3)	6 (6)	0.042
Ischemic stroke	2 (0)	1 (1)	0.29
Peripheral artery disease	6 (1)	4 (4)	0.016
CV data at the time of study			
Carotid plaques	244 (31)	38 (39)	0.098
IMT mm	0.642 ± 0.142	0.664 ± 0.170	0.16
IMT ≥ 900 mm	40 (5)	6 (6)	0.66

Abbreviations: AS = ankylosing spondylitis. AxSpA = axial spondylitis. CV = cardiovascular. IMT = intima-media wall thickness. Nr-axSpA = no-radiographic axial spondylitis.

Conclusion: The presence of Ps may confer additional CV risk to axSpA patients and is associated with particular disease related factors.

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POS0978

DISEASE CONTROL IN PSORIATIC ARTHRITIS PATIENTS WITH OR WITHOUT AXIAL MANIFESTATIONS IN REAL CLINICAL PRACTICE IN SPAIN: RESULTS FROM THE MIDAS STUDY

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Background: MIDAS study assessed the disease activity in psoriatic arthritis (PsA) patients treated in clinical practice in Spain.

Objectives: This sub-analysis compared disease activity between PsA patients with or without axial manifestations.

Methods: MIDAS is an observational, non-interventional, cross-sectional, multicenter study conducted in Spain. Patients included were ≥ 18 years old with ≥ 6 months since diagnosis, were classified by CASPAR criteria and had initiated treatment ≥ 3 months. Disease activity was measured by Disease Activity in Psoriatic Arthritis (DAPSA) and Minimal Disease Activity (MDA). Axial involvement was defined according to the presence of inflammatory back pain assessed by rheumatologist.

Results: 312 evaluable PsA patients were included in this analysis, 12.2% of which presented with axial involvement. PsA patients with axial manifestations reported longer time from onset of symptoms to diagnosis and disease duration, higher presence of concomitant diseases, HLA-B*27+ status, C-reactive protein

(CRP) levels, perception of uncontrolled disease and presence of swollen and tender joints compared to patients without axial involvement. A higher proportion of PsA patients with axial manifestations were treated with a biologic compared with those without axial involvement 68.4% vs 57.3% (Table 1). Patients with axial involvement showed a higher impairment of their quality of life compared to those without axial manifestations by a worse higher mean (SD) Psoriatic Arthritis Impact of Disease 12-item questionnaire (PSAID12) score (5.0 [2.4] vs 2.7 [2.2], respectively). In terms of disease control more patients with axial manifestations presented with moderate to high disease activity (DAPSA>14: 65.7% vs 36.8%, respectively) and did not meet the MDA criteria for remission (89.5% vs 42.7%, respectively) (Figure 1).

Conclusion: PsA patients with axial manifestations presented with a higher burden of disease and showed a worse disease control compared to those without axial involvement.

Table 1. Baseline demographic and clinical characteristics

	With axial manifestations (n=38)	Without axial manifestations (n=274)	PsA (n=312)
Age (years), mean (SD)	53.1 (10.4)	54.1 (12.4)	54.0 (12.2)
Sex (male), n (%)	17 (44.7%)	153 (55.8%)	170 (54.5%)
Time since diagnosis (years), mean (SD)	13.6 (10.1)	10.1 (8.8)	10.5 (9.0)
Time from onset of symptoms to diagnosis (years), mean (SD)	4.3 (6.1)	2.8 (4.8)	3.0 (5.0)
Presence of concomitant diseases, mean (SD)	26 (68.4%)	166 (60.6%)	192 (61.5%)
Anemia, n (%)	3 (7.9%)	7 (2.6%)	7 (2.2%)
Anxiety, n (%)	6 (15.8%)	9 (3.3%)	1 (0.3%)
Asthma, n (%)	2 (5.3%)	7 (2.6%)	1 (0.3%)
Depression, n (%)	6 (15.8%)	1 (0.4%)	1 (0.3%)
Dyslipidemia, n (%)	3 (7.9%)	8 (2.9%)	9 (2.9%)
Hypertension, n (%)	3 (7.9%)	7 (2.6%)	9 (2.9%)
Others (excluding skin psoriasis, uveitis, or IBD), n (%)	3 (7.9%)	17 (6.2%)	19 (6.1%)
Presence of HLA-B*27+, n (%)	6 (15.8%)	28 (10.2%)	34 (10.9%)
CRP levels (mg/l), mean (SD)	7.3 (11.3)	4.6 (6.5)	4.9 (7.3)
Patient perceived disease control (PASS), n (%)	30 (78.9%)	228 (83.5%)	258 (83.0%)
Presence of swollen (SJC≥1), n (%)	22 (57.9%)	117 (42.7%)	139 (44.6%)
Presence of tender joints (TJC≥1), n (%)	14 (36.8%)	74 (27.0%)	88 (28.2%)
Patients treated with biological	26 (68.4%)	157 (57.3%)	183 (58.7%)

COPD, chronic obstructive pulmonary disease; CRP, C-reactive protein; HLA-B*27, human leukocyte antigen B27; IBD, inflammatory bowel disease; PASS, patient acceptable symptom state; PsA, psoriatic arthritis; SD, standard deviation; SJC, swollen joint counts; TJC, tender joint counts.

Figure 1. Disease status according to clinical phenotype of PSA **A)** Disease activity according to DAPSA **B)** Disease activity according to MDADAPSA, Disease Activity in Psoriatic Arthritis; MDA, Minimal Disease Activity; PsA, psoriatic arthritis.

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POS0979 ASSOCIATION BETWEEN HIGHER INTAKE OF CARBOHYDRATES AND FREE SUGAR WITH HIGHER DISEASE ACTIVITY IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS

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Background: Diet has been previously described as an impact factor on the course of rheumatic diseases, such as rheumatoid arthritis and systemic lupus erythematosus (SLE). It has been previously reported that dietary sugar intake may contribute to subclinical inflammation and disease activity in SLE. However, there is very little investigation on the possible association between nutritional parameters and their influence on spondyloarthritis (SpA).

Objectives: To investigate the possible impact of nutritional parameters on the disease activity in patients with SpA.

Methods: Patients with radiographic axial SpA and starting a biological therapy were recruited between 2015 and 2019 in an extension of the prospective German Spondyloarthritis Inception Cohort (GESPIC). Dietary habits were collected at baseline using the country-specific validated food frequency questionnaire (FFQ) developed for the use in the German Health examination Survey for Adults 2008-2011. The FFQ includes questions about the frequency and amount of 53 food items, consumed during the past 4 weeks, and enabled to compute individual mean consumptions of foods in grams per day. Total energy intake (in Kcal per day) and nutritional parameters: carbohydrates, free sugars, total fats, saturated fats, mono and poly-unsaturated fats, proteins and dietary fiber, were calculated for each patient using a nutrition organization software and the database of Federal Food Code (Bundeslebensmittelschlüssel), version 3.02. Disease activity measures (BASDAI, CRP and ASDAS), as well as height, weight and body mass index (BMI) were assessed at baseline before starting the biological treatment.

Results: A total of 104 patients from 129 patients with axial SpA enrolled in the cohort were included in this nutritional analysis. The mean age (mean±SD) was 37.0±11.0 years old with symptoms duration of 11.3±9.9 years, 68.3% were males, and 86.5% were HLA-B27 positive. Patients presented BMI of 25.1±4.3 kg/m², BASDAI 5.6±1.4, CRP 14.0±18.2 mg/l, and ASDAS 3.5±1.0.

In the univariable and multivariable regression analysis, a higher energy intake and carbohydrates were associated with higher disease activity, measured by ASDAS, BASDAI and CRP. This association was attributable to the full intake of carbohydrates and specifically to the total of free sugars (monosaccharides