inflammatory lesion observed in 4 % (n=16) of the entheses, followed by hypoechogenecity (0.5 %, n=2). Enthesophytes were the most frequent chronic damage lesions detected in 1.25% (n=5) of the entheses followed by erosions (0.5%, n=2). The highest total US scores per entheseal site were observed at the calcaneal enthesis [mean (SD) 0.27(0.59)], followed by plantar fascia [0.18(0.50)] and distal patellar tendon origins [0.10 (0.37)]. Age was not associated to higher scores (total, inflammation, chronic damage; p=0.339, p=0.412, p=0.531). Female participants had higher inflammation scores than males (mean inflammation scores (SD) 0.69 (1.44) versus 0.39 (0.71), p=0.044). The BMI was correlated to higher inflammation score (p=0.020, r=0.368) but not to chronic damage nor to total scores (p=0.478, p=0.104). Intense physical activity was associated to higher chronic damage score comparing to moderate physical activity (mean chronic damage scores (SD) 0.30(0.67) versus 0.003(0.00), p=0.058) and to low physical activity (mean chronic damage scores (SD) 0.30(0.67) versus 0.0018(0.00), p=0.043). No association between physical activity and inflammation score had been observed.

Conclusion: Our study demonstrates that US changes within the enthesis are associated with higher BMI and physical activity. These results support the effect of biomechanical forces on the entheses that should be considered when differentiating by US pathological from healthy entheses.

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AB0952 CHARACTERIZATION OF PATIENTS WITH PSORIATIC ARTHRITIS IN DERMATOLOGIC AND RHEUMATOLOGIC CARE: AN ANALYSIS OF TWO DISEASE REGISTRIES

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Background: Psoriatic arthritis (PsA) is a chronic inflammatory disease affecting the musculoskeletal system, skin and nails. Therapeutic management in Germany is usually provided by a dermatologist or rheumatologist.

Objectives: The aim is to characterize the socioeconomic and clinical patient profiles in dermatologic and rheumatologic settings.

Methods: Baseline data of patients with PsA from [1] the dermatological German Psoriasis Registry PsoBest (PB) and [2] the rheumatological German disease register RABBIT-SpA (RS) [2] were analyzed. For this purpose, comparable anamnestic and clinical variables collected in the period 10/2017 to 12/2020 were identified and descriptively analyzed. The analysis was carried out in each of the data-holding registers.

Results: 1066 RS patients and 704 PB patients were included in the analysis (Table 1). The proportion of women was higher in the rheumatology setting (RS) (60% vs. 49%). Disease duration of psoriasis was longer in the dermatology setting (PB). Cutaneous severity was higher in PB, including affected body surface area and nail psoriasis. However, more patients in RS had tender joints and swollen joints. The physician-reported global disease activity was higher in RS. The mean DLQI (Dermatology Life Quality Index) was higher in PB and the mean HAQ (Health Assessment Questionnaire) was higher in RS. Patient reported global disease activity and pain were lower in PB. Most of the patients received biologics at inclusion (RS: 71% and PB: 73%). In the dermatology setting IL23 inhibitors were used more frequently, whereas TNF inhibitors were used more frequently in the rheumatology setting.

Table 1. Baseline data of patients with PsA from the registers PsoBest and RABBIT-SpA included 10/2017 to 12/2020.

	RABBIT-SpA (Rheumatology setting)	PsoBest (Dermatology setting)
N	1066	704
Age, mean (SD)	51.9 (12.2)	51.7 (13.2)
Female, n (%)	637 (60)	346 (49)
Disease duration skin, mean (SD)	14.3 (13.9)	21.6 (16.0)
Body surface area, mean (SD)	8.5 (15.0)	20.8 (19.8)
Nail psoriasis, n (%)	434 (41)	407 (58)
Tender joints, n (%)	905 (85)	498 (71)
Swollen joints, n (%)	708 (67)	387 (55)
Physician reported disease activity, mean (SD)	5.2 (1.9)	4.6 (2.7)
DLQI, mean (SD)	5.6 (6.2)	12.2 (7.6)
HAQ, mean (SD)	0.9 (0.7)	0.7 (0.6)
Patient reported disease activity, mean (SD)	5.7 (2.4)	4.9 (2.9)
Patient reported pain, mean (SD)	5.5 (2.4)	5.2 (2.8)
bDMARD, n (%)	751 (71)	514 (73)
TNF, n (%)	346 (46)	117 (23)
IL17, n (%)	351 (47)	246 (48)
IL23, n (%)	54 (7)	151 (29)
tsDMARD, n (%)	109 (10)	47 (7)
csDMARD, n (%)	195 (18)	142 (20)

Conclusion: The clinical specialization of the treating physician was associated with a different treatment and clinical status of patients with PsA. Our analysis showed that patients in the rheumatology setting more frequently had joint affections and lower functional status, whereas skin severity was worse in the dermatology setting, indicating selection effects of health care access. We hypothesize out that these differences may be biased due to different diagnostic and therapeutic routines in the specialized health care settings. Psoriatic arthritis should be treated in a multidisciplinary approach to take into account all facets of this complex disease.

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[1] PMID: 24393314

[2] PMID: 30874933

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AB0953 LACK OF RACIAL DIVERSITY IN CLINICAL TRIALS OF PSORIATIC ARTHRITIS

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Background: Participant diversity in clinical trials of therapeutics in rheumatology is important to understand how persons of different races and ethnicities might respond differently to therapeutics. Specifically, for psoriatic arthritis (PsA), although people of color (POC) have lower disease prevalence, prevalence still ranges from 0.04-0.19% in Blacks, 0.13-0.19% in Asians, and 0.09-0.30% in Hispanics versus 0.19-0.34% in Whites in the insured population of the US[1]. Literature on the diversity of PsA clinical trials remains limited, though data suggest that minorities are underrepresented in clinical trials[2]. This analysis aims to evaluate the diversity of participants in randomized clinical trials (RCTs) of US Food and Drug Administration approved targeted therapies for PsA.

Objectives: To evaluate the reporting of race and ethnicity in published RCTs of targeted therapeutics approved for the treatment of PsA in the US.

Methods: Targeted therapies approved for use in the treatment of PsA in the US were identified. Package inserts and ClinicalTrials.gov (CT.gov) were used to

identify the pivotal double blind, RCTs in PsA which supported the approval of the identified therapeutics in the US. The articles reporting the primary endpoint data were obtained. Race and ethnicity data were extracted from the published data. Countries in which the studies were conducted were identified from the publications or CT.gov. Descriptive analyses were performed.

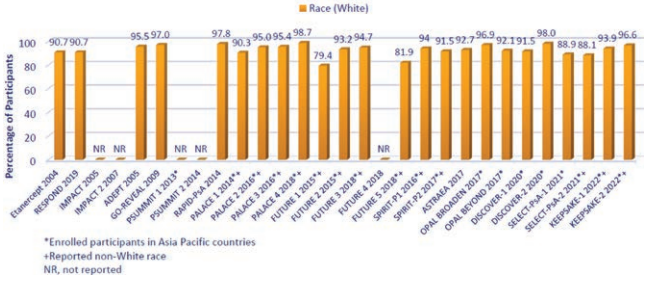
Results: Twenty-nine pivotal RCTs in PsA evaluating targeted therapeutics, published from 2002 – 2022, were identified; 24 reported race; non-White race was reported in only 13 (45%) (Table 1 and Figure 1). In the latter, people of Black race comprised <1% of the overall population in 12 RCTs and 2.7% in the remaining RCT. People of Asian race comprised 6.1% of the overall population reflecting <10% of the population in 11 studies and 11.3% and 19.0% in the remaining 2 studies. Overall, 19 (65.6%) trials recruited participants from Asia Pacific countries. Hispanic/Latinx ethnicity was not reported in any study. Studies published from 2017-2022 reported non-White race (n=7 of 15 [47%]) no more frequently than studies published from 2004-2016 (n=6 of 14 [43%]). Although the 13 RCTs reporting non-White race may not reflect unique individuals, the total number of people included across these RCTs was 7261, of which 48 (0.7%), 441 (6.1%), and 6598 (90.9%) were Black, Asian, and White, respectively.

Table 1. Race Reporting in Psoriatic Arthritis Pivotal Clinical Trials of Targeted Therapeutics

Race Reporting Status	Total Trials (N)	Trials which recruited in AP countries (n [% of N])	Total Participants (N)	White (n [% of N])	Black (n [% of N])	Asian (n [% of N])	Other* (n [% of N])
Not reported	5	1 (20.0)	1572	-	-	-	-
Non-White race reported	13	13 (44.8)	7261	6598 (90.9)	48 (0.7)	441 (6.1)	172 (2.4)
Non-White race not reported	11	5 (45.5)	6588	5803 (88.1)	-	-	-
Total (N)	29	19 (65.5)	15421	-	-	-	-

Abbreviations: AP, Asia Pacific; N and n, number.*Other also includes American Indian/Alaskan Native, mixed race, unknown raceNote: Numbers across rows may not add up to 0, and the total number of individuals reported in any one group may not be unique. Dashes reflect data not provided or able to be calculated.

Figure. Pivotal Trials of Targeted Therapeutics Published Between 2004-2022



Conclusion: Our data show under-reporting of race and ethnicity in publications of pivotal PsA RCTs, and no evidence of improved reporting over time. Whites were overrepresented in pivotal trials of PsA, especially when considering 72 and 62% of the US population was White in 2010 and 2020 (US Census data), respectively, and the reported prevalence of PsA by race in the insured population of the US[1]. Improved reporting of race/ethnicity and increased representation of racial/ethnic minorities in PsA RCTs are needed.

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AB0954

CONCORDANCE BETWEEN DIFFERENT COMORBIDITIES SCORES IN PATIENTS WITH PSORIATIC ARTHRITIS

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Background: Patients with psoriatic arthritis (PA) are more likely to suffer from other chronic medical conditions, associated comorbidities having significant impact upon both quality of life and survival. As disorders like the cardiovascular disease, metabolic syndrome, hepatic or renal pathologies were shown to be more prevalent in PA [1], assessment of comorbidities is important in these patients [2].

Objectives: To investigate the concordance of different comorbidities scores in patients with PA.

Methods: Prospective inclusion of patients diagnosed with PA according to the CASPAR (ClASsification criteria for Psoriatic ARthritis) criteria. Associated comorbidities were prospectively assessed using the Psoriatic arthritis comorbidity index (PsACI) with a cut-off of 8 points as previously defined [2]. Also, the following comorbidities scores were completed in all patients: Charlson comorbidity index (CCI), Rheumatoid Arthritis Comorbidity Index (RACI), Rheumatic Diseases comorbidity index (RDCI), Functional comorbidity index (FCI).

Results: A total of 56 patients were included: 27 (48.2%) were female, with a med (q1;q3) disease duration of 17.5 (12.7; 26.5) years for the cutaneous disease and 6.0 (4.0; 13.0) years for the articular one. At inclusion, the results of the comorbidities scores assessed were as follow: PsACI 3.2 (2.0; 6.5), CCI 1.0 (0.0; 2.0), RACI 3.5 (1.5; 6.5), RDCI 1.0 (0.0; 2.0), and FCI 2.0 (0.0; 2.0), respectively. According to PsACI, hypertension, hyperlipidemia, osteoarthritis, liver disease, and diabetes mellitus were the most frequent associated comorbidities in PA patients, in 53.6%, 44.6%, 41.1%, 37.5%, and 28.6% cases, respectively (see Table 1).

Table 1. Comorbidities according to the Psoriatic Arthritis Comorbidity Index

Parameter	n (%)	Parameter	n (%)
Diabetes mellitus	16 (28.6)	Cerebrovascular disease	1 (1.8)
Metabolic syndrome	8 (14.3)	Peripheral vascular disease	2 (3.6)
Ischemic heart disease	9 (16.1)	Osteoporosis	4 (7.1)
Myocardial infarction	1 (1.8)	Fracture	3 (5.4)
Hypertension	30 (53.6)	Fall	1 (1.8)
Hyperlipidemia	25 (44.6)	Liver disease	21 (37.5)
Arrhythmia	2 (3.6)	Renal disease	2 (3.6)
Depression	6 (10.7)	Pulmonary disease	6 (10.7)
Anxiety	10 (17.9)	Gastrointestinal tract	2 (3.6)
Endocrine	7 (12.5)	Osteoarthritis	23 (41.1)
Periodontitis	1 (1.8)	Fibromyalgia	3 (5.4)
Smoking	6 (10.7)	Amyloidosis	1 (1.8)
Infection	0 (0.0)	Eyes inflame/ uveitis	0 (0.0)
Vasculitis	0 (0.0)	Tumor	3 (5.4)

In bivariate analysis, we found significant correlations between the results of PsACI and those of the other comorbidities scores used: CCI (p<0.001, rho=0.668), RACI (p<0.001, rho=0.792), RDCI (p<0.001, rho=0.691), and FCI (p<0.001, rho=0.697), respectively. The ability of the comorbidities scores assessed to discriminate a PsACI high value is presented in Figure 1, AUC (95%CI): CCI 0.743 (0.601- 0.886) p=0.017, RACI 0.815 (0.634 - 0.996) p=0.002, RDCI 0.818 (0.657-0.980) p=0.002, and FCI 0.837 (0.725-0.948) p=0.001, respectively.

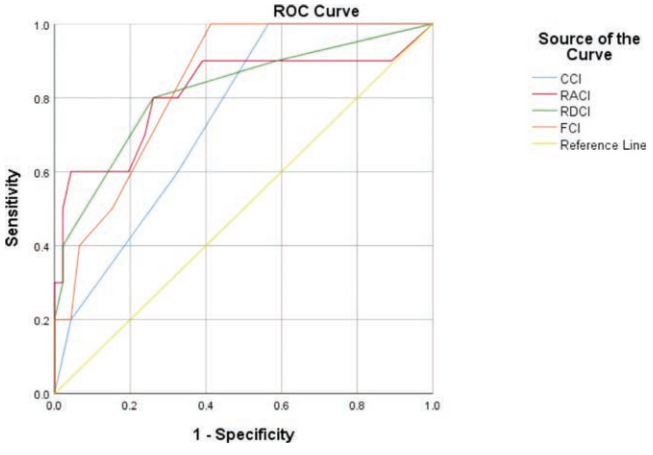

Figure 1. The Area Under the curve of the Receiver Operating Characteristic (AUROC) for high PsACI results (PsACI > 8)

Conclusion: The composite indexes offer the advantage of reducing all associated comorbidities as long with their severity into a single score. We herein