POS1081

OSTEOPOROSIS AND INSUFFICIENCY RISK FACTORS IN PSORIATIC ARTHRITIS

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Background: Osteoporosis (OP) has been described to be frequent in spondyloarthritis [1]. However, the specific association of psoriatic arthritis (PsA) and bone fragility remains inconclusive, with a prevalence of OP ranging from 1.4–68.8 [2, 3].

Objectives: The aim of this study was to describe the prevalence of osteopenia and OP in a representative cohort of patients with PsA

Methods: Multi-centric, cross-sectional, descriptive study of patients with clinical diagnosis of PsA. Patients were randomly selected; they were invited to participate and were included after signing informed consent until the calculated sample size was reached. Clinical and demographic characteristics were recorded, as well as several protective and risk factors for osteoporosis and insufficiency fractures. Patients were asked to undergo a hip and lumbar (L2-L4) densitometry by DXA, and lateral X-Ray of the dorsal and lumbar spine if they had not these tests available in the previous year. The prevalence of osteoporosis and the risk factors was calculated. The characteristics of the patients with OP were compared to those without by univariate analyses, and were adjusted by age and sex. Multivariate analysis by ANOVA test was done to study the association of OP and fractures with clinical characteristics of the disease. The Clinical Research Ethics Committee of the Hospital General Universitario de Alicante (ISABIAL- approval number 180264) approved the study

Results: 166 patients were included (Female 69%, male 30.1%), median age 58 (IR 51-65). Basal characteristics are shown in Table 1. Osteopenia or OP was present in 100 patients (60.2%). OP was present in 44 patients (26.5%). Among these, 9 patients (20.5%), all women ≥ 50 years old, had a total amount of 14 insufficiency fractures (4 vertebrae, 2 hips, 4 distal radius, 4 others). OP was present in 21.7% of the women, and 4.8% of the men. The most frequent risk factors among patients with OP were D-vitamin deficit (54.5%), sedentary life style by WHO standards (43.2%) and low calcium intake (38.6%). The most frequent protector factors in the group without osteopenia/nor OP was the intake of statins for ≥ 12 months. The presence of vertebral fractures was associated with female sex, sedentary lifestyle and age.

Conclusion: The prevalence of insufficiency fractures among PsA patients was very superior to that recently found in the general population in Spain (prevalence 1.83%) [4]. Fractures are associated, similar to the general population, to female sex, sedentary life and age. Inherent factors to psoriatic disease may be responsible for this increased prevalence

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Table 1. Basal characteristics (n=166)

Age (years)	57,9 (SD 0,8)	Median 58 (IR 51-65)
Sex		
Male	50 (30.1%)	
Female	116 (69.9%)	
Duration of disease (years)	10.3 (SD 0.63)	Median 9 (IR 4.75-13)
Type of PsA		
Axial	15 (9%)	
Peripheral	125 (75.3%)	
Both	26 (15.7%)	
HAQ (n=142)	0.47 (SD 0.05)	Median 0.25 (IR 0-1)
BASFI (n=40)	3.7 (SD0.5)	Median 3.6 (IR 1-5.75)
cDMARD		
Never	25 (15.1%)	
Previous/actual	141 (85%)	
bDMARD		
Never	84 (50.6%)	
Previous/actual	82 (49.4%)	

PsA: psoriatic arthritis; HAQ: Health Assessment Questionnaire; BASFI: Bath Ankylosing Spondylitis Functional Index; cDMARDs: classical disease modifying anti-rheumatic drugs; bDMARDs: biological drugs

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CATASTROPHIZING IN PATIENTS WITH PSORIATIC ARTHRITIS

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Background: Catastrophizing is a negative cognitive-affective response to an anxiety-provoking stimulus, especially anticipated or actual pain. It can be quickly assessed using a validated questionnaire: the Pain Catastrophizing Scale (PCS)¹. Catastrophizing plays a role in maintaining chronic pain and is associated with several pain-related outcomes in osteoarthritis and low back pain. To our knowledge, there are no data on catastrophizing in patients with psoriatic arthritis (PsA).

Objectives: To assess the prevalence of catastrophizing and associated factors in PsA.

Methods: We performed a bi-centric observational, prospective study. All patients aged 18 or over with PsA fulfilling the 2006 CASPAR criteria were consecutively included. Sociodemographic data, information on the disease and its treatments were collected as well as questionnaires for disease activity (BASDAI), function (HAQ, BASFI), quality of life (SF12, EQ5D), anxiety and depression (HADS, GAD7), fibromyalgia (FIRIST), insomnia (ISI) and catastrophizing scores (PCS). Statistical analysis included samples T-test, one-way variance analysis, Spearman's correlation coefficient, Chi² test, Fisher's exact test, Wilcoxon test, multivariate linear regression (considering catastrophizing as a continuous variable) and multivariate logistics regression (considering catastrophizing as a categorical variable: PCS ≥ 20 = high level catastrophizing).

Results: From September 2019 to March 2020, 85 PsA patients were included: 54.1% were women, the median age was 54.0 years and 33 patients (39.8%) were professionally active. The majority of patients (88.2%) had a disease lasting for more than 2 years. Axial involvement was found for 39 patients (45.9%), almost all patients (98.8%) had peripheral involvement, 32 patients (37.7%) had enthesitic involvement and 14 patients (16.7%) had erosions. Median DAS28 CRP was 3.12 [2.13-4.46] and the median BASDAI score was 5.50 [4.30-6.70]. The prevalence of a PCS score ≥ 20 was 45.9% [35.3;56.5]. The median PCS score was 16 [6-29]. In multivariate logistics regression, high-level catastrophizing was significantly associated with the HADS anxiety score (OR=1.35 [1.15-1.61]) and pain VAS (OR=1.04 [1.02-1.06]). In multivariate linear regression, catastrophizing was significantly associated with the HADS anxiety score (p=0.004), pain VAS (p=0.001), HADS depression score (p=0.018) and insomnia score (p=0.034).

Conclusion: Almost half the patients with PsA were high catastrophizers. Catastrophizing is related to anxiety, pain, depression and insomnia. It may be interesting to detect catastrophizing in order to improve the care of our patients.

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POS1083

PSORIATIC DISEASE – A HETEROGENEOUS DISEASE WHO NEEDS A MULTIDISCIPLINARY CARE!

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Background: Rheumatologists and Dermatologists usually manage Psoriatic Arthritis (PsA) and Psoriasis (PsO) separately, but early diagnosis and integrated management could achieve better outcomes with gains in quality of life of the patients. A multidisciplinary care is essential to achieve these goals.

Objectives: The aim of this study is to describe a model of integrated multidisciplinary approach for early diagnosis of PsA and the multidisciplinary management of PsA patients.

Methods: A retrospective study including patients that attended the multidisciplinary clinical from January 2019 to December 2020 was performed. Patients with PsO complaining articular symptoms and patients with articular symptoms with cutaneous lesions suspected to be PsO was referred to this clinical. Demographic, clinical data and disease activity measures were collected. Descriptive, Student's t and Fisher test and Odds Ratio were estimated.

Results: A total of 50 patients were referred to multidisciplinary clinical. Of these, 40 patients met criteria for psoriatic arthritis according to CASPAR criteria:

22 (55%) were male and median age was 49.5 ± 11.5 years. Family history of psoriasis was present in 19 (47.5%) and 7 (17.5%) had spondyloarthritis family history. Obesity and overweight were the comorbidities most found, 42.9% and 37.1%, respectively, followed by hypertension 25%, dyslipidaemia and depression 22.5% and metabolic syndrome 15%. Thirty-three patients (84.6%) were under topical treatment, 23 (59%) were under csDMARDs and 13 (32.5%) were under bDMARDs. After multidisciplinary clinical evaluation, treatment change was made - switch to another bDMARDs in 5 patients and bDMARD was started in 7 patients. All patients had a previous evaluation for infection risk assessment and 11 patients performed 9 months isoniazid for latent tuberculosis treatment. Eleven patients (28.9%) presenting moderate to severe PASI. Thirty-one patients presenting prolonged disease duration (> 10 years) with cutaneous (74.2%) and articular (61.3%) involvement. Peripheral disease without axial involvement was present in 28 patients (90%) while the others (10%) had both axial and peripheral involvement. Severe or moderate articular disease activity (DAS28) was present in 52.6% of the patients. The most frequent extra-articular manifestation was dactylitis (23.3%) and enthesitis (19.4%). The average number of multidisciplinary clinical consultations for these patients was 2.

There was a statistically significant difference at the mean age, gender and disease duration > 10 years between patients with psoriatic disease with and without arthritis ($p = 0.047$; $p = 0.01$ and $p = 0.03$, respectively); there was no statistically significant differences in family history of psoriasis ($p = 0.711$) and spondyloarthritis ($p = 0.174$), nutritional status ($p = 0.732$) and comorbidities such as diabetes mellitus ($p = 0.545$), hypertension ($p = 0.404$), dyslipidaemia ($p = 0.394$) and depression ($p = 0.089$).

In the remaining 10 patients screened, the osteoarthritis and/or tendonitis were responsible for the articular complaints in 6 patients and scalp seborrhoea and eczema were responsible for the cutaneous complaints in the rest.

Conclusion: Despite the small number of patients observed in our multidisciplinary clinical, we found that this kind of clinical care may facilitate the diagnosis of joint disease and offers a more comprehensive treatment approach for patients with both psoriasis and PsA.

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POS1084

COMPARISON OF NUMERICAL RATING SCALE (NRS) AND VISUAL ANALOGUE SCALE (VAS) IN THE PATIENT REPORTED OUTCOME MEASURES OF 3VAS AND 4VAS IN PSORIATIC ARTHRITIS

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Background: There is a recognised need for a feasible continuous composite measure in routine clinical care for psoriatic arthritis (PsA). Two multidimensional composite Visual Analogue Scales (VAS) have been proposed; the 3 and 4VAS¹, but there may be some advantages to using a numerical rating scale (NRS) over VAS in patient reported outcomes. VAS is a 100mm horizontal line, and the NRS a 21-point scale ranging from 0 to 10 in increments of 0.5. NRS are simple and faster to score, less susceptible to measurement error and may reduce the floor and ceiling effects, whereby patients avoid using the extremes of the scale. A previous study has demonstrated good agreement between VAS and NRS for the separate patient reported outcome measures in PsA, which correlate with disease severity and life impact.²

Objectives: To test the performance of NRS, compared with VAS, in the composite 3 and 4VAS scores.

Methods: Data were collected prospectively across three UK hospital trusts from 2018-2019, as part of a study assessing the use of NRS in patient reported outcome measures in PsA.² Patients completed the VAS and NRS for pain, arthritis, skin psoriasis, and global disease activity. The 3 VAS comprises of a physician global VAS, patient global VAS and patient skin VAS and the 4 VAS comprises of the physician global VAS, patient pain VAS, joint VAS and skin VAS. NRS and VAS versions of the patient reported measures were tested. Physician global scores were not available from the study data, therefore only the patient reported components are included. Agreement between the scales was assessed using the intraclass correlation coefficients (ICCs), with a two-way mixed absolute agreement model, and Bland-Altman plots. Spearman's rank correlation coefficients

were used to assess dependency between scale scores and clinical parameters including tender and swollen joint count, PsAID12 and HAQDI.

Results: Data from 209 patients were analysed. 60.0% were male, with mean age of 51.7 years and median PsA duration of 7.0 years. Mean 3VAS score was 3.57 and the mean NRS-3VAS was 3.79, with ICC 0.98 (95% CI 0.96-0.98). Mean 4VAS was 3.71 and NRS-4VAS was 3.90 with ICC 0.98 (95% CI 0.97-0.98). Average NRS scores were slightly higher than VAS scores. The Bland-Altman plots comparing NRS and VAS for the patient-reported components of 3VAS and 4VAS are demonstrated in Figure 1. 64.1% patients reported a preference for NRS over VAS. Correlation of the 3/4VAS with PsAID, HAQ and joints counts are reported in Table 1. Visual representation of the NRS and VAS scales for 3VAS and 4VAS as histograms demonstrated that there is marginally less floor effect using NRS compared to VAS.

Conclusion: There is good agreement between VAS and NRS for the patient-reported components of 3VAS and 4VAS, supporting that VAS scores are reproducible as NRS scores. Both NRS and VAS versions of the 3 and 4VAS scales correlate with disease activity and life impact.² There may be advantages in testing the 3/4VAS as NRS moving forward.

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Table 1. Spearman's correlations of the 3 and 4 VAS scores with TJC, SJC, PsAID and HAQ

Patient Reported	TJC	SJC	PsAID	HAQDI without aids
3 VAS vas	0.51	0.44	0.88	0.62
4 VAS vas	0.54	0.47	0.89	0.65
3 VAS nrs	0.49	0.43	0.89	0.63
4 VAS nrs	0.53	0.46	0.92	0.67

Key: 3VAS: Patient global and skin VAS, 4 VAS: Patient pain, joint and skin VAS. 3 and 4 NRS: Numeric Rating Scale (NRS). TJC/ SJC: Tender/Swollen Joint count. PsAID: Psoriatic Arthritis Impact of Disease. HAQDI: Stanford Health Assessment Questionnaire.

Figure 1: Bland-Altman plots comparing VAS and NRS for patient reported components of 3VAS (left) and 4VAS (right). VAS: visual analogue scale (scored 0-10); NRS: numerical rating scale (scored 0-10).

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POS1085

OSTEOPOROSIS IN PSORIATIC ARTHRITIS: A 5 YEAR PROSPECTIVE STUDY OF AN OUTPATIENT CLINIC COHORT

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Background: Data addressing whether patients with psoriatic arthritis (PsA) are at increased risk of osteoporosis have been inconclusive (1). Most studies have reported cross sectional data, and there is a lack of longer-term studies. We have previously reported bone density data from an outpatient PsA clinic cohort (2). Herein, we present 5-year follow up data from that same cohort.

Objectives: To explore longer-term change in bone mineral density (BMD) at femoral neck and spine (L1-4) in an outpatient PsA cohort.