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THU0303 THE EARLY PSORIATIC ARTHRITIS SCREENING QUESTIONNAIREIDENTIFIES PATIENTS WITH PSORIATIC ARTHRITIS AMONGST TREATED PATIENTS WITH PSORIASIS

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Background: Studies suggest a high prevalence (approximately 15%) of undetected psoriatic arthritis (PsA) amongst patients with psoriasis[1]. A number of screening questionnaires have been designed to allow detection of such patients. This includes the Early Psoriatic Arthritis Screening Questionnaire (EARP) which detects early PsA in untreated patients with psoriasis, with a sensitivity of 85.2% and specificity of 91.6%[2]. Little is known about whether such questionnaires are also able to detect PsA in treated patients with psoriasis.
Objectives: To determine the case finding ability of EARP in a tertiary centre cohort of treated psoriasis patients.
Methods: All patients attending a tertiary centre psoriasis clinic were invited to complete the EARP. EARP comprises a 10 point patient reported questionnaire regarding symptoms of joint disease. Scores of 3 or more are considered positive. All patients who completed the questionnaire and received a positive score were assessed by a rheumatologist. Diagnosis of PsA was made by clinician impression and CASPAR criteria. Disease activity was assessed using psoriasis area severity index (PASI), 66/68 swollen and tender joint count, SPARCC enthesitis index, CRP and Health associated quality of life disability index (HAQ-DI). The composite disease activity measure DAPSA and the OMERACT definition of minimal disease activity were determined.
Results: 133 patients were invited to complete the EARP questionnaire and 119 participated. Fifty patients had a positive result (42%). Of these, 8 were known to have PsA and under rheumatologic care. A further 21 attended for formal rheumatologic assessment. Thirteen of the 21 patients (61.9%) were found to have psoriatic arthritis and were not under the care of a rheumatologist. This represents 10% of the initial 133 patients screened. Ten of those patients were further assessed. The average age was 52.8 and BMI 33.2. Seven patients were male. All 10 were on biologic agents but only 3 on concurrent conventional DMARDs. Average tender joint count was 16, swollen joint count 3.6, SPARCC 6.2 and PASI score 3.42. Only 1 patient was in minimal disease activity.
Conclusions: The EARP tool can identify patients with active PsA amongst patients with psoriasis, even those on treatment with biologic agents. Such a tool may be useful in identifying patients who may benefit from rheumatology care.

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THU0304 ASSOCIATION OF ANXIETY, DEPRESSION AND FATIGUE WITH DISEASE ACTIVITY, JOINTS EROSION AND SKIN LESION SEVERITY IN EARLY PSORIATIC ARTHRITIS PATIENTS

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Background: Depression is one of the precursors of psoriasis and psoriatic arthritis (PsA) development. It was found that depression and anxiety negatively affect the achievement of remission in PsA. B. Michelsen 2017] Interrelation of anxiety, depression and fatigue (according to patient-reported outcomes) with disease activity, erosive arthritis and skin lesion severity in early PsA hadn't been sufficiently studied.
Objectives: To study anxiety, depression and fatigue disorders (according to patient-reported outcomes) and their correlation with disease activity, erosive arthritis and severity of psoriasis in early PsA patients (pts).
Methods: 78 pts (M/F–39/39) with early PsA according to CASPAR criteria were included; all pts had peripheral arthritis for ≤2 years; mean age 36.5±10.7 years, disease duration 12.2±10.3 mo. It was a treatment naïve cohort. All pts underwent standard clinical examination of PsA activity. Mean disease activity indexes (DAS)=4. 0±1.4, DAS28=4.2±1.1. 78 patients were studied for fatigue (according to FACIT), patient global disease activity (PGA), patients pain measured by VAS, and Health Assessment Questionnaire (HAQ); 66 patients (M/F–33/33) were studied for anxiety and depression (according to HADS). At HADS score ≥8 patients had anxiety and depression disorders. Higher scores for FACIT scales indicate better quality of life (less fatigue). Skin lesion severity was evaluated in terms of body surface area (BSA) affected and Psoriasis Area Severity Index (PASI). When BSA was ≥3%, PASI was calculated. PASI≥11 indicates moderate and severe psoriasis. Descriptive statistics was used, M±SD, Me [Q25;Q75], U-test were performed; p<0.05 was considered to indicate statistical significance.
Results: Mean FACIT score was low amounting to 35.3±9.6, testifying increased fatigue; mean anxiety index was 5.7±3.1, depression index was 3.8±3.0. Anxiety disorders were detected in 16 out of 66 (24.2%) pts, depression disorders in 9 out of 66 (13.0%) pts. Negative correlation was found between FACIT score and DAS (r=-0.26), DAS28 (r=-0.26), CRP (r=-0.27), PGA (r=-0.35); and pain VAS (r=-0.25). Depression was more pronounced in pts with erosive arthritis in hands and/or feet (r=0.31). Negative correlation of FACIT score (r=-0.54), correlation of anxiety (r=0.26) and depression (r=0.33) indexes was found with health-related functional indexes according to HAQ. HADS indexes (anxiety and depression) are cross-correlating (r=0.51) and are negatively correlating with FACIT scores (r=-0.49 and r=-0.48, accordingly). An association was found of anxiety and depression indexes with the severity of psoriasis PASI index (r=0.38 and r=0.31, accordingly).
Conclusions: In early treatment-naïve PsA patients, increased fatigue and in a quarter of cases anxiety disorders, in 13% of patients depression disorders had been found. Psychological disorders are associated with PsA activity, the severity of psoriasis and joints erosion. Fatigue, anxiety and depression in early PsA patients result in the reduction of their functional capacity.
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THU0305 MINIMAL DISEASE ACTIVITY (MDA) ATTAINMENT AFTER STARTING BIOLOGICAL (B) DMARDS AND NON-BDMARDS TREATMENT IN PSORIATIC ARTHRITIS PATIENTS (PTS) IN ROUTINE CARE: RUSSIAN PSORIATIC ARTHRITIS REGISTRY (RU-PSART) DATA

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Background: MDA is a valid instrument for evaluating PsA treatment results. There is limited data about MDA attainment after starting bDMARDs and non-bDMARDs in routine care. RU-PsART collected data from 25 rheumatology clinics in the Russian Federation.
Objectives: evaluate MDA attainment after starting bDMARDs and non-bDMARDs treatment in PsA pts in routine care.
Methods: 294 (M/F–133/161) pts with PsA, diagnosed according to CASPAR criteria, mean age 41.2±1.9 (Min 21 – Max 72) years (yrs.), PsA duration 6.1±5.3 (Min 0 – Max 31) yrs., psoriasis duration 13.6±10.7 (Min 0.2 – Max 54.8) yrs. were included in the RU-PsART after signing consent participation forms. The present analysis included 274 pts who have data concerning PsA activity, treatment and MDA. The number of pts who reached MDA at least once were calculated. At the time of evaluation 81 out of 274 pts (29.6%) were taking bDMARDs±sDMARDs Infliximab (25 pts), Etanercept (16 pts), Adalimumab (14pts), Ustekinumab (8pts), Golimumab (5pts), Sekukinumab (2pts). 193 out of 274 pts (70.4%) were taking other types of treatment - sDMARDs±NSAID, mostly methotrexate (74.2%), sulfasalazine (12%), leflunomide (3.6%), hydroxichlorochine (0.4%); steroids (9.8%). All pts underwent evaluation of PsA activity by DAS28, CRP, Pt/Physician GA, Pain GA by VAS (0–100 mm), swollen/tender joints count (SJC/TJC), DAPSA and considered REM≤4/LDA≤14. M±SD, Me [Q25; Q75], Min-Max,%, U-test, ORs with 95% CI were performed. All CI >1, p≤0.05 were considered to indicate statistical significance.
Results: At time of evaluation 60 out of 274 pts (21%) reached MDA at least once. Mean duration of sDMARDs and bDMARDs±sDMARDs was $11^{6;17}$/Min 3 - Max 204 months and $9^{7;15}$/Min 2 - Max 82 months accordingly. 28 out of 193 pts (10.4%) taking sDMARDs achieved MDA. Among 81 pts taking bDMARDs ±sDMARDs MDA was seen in significantly more cases - 32 pts (30.8%), OR=3.85 [CI 95% 2.11–7.01]. REM/LDA by DAPSA was found in significantly more cases compared to pts taking other therapies – in 50 out of 81 pts (61.7%) and in 56 out of 193 pts (29%) accordingly (p≤0.05, U-test). Pts who had ever

taken bDMARDs±sDMARDs had significantly less PsA activity compared to those who had taken other types of treatment (table 1).

Abstract THU0305 – Table 1

Parameters	bDMARDs	other therapy
DAS28	1.8 [1.8;4.2]*	3.4 [2.8;5.1]
CRP	1.3 [0.9;7.9]*	6 [2.5;17.8]
Pain, VAS	20 [13;50]*	30 [30;60]
PGA, VAS	30 [17;60]*	40 [30;60]
PhGA,VAS	30 [10;50]*	38 [30;60]
SJC	1 [0;5]*	1 [0;8]
TJC	1 [0;2]*	1[0;6]

* p≤0.05, U-test

Conclusions: MDA was seen in 21% of PsA pts in routine care but starting bDMARDs has a significantly higher probability of reaching MDA in most cases despite duration of treatment.

Disclosure of Interest: None declared

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THU0306 CLINICAL SPECIALTY SETTING AS A DETERMINANT FOR DISEASE MANAGEMENT IN PATIENTS WITH PSORIATIC ARTHRITIS: RESULTS FROM LOOP, A CROSS-SECTIONAL, MULTI-COUNTRY, OBSERVATIONAL STUDY

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Background: Evidence suggests that timely and effective management can improve long-term outcomes in patients (pts) with psoriatic arthritis (PsA); however factors influencing treatment management decisions are not well understood.

Objectives: To evaluate the association between the clinical specialty setting and time from inflammatory musculoskeletal symptom onset to PsA diagnosis and to different management steps in pts with a diagnosis of PsA.

Methods: LOOP is a large cross-sectional, multi-centre, observational study conducted in 17 countries across Western and Eastern Europe, Latin America, and Asia. Adult pts (≥18 years) with a suspected or an established diagnosis of PsA routinely visiting a rheumatologist (rheum), dermatologist (derm) or non-rheum/non-derm site were eligible to participate in this study. Each enrolled patient in the study was assessed by both rheum and derm. Main endpoints assessed were time from inflammatory musculoskeletal symptom onset to PsA diagnosis, time from PsA diagnosis to first csDMARD and to first bDMARD, and time from first csDMARD to first bDMARD.

Results: Of the 1483 pts enrolled in this study, 1273 pts with a confirmed diagnosis of PsA were included in this analysis. A majority of pts were recruited by rheums (671, 52.7%), followed by derms (541, 42.5%), physiatrists (36, 2.8%), and other specialties (25, 2.0%). PsA was first suspected by a rheum in 726 (57.0%) pts and by a derm in 541 pts (42.5%). Pt demographics and disease characteristics were mostly comparable between rheum and derm settings. Current disease activity and disease burden of patients with PsA categorised by clinical specialty are shown in **table 1**. Disease activity was higher in PsA pts in derm setting compared with rheum setting. The timing of different disease management steps by clinical specialty is reported in **table 2**. The mean time from symptom onset to PsA diagnosis was 24 months (mo) in rheum setting and 1 mo longer for derms. In rheum and derm settings, the mean time from PsA diagnosis to first csDMARD were 11 and 25 mo, respectively; whereas the mean time to first bDMARD were 52 and 55 mo, respectively. The mean time from first csDMARD to first bDMARD was 42 mo for rheums; while it was 3 months shorter for derms.

Abstract THU0306 – Table 1. Baseline Characteristics and Current Disease Activity and Disease Burden by Clinical Specialty in Patients with PsA from LOOP Study

Characteristic/Measure[a]	Rheum (N=726)	Derm (N=541)	P-value[a]
Age, years	51.1 (12.9)	50.7 (13.1)	.646
Gender, male, n (%)	375 (51.7)	270 (49.9)	.570
Weight, kg	77.3 (16.4)	77.7 (17.1)	.708
BMI, kg/m²	27.4 (5.5)[c]	27.4 (5.3)	.962
TJC68	6.0 (10.1)[d]	8.5 (12.6)[d]	<.001
SJC66	2.2 (4.3)[f]	3.2 (6.2)[g]	.001
Dactylitis count	0.4 (1.3)[h]	0.8 (2.6)[i]	<.001
Tender entheseal points	0.8 (1.7)[j]	1.5 (2.6)[k]	<.001
DAPSA	19.4 (24.0)[l]	23.9 (30.9)[m]	.017
DAS28	2.8 (1.3)[n]	2.9 (1.5)[o]	.066
MDA, n (%)	309 (46.7)[p]	186 (39.2)[q]	.012
PGA	3.3 (2.6)[r]	4.4 (2.7)	<.001
BSA (%)	6.6 (11.3)[s]	13.1 (19.7)[s]	<.001
Psoriatic nail count	4.0 (5.5)[t]	5.3 (6.3)[u]	<.001
HAQ-DI	0.7 (0.7)[v]	0.7 (0.7)[w]	.783
SF1v2 PCS	43.0 (10.6)[x]	42.6 (10.1)[y]	.544
SF12v2 MCS	44.9 (10.5)[x]	44.8 (12.1)[y]	.803
WPAI-PsA, TWPI (%)	30.1 (30.2)[z]	29.5 (31.7)[aa]	.824
WPAI-PsA, TAI (%)	35.0 (29.8)[y]	39.2 (31.4)[ab]	.017
DLQI	5.3 (6.2)[c]	7.6 (7.2)[ac]	<.001

[a]P-value from simple linear regression: Rheumatologist vs Dermatologist.
[b]All data are presented as mean (SD) unless otherwise specified.
[c]N=722; [d]N=720; [e]N=715; [f]N=540; [g]N=713; [h]N=537; [i]N=710; [j]N=536; [k]N=712; [l]N=523; [m]N=560; [n]N=313; [o]N=526; [p]N=330; [q]N=662; [r]=475; [s]N=704. [t]N=721; [u]N=709. [v]N=534; [w]N=717; [x]N=525; [y]N=667. [z]N=478; [aa]N=272. [ab]N=189; [ac]N=524; [ad]N=532.
BMI = body mass index; BSA = body surface area; DAPSA = disease activity in PsA; DAS28 = 28-joint disease activity score; Derm = dermatologist; DLQI = Dermatology life quality index; HAQ-DI = health assessment questionnaire – disability index; MCS = mental component score; MDA = minimal disease activity; PCS = physical component score; PGA = physician global assessment; PsA = psoriatic arthritis; Rheum = rheumatologist; SF12v2 = Short form 12-item health survey version 2.0; SD = standard deviation; SJC66 = swollen joint count, 66 joints; TAI = total activity impairment; TJC68 = tender joint count, 68 joints; TWPI = total work productivity impairment; WPAI-PsA = Work productivity and activity impairment questionnaire PsA.

Abstract THU0306 – Table 2. Timing of Disease Management Steps by Clinical Specialty in Patients with PsA from LOOP Study

Duration in months, Mean (SD)	Rheum	Derm	P-value[a]
Time from inflammatory musculoskeletal symptom onset to PsA diagnosis[b]	23.6 (70.7)	24.9 (72.1)	.747
Time from PsA diagnosis to first csDMARD[b]	10.7 (59.4)	25.2 (93.9)	.004
Time from PsA diagnosis to first bDMARD[c]	52.3 (81.0)	54.7 (91.6)	.715
Time from first csDMARD to first bDMARD[d]	42.4 (62.7)	39.1 (63.5)	.556

[a]P-value from simple linear regression: Rheumatologist vs Dermatologist.
[b]Rheum, N=694, Derm, N=521; [c]Rheum, N=631, Derm, N=327; [d]Rheum, N=428, Derm, N=264; [e]Rheum, N=372, Derm, N=178.
bDMARD = biologic disease modifying antirheumatic drug; csDMARD = conventional synthetic disease modifying antirheumatic drug; Derm = dermatologist; PsA = psoriatic arthritis; Rheum = rheumatologist; SD = standard deviation.

Conclusions: Although the duration from symptom onset to PsA diagnosis was similar between rheum and derm setting, there were differences in the timing of introduction of different DMARD classes. Notably, mean time to first csDMARD was significantly shorter in rheum setting. PsA pts in derm setting had significantly higher disease activity. These data lend further support to the need for rheum-derm collaborative approach to optimise management of pts with PsA.

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