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

J. Day¹, W. Ye², W. Tillett¹, L. C. Coates³. ¹Royal National Hospital for Rheumatic Diseases, Rheumatology, Bath, United Kingdom; ²Oxford University, Rheumatology, Oxford, United Kingdom; ³Oxford University, Nuffield Department of Orthopaedics, Oxford, United Kingdom

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

S. Bråndland¹, A. Kavanaugh², G. Haugeberg^{1,3}. ¹Sørlandet Hospital Kristiansand, Division of Rheumatology, Dept of Internal medicine, Kristiansand, Norway; ²University of California San Diego, Division of Rheumatology, Allergy, and Immunology, La Jolla, United States of America; ³Norwegian University of Science and Technology, Division of Rheumatology, Trondheim, Norway

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.