Background: The efficacy of guselkumab (GUS), an interleukin (IL)-23 p19 subunit inhibitor, has been demonstrated for psoriatic arthritis (PsA) in two pivotal phase 3 trials (DISCOVER 1 & 2). A third phase 3 trial (DISCOVER 3) evaluated GUS in patients with PsA who had an inadequate response (IR) to tumor necrosis factor inhibitors (TNFi). GUS has previously been compared to targeted PsA therapies through network meta-analysis (NMA).

Objectives: This NMA update was to include data for GUS in TNFi-IR patients from COSMOS, as well as two additional key comparators, risankizumab (RIS), an IL-23 inhibitor, and upadacitinib (UPA), a Janus kinase inhibitor (JAKi).

Methods: A systematic literature review identified PsA randomized controlled trials up to February 2021. A subsequent hand-search identified new data for newer treatments, with a GUS dose regimen that was not included in previous analyses. The primary outcome was ACR response ranks, compared to most other active agents, including UPA, and other small molecules, as demonstrated by non-overlap in 95% CIs. Other outcomes included Psoriasis Area and Severity Index (PASI) response, modified van der Heijde-D Sickle (vdH-S) score, and serious adverse events (SAEs). Analyses used a network approach with a GrR and ranked similar interventions on baseline risk when feasible. Multinomial models were used for ACR response, GUS Q8W and Q4W ranked 14th and 12th among 23 treatments and were comparable to most other active agents, including RIS and UPA, subcutaneous (SC) TNFi, and most IL-17A inhibitors (IL-17A), as demonstrated by overlap in pairwise 95% CIs with unity. Results were similar for ACR 50 and 70 responses. For PASI 90, GUS Q8W and Q4W ranked 2nd and 1st among treatments and were better than multiple agents, including all SC TNFi, JAKi, including UPA, and other small molecules, as demonstrated by non-overlap in pairwise 95% CIs. GUS Q8W and Q4W were similar to RIS and most IL-17A for PASI 90, but point estimates consistently favored GUS. For vdh-S score, GUS Q8W and Q4W ranked 8th and 3rd among 18 treatments; GUS Q4W was better than RIS, and both GUS Q8W and Q4W were comparable to most other agents, including UPA. SAEs were comparable across most agents.

Conclusion: GUS demonstrated better skin efficacy than most other targeted PsA therapies, including UPA. For vdh-S, both GUS dose regimens were comparable to most treatments, with both GUS doses showing a tendency to higher versus most, including UPA and RIS. Both GUS dose regimens demonstrated ACR responses that were comparable to most other agents, including UPA and RIS, and ranked favorably in the network for SAEs.

REFERENCES: None

Disclosure of Interests: None

AB0896 IMPACT OF RISANKIZUMAB ON IMPROVING SYMPTOMS AND HEALTH-RELATED QUALITY OF LIFE AND REDUCING FATIGUE AND PAIN AMONG PSORIATIC ARTHRITIS PATIENTS WITH MODERATE-TO-SEVERE SKIN INVOLVEMENT: EVIDENCE FROM TWO PHASE III TRIALS

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Background: Psoriatic arthritis (PsA) greatly affects patient-reported health-related quality of life (HRQoL).

Objectives: To assess the impact of risankizumab (RZB) on patient-reported outcomes (PROs) in patients with high skin burden using integrated efficacy data from two Phase III clinical trials (KEEPSAKE-1 and KEEPSAKE-2).

Methods: Adult patients with PsA with inadequate response or intolerance to disease-modifying antireumatic drugs were randomized 1:1 to receive RZB (150mg) or placebo (PBO). Improvement from baseline in PROs (Patient’s Global Assessment of Disease Activity [PGA] by visual analog scale [VAS], Short-Form 36 Health Questionnaire physical and mental component summary scores [SF-36 PCS and MCS], Health Assessment Questionnaire – Disability Index [HAQ-DI], EQ-5D-5L index) was assessed up to February 2021. A subsequent hand-search identified new data for newer treatments and was updated up to February 2022. A network meta-analysis (NMA) was conducted to compare treatments on American College of Rheumatology (ACR) response, Psoriasis Area and Severity Index (PASI) response, modified van der Heijde Sharp (vdH-S) score, and serious adverse events (SAEs). Analyses used a network approach with a GrR and ranked similar interventions on baseline risk when feasible. Multinomial models were used for ACR response, GUS Q8W and Q4W ranked 14th and 12th among 23 treatments and were comparable to most other active agents, including RIS and UPA, subcutaneous (SC) TNFi, and most IL-17A inhibitors (IL-17A), as demonstrated by overlap in pairwise 95% CIs with unity. Results were similar for ACR 50 and 70 responses. For PASI 90, GUS Q8W and Q4W ranked 2nd and 1st among treatments and were better than multiple agents, including all SC TNFi, JAKi, including UPA, and other small molecules, as demonstrated by non-overlap in pairwise 95% CIs. GUS Q8W and Q4W were similar to RIS and most IL-17A for PASI 90, but point estimates consistently favored GUS. For vdh-S score, GUS Q8W and Q4W ranked 8th and 3rd among 18 treatments; GUS Q4W was better than RIS, and both GUS Q8W and Q4W were comparable to most other agents, including UPA. SAEs were comparable across most agents.

Conclusion: GUS demonstrated better skin efficacy than most other targeted PsA therapies, including UPA. For vdh-S, both GUS dose regimens were comparable to most treatments, with both GUS doses showing a tendency to higher versus most, including UPA and RIS. Both GUS dose regimens demonstrated ACR responses that were comparable to most other agents, including UPA and RIS, and ranked favorably in the network for SAEs.

REFERENCES: None

Disclosure of Interests: None
AB0898

GUSELKUMAB IMPROVES DACTYLITIS IN PSA PATIENTS WITH INADEQUATE RESPONSE TO TNFI:
DATA FROM THE PHASE 3B COSMOS TRIAL


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Among 12 GUS pts with persistent dactylitis at W48, 9 (75%) had partial resolution. The 36 PBO pts with dactylitis crossed over to GUS at W16 (n=23; EE) or W42 (n=13; planned). As observed, 88% of these PBO→GUS pts had complete resolution of dactylitis at W48 (Figure 1). Of 105 dactylitis-free pts at BL in the GUS arm, 8 (6%) developed dactylitis before W48: 4 at W4, 2 at W8 and 1 each at W16 and 36. Complete resolution was seen in 6 (75%) of the 8 pts by W48, when 1 further new-onset case occurred. Utilizing observed data among GUS-randomized pts with and without BL dactylitis, 32% and 34%, respectively, achieved MDA at W48. Complete response rates were 59% and 55% for DAPSA LDA, and 28% and 15% for DAPSA remission. In those who did and did not achieve complete dactylitis resolution at W48, respective response rates were 38% and 0% for MDA, 88% and 13% for DAPSA LDA, and 31% and 0% for DAPSA remission. Of 69 pts with both enthesis and dactylitis at BL who continued to receive GUS through W48, GUS resolved both manifestations in 72%, neither in 16%, only enthesis in 4%, and only dactylitis in 7% of pts.

Conclusion: Complete dactylitis resolution was achieved in ≥80% of pts who continued to receive GUS at W48, with partial resolution seen in most remaining pts in an as-observed analysis. Response rates increased through W48. Dactylitis resolution in this difficult-to-treat TNFI-IR PsA population was frequently associated with enthesitis resolution and achievement of clinical outcomes representing low levels of disease activity.

REFERENCES: