Methods: Patients fulfill the CASPAR 2006 for psoriatic arthritis (PsA) and 2009 ASAS criteria for axial spondylitis (AxSpA) were recruited. This cross sectional analysis included the first 188 patients recruited across 7 Asia Pacific regions (Hong Kong, Singapore, Korea, Thailand, India, Qatar & Pakistan).
Results: 83 patients PsA and 115 AxSpA patients were included. They had moderate inflammation (DAPSA: 19.61±14.29, ASDAS: 2.32±1.07). Majority of PsA patients received conventional synthetic disease-modifying drug (csDMARDs, 81%) with relatively low prevalence of biologic DMARDs (bDMARDs) (24%). Most AxSpA patients used NSAIDs (79%) while nearly half of them received bDMARDs (49%). Other details listed in Table 1. Prevalence of bDMARDs use in our registry was lower than that from the USA (Corrona PsA Registry, 59%), Turkey & Canada (PsArt-ID, 40%) and the Netherlands AxSpA registry (56%) (1-3). Regarding T2T, 28% and 44% of PsA patient achieved minimal disease activity (MDA) and Disease Activity in Psoriatic Arthritis low disease activity (DAPSA LDA) respectively. The proportion of patients achieving target in other cohorts were 46% for MDA (PsArt-ID) and 46% for DAPSA LDA (Corrona) (1, 2). 37% and 47% of AxSpA patient achieved Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)<4 and Ankylosing Spondylitis Disease Activity Score (ASDAS) LDA. Proportion of patients achieving ASDAS LDA were similar to the Netherlands registry for patients with ASDAS LDA or BASDAI<4 (Figure 1A)(3). Patient on bDMARD were more likely to achieve treatment target (Figure 1B). There were no significant difference between socio-economic status and disease features between bDMARD user and non-user.

Table 1. Demographics, clinical features and disease activity of patients

	PsA (n=83)		AxSpA (n=115)	
Age	50.0	12.8	36.5	12.4
Male n, %	42	51%	85	83%
Asian n, %	83	100%	101	96%
Disease duration, years	7.1	7.3	5.2	7.6
Any sacroiliitis n, %			102	99%
HLA B27, positive n, %			91	89%
Duration of early morning stiffness, min	30	39	25	29
Tender joint count	7	9	0	1
Swollen joint count	3	4	0	0
No. of dactylitis digit	1	1	0	0
PASI	4.0	5.0		
SPRACC	1	2	0	1
BASDAI			2.8	2.0
ESR, mm/h	31	26	20	16
CRP, mg/L	10	15	11	27
HAQ-DI	0.61	0.61	0.39	0.51
DAPSA	19.61	14.29		
ASDAS CRP			2.32	1.07

Data given in mean SD unless stated. No. of case from Hong Kong 40; Singapore 46; Korea 24; Thailand 20, India 15; Qatar 10; Pakistan 33; HLA - human leucucyte antigen; PASI - psoriasis area and severity index; SPRACC - Spondyloarthritis Research Consortium of Canada Enthesitis Index; BASDAI - Bath Ankylosing Spondylitis Disease Activity Index; ESR - erythrocyte sedimentation rate; CRP - C-reactive protein; HAQ-DI - Health assessment questionnaire disability index; DAPSA - Disease activity in Psoriatic Arthritis; ASDAS - Ankylosing Spondylitis Disease Activity Score

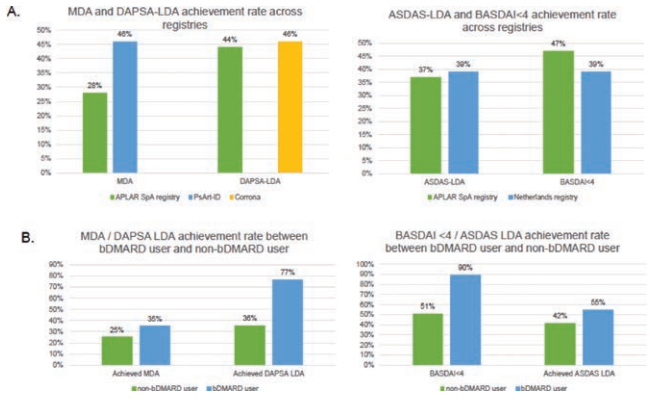

Figure 1. (A) Achievement of LDA in APLAR SpA registry and other registry and (B) use of bDMARDs among patients in APLAR SpA registry with or without achieving LDA

Conclusion: Patient using bDMARDs were more likely to achieve treatment target. We expect that when T2T is widely applied, better outcomes will be reported in future.

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AB0762

INCIDENCE OF ANTERIOR UVEITIS IN AXIAL SPONDYLOARTHRITIS DURING SECUKINUMAB TREATMENT: TWO YEARS REAL LIFE EXPERIENCE FROM TURKBIO REGISTRY

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Background: Secukinumab (SEC), a human anti-IL-17A monoclonal antibody, has similar treatment response rates to tumor necrosis factor (TNF) inhibitors in patients with axial spondyloarthritis (SpA). However, the efficacy of SEC on anterior uveitis (AU) is unclear.
Objectives: This study aimed to evaluate the risk of new-onset or relapsing AU in axial SpA patients treated with SEC.
Methods: In this prospective cohort study, 130 axial SpA patients receiving SEC at the TURKBIO registry between 2019 and 2021 were evaluated. Demographic and clinical characteristics and data about the presence of AU pre or post-treatment were collected. The univariate and multivariate logistic regression analyses were performed to evaluate the predictors of AU development.
Results: The mean age of the patients (F/M: 59/71) was 47.4±10.9 years. The median follow-up time was 540 days (IQR: 330-630). SEC was the first biological agent in 50 (38.4%) patients and 35 (26.9%) patients were using at least one concomitant conventional synthetic DMARD (Table 1). While continued SEC therapy was in 93 (71.5%) patients, treatment withdrawal was in 37 cases (in 26 due to ineffectiveness, two adverse events and nine other reasons). Overall, 15(11.5%) patients had a history of AU before the SEC. During follow-up, AU attacks were seen in the 6 cases (4 were new-onset and 2 were flare) and 5 of these patients have a history of inadequate response to TNF inhibitors. The frequency of AU was

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calculated as 3.42 per 100 patient-years during SEC treatment. The only significant predictor of AU development was the baseline high C-reactive protein (CRP) level on multivariate analysis (p=0.003, OR: 1.063 [95% CI 1.021-1.107]).

Table 1. Demographics and clinical characteristics of the patients

	Total (n:191)
Gender (F/M)	59/71
Age (years) (mean±SD)	47.4±10.9
Diagnosis; n (%)	
AS	125 (96.2)
nr-axSpA	5 (3.8)
BASDAI (mean±SD)	47.2±20.48
Missing n (%)	4 (3.07)
ASDAS (mean±SD)	3.32±0.92
Missing n (%)	14 (10.7)
C-reactive protein (mg/L) median (IQR)	12.6 (4.67-22.62)
Sedimentation (mm/h) median (IQR)	22 (9-42)
Concomitant csDMARDs n (%)	35 (26.9)
Secukinumab dose n (%)	
150 mg	120 (92.3)
300 mg	10 (7.7)
TNFi-naive patients n (%)	50 (38.5)
Number of previous bDMARDs n (%)	
1	36 (27.7)
2	23 (17.7)
≥ 3	21 (16.1)
History of previous TNFi n (%)	
Monoclonal TNFi	64
Etanercept	16

AS; Ankylosing spondylitis, *nr-axSpA;* Non radiographic axial spondyloarthritis, BASDAI; Bath Ankylosing Spondylitis Disease Activity Index, *ASDAS;* Ankylosing Spondylitis Disease Activity Score, *csDMARD;* conventional synthetic disease modifying anti-rheumatic drug, *TNFi*; Tumor necrosis factor inhibitors, *bDMARD*; biological DMARD. Datas were expressed as number (%), mean±SD or median (IQR).

Conclusion: In this real-life data from the TURKBIO registry, the incidence of AU in axial SpA patients treated with SEC was calculated as 3.42 per 100 patient-years. A high baseline CRP level was an independent factor for developing AU.
Disclosure of Interests: None declared
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AB0763 PERSONAL APPROACH IN AXIAL SPONDYLOARTHROPATHY MANAGEMENT

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Background: Spondyloarthropathies (SpAs) are a group of diseases characterized by arthritis in the spine (axialSpA - axSpA) and peripheral joints, and extra-articular symptoms like uveitis, psoriasis or inflammatory bowel diseases. The onset of the disease is difficult to observe. Due to the lack of a pathognomonic test, diagnosis is based on a combination of physical examination, laboratory test and imaging results. The pathogenesis of SpAs is not fully understood, and genetic, environmental and immunological factors are assumed to play a pivotal role.
Objectives: The study aimed to evaluate selected polymorphisms (ERAP1 rs2287987, ERAP2 rs2549782, TNF rs1800629, TNFRSF1B rs1061622, FCGR2A rs1801274) as prognostic factors of clinical presentations, and response predictors of anti-TNF treatment in axSpA patients.
Methods: The study enrolled 216 Caucasians: 106 axSpA patients and 110 healthy controls. AS patients were diagnosed according to modified New York criteria, while nr-axSpA patients were diagnosed according to ASAS criteria. Genotyping was performed using LightSNiP assays on the Real-Time PCR Instrument. Clinical data were assessed at baseline, as well as after three and six months of anti-TNF treatment. In addition, information's about extra-articular symptoms were collected.
Results: The statistical analysis revealed that TNFRSF1B rs1061622-GG was significantly associated with a higher VAS score at baseline (TT + TG vs GG, p = 0.001), and a higher BASDAI score corrected for the first therapy cycle (X1C BASDAI: TT + TG vs GG, p = 0.005). Moreover, homozygotes were more frequently observed with a lack of BASDAI improvement after six months (X1C BASDAI: TT+GG vs TG, p = 0.045, OR = 2.46, 95%CI 1.00-6.12). ERAP1 rs2287987- GG was more frequently observed with enthesitis (AA vs G+, p = 0.049, OR = 4.636, 95%CI 1.101-21.24). The GG genotype of TNFRSF1B rs1061622 was more common in patients with uveitis than TT variant (GG vs TT, p =0.042, OR = 5, 95%CI 1.08-20). Associations between genetic variants and clinical outcomes were evaluated using laboratory parameters. A lack of the ESR improvement after six months of treatment was more frequently observed within ERAP1 rs2287987-AG (AG vs AA + GG, p = 0.027, OR = 2.72, 95%CI 1.115-6.137) and TNFRSF1B rs1061622- TT (TT vs G+, p = 0.020, OR = 3, 95%CI 1.27-6.9) compared to other genotypes. After three months of therapy, the GG variant of ERAP2 rs2549782 polymorphism was more common among individuals with the lack of ESR improvement than T allele carriers (GG vs T+, p = 0.037, OR = 2.76, 95%CI 1.13-6.72). Differences were also detected between the FCGR2A rs1801274 polymorphism and X1CBASDAI score after six months. The low disease activity (BASDAI < 3) and BASDAI improvement was more frequently observed in patients carrying the A allele than the GG genotype (AA+AG vs GG, p = 0.028, OR = 4.545, 95%CI 1.337-16 and p = 0.012, OR = 6.212, 95%CI 1.683-20.47, respectively). The AG genotype was more common among patients with remission (BASDAI < 2) compared to homozygotes (AG vs AA+GG, p = 0.046, OR = 2.36, 95%CI 1.05-5.13).
Conclusion: Genetic profiling of patients will help to identify those at risk of high initial disease activity or the presence of extra-articular symptoms. Identifying patients less responsive to treatment may allow selecting a drug with an appropriate efficacy profile.
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AB0764 FACTORS ASSOCIATED WITH REMISSION AFTER GRADUAL DECLINE OF TNFI IN SPONDYLOARTHRITIS

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Background: The natural history of axial spondyloarthritis (axSpA) includes periods of remission interspersed with flares. It is recommended to target remission during the disease management, the 2 most used definitions are ASAS partial remission and inactive disease (ASDAS <1.3 and / or BASDAI score <3.6). The factors associated with the gradual decline of biologics after achieving remission have been little explored.
Objectives: The objective of this work was to assess the proportion of patients with axSpA treated with TNFi in whom remission was maintained concomitantly with tapering at 3 years of follow-up and to identify the factors associated with this remission.
Methods: Single-center prospective descriptive study. A total of 44 patients included who attempted to space TNFi injections (etanercept, infliximab, adalimumab) among the 192 patients treated with bDMARDs, all of the patients fulfilled the ASAS criteria for SpA. Data collected: socio-demographic, clinical-biological and imaging data up to 3 years of follow-up.
Results: At the 3-year visit, a biologic decrease was achieved in 22.9% (86.4% maintenance of remission and 9.1% with relapse). That is a total of 19.8% (38/192) of patients (mean age 34.2 ± 8.1 years; 71% of men with HLAB27 positive 63.2% with low BMI in 68.4%) maintained clinical remission with TNFi tapering at the 3-year visit There was a significant association between ASDAS (p <0.001), BASDAI (p <0.001) and CRP (p = 0.004) per visit and maintenance of remission. Likewise, patients in remission more often presented strictly axial damage without enthesitic or peripheral damage and minimal structural on concomitant radiography (p = 0.03). They reported low smoking and stopping use of NSAIDs. Factors associated with successful 3-year TNFi spacing were a shorter delay between diagnosis and initiation of the biologic (0.9 [0.64-1.3]) and initial presentation of acute illness according to patient examination (2.37 [1.06-5.26]), a lower BASDAI and BASFI (respectively 1.3 [0.84-1.6] and 0, 9 [0.74-1.4]) and a lower NSAID score (0.715 [0.43-0.9]).
Conclusion: AxSpA patients in remission as defined by ASAS had significantly fewer objective signs of inflammation concomitantly but also over time. It is possible to maintain this remission after gradual decline in the biologics at 3 years in axSpA. Low activity and functional scores, as well as low consumption of NSAIDs are predictive of the success of tapering. Discontinuation treatment is not recommended due to the high risk of relapse.
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