Results: At baseline physical function in both groups were similar.
Immediately after the intervention, participants who undertook ESCAPE-knee pain reported better physical function than participants who remained on usual care remained unchanged.
Physical function of participants who undertook the ESCAPE-knee pain program improved at each assessment compared with baseline value, i.e. mean WOMAC-func decreased, (post-rehabilitation WOMAC-func -5.49 (95% CI -7.78, -3.19; P < 0.0001); 6-month WOMAC-func -4.44 (-6.54, -2.33; P < 0.0001); 12-month WOMAC-func -3.10 (-5.64, -0.76; P < 0.0001)); however, declined over time becoming more similar to the usual care values.

Conclusions: ESCAPE-knee pain is an exercise-based rehabilitation programme for chronic knee pain that has sustained improvement in physical function for up to 2½ years after completing the programme. Models of care should be developed that will sustain for longer the initial improvement in physical functioning.

Disclosure statement: All authors have declared no conflicts of interest.

OP39. THE CONSEQUENCE OF USING DIFFERENT METHODS OF JOINT ASSESSMENT ON THE ELIGIBILITY FOR ACCESS TO ANTI-TNF IN PSORIATIC ARTHRITIS

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Rheumatology, Derby Royal Hospital, Derby, UK

Background: Despite the 2006 NICE guidelines for the use of anti-TNF to treat Psoriatic Arthritis (PsA), a recent poll of 17 Rheumatology departments has shown that there is a lack of consistency in the methods used when determining eligibility to start-anti-TNF and when assessing response to treatment. Of the departments surveyed, 12% were using a 28/28 joint count, instead of the recommended 76/78, to assess response to treatment. There were further disparities with regards to the timing of the assessments and whether a simple joint count or a graded score should be used for each joint.

Objectives of report are to:
1. determine what affect the use of a DAS28 5.1 or a swollen and tender joint count, using 28/28, 66/68 or 76/78 counts, has on determining eligibility to start-anti-TNF and
2. determine what affect the use of the DAS28, EULAR, PsARC 28/28, PsARC 66/68, or PsARC 76/78 response criteria has when assessing response to treatment.

Methods: A retrospective audit was carried out using Derby’s anti-TNF database, comprising 40 PsA patients. The data gathered was used to analyse how the decision to start and continue anti-TNF therapy would have been affected had the different methods of assessing patients been used. The 76 swollen and 78 tender joint counts, ESR/CRP and VAS from the two pre-anti-TNF assessments 1 month apart, baseline assessment (at time of first anti-TNF treatment) and 3 month assessments were analysed. The 76/78 joint counts were used to calculate the 28/28 and 66/68 joint counts and the DAS28 and EULAR scores were calculated from the data.

Results: Eligibility to start anti-TNF: NICE state that 3 tender and 3 swollen joints must be elicited, on two separate occasions. When using either a 66/68 or a 76/78 joint count, all 40 patients met the criteria. If a 28/28 joint count was used 5 patients (12.5%) were excluded. If a DAS28 > 5.1 was used, 16 (40%) patients would be excluded.

NICE state that patients must be shown to have responded when using the PsARC criteria. At 3 months, 5% fewer patients would have shown a response if the PsARC was calculated using the 28/28 joint count when compared with the 76/78, 66/68 joint counts or the EULAR response criteria, all of which produced identical results (97.5% response). At 6 months, 7.5% fewer patients would have been eligible to continue if a DAS28 improvement of greater or equal to 1.2 had been used as the assessment criteria.

Conclusions: There is a lack of consistency between rheumatology departments and a number of different methods for assessing patients with PsA are currently being used. The use of different joint counts and response criteria has potentially significant consequences in determining eligibility to start-anti-TNF and to continue treatment.

Disclosure statement: C.D. Wyeth and Abbott - Honoraria for presentations, Wyeth, Abbott and Schering-Plough - Department grant, ultrasound machine and training, research nurse and biologics database clerk. All other authors have declared no conflicts of interest.

Concurrent Oral 6 – Spondyloarthropathies

OP40. ASSOCIATION OF IL23R AND IL12B POLYMORPHISMS WITH PSORIATIC ARTHRITIS


Rheumatology, Royal National Hospital for Rheumatic Diseases, Bath, UK; "Rheumatology, Bath Institute for Rheumatic Diseases, Bath, UK; "ARC Epidemiology Unit, University of Manchester, Manchester, UK

Background: Between 7–42% of psoriasis patients are affected by psoriatic arthritis (PsA). Genetic studies have demonstrated associations between interleukin-23 receptor (IL-23R) and interleukin-12-beta (IL-12B) gene variations with susceptibility to PsA and psoriasis. The aim of this study was to investigate previously reported single-nucleotide polymorphisms (SNPs) in genes coding for IL-23R and IL-12B, to ascertain if they related to more specific clinical phenotypes within PsA.

Methods: 267 patients (134 males, median age 35 years, IQR 27–49) attending the RNRD, in Bath, with a diagnosis of PsA were compared with 4941 (5422 for rs6887695) controls (Wellcome Trust Case Control Consortium) for IL-23R and IL-12B. The two groups were genotyped for SNPs in the IL-23R region of chromosome 1 (rs1209026 and rs7530511) and IL-12B region of chromosome 5 (rs6887695).

A diagnosis of PsA was made using the Moll and Wright classification and the following clinical phenotypes measured: age at onset of psoriasis / PsA, number of involved joints, radiographic erosions and PASI score (Psoriasis Area Severity Index).

Statistical analysis was performed using the Pearson Chi-Square with Yates Continuity Correction test or the Mann-Whitney U Test for non-parametric data. The data was analysed using SPSS-14.

Results: Genotype frequencies in both groups were in Hardy-Weinberg equilibrium. There was a strong association between the IL-12B SNP (rs6887695) and PsA, with homozygosity for the common allele being more frequent in PsA than in controls [see Table, odds ratio 1.7 (1.3 - 2.2), P = 0.001]. There was no association with any particular clinical phenotype. Previously reported associations between IL-23R SNPs and PsA were not confirmed, although homozygosity for the minor allele of rs1209026 was absent in PsA and there was a trend for the minor allele to be less frequent in patients with erosive joint disease than in those without erosion or in controls (8.9%, 13.3% and 12.8%, respectively).

Conclusions: There is a strong association between the rs6887695 SNP of IL-12B and PsA. A possible association between IL-23R and erosive joint disease may emerge with larger studies.

Comparison of IL-23R and IL-12B genotype frequencies

<table>
<thead>
<tr>
<th>Locus</th>
<th>Controls, n</th>
<th>Control genotype frequency</th>
<th>PsA cases, n</th>
<th>PsA cases genotype frequency</th>
<th>Odds ratio (CI)</th>
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</thead>
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<td>24</td>
<td>0.004</td>
<td>0</td>
<td>0.000</td>
<td>-</td>
</tr>
<tr>
<td>GC</td>
<td>606</td>
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<td>0.113</td>
<td>-</td>
</tr>
<tr>
<td>CA</td>
<td>4311</td>
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<td>236</td>
<td>0.887</td>
<td>1.1 (0.8-1.7)</td>
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<tr>
<td>AA</td>
<td>5703051</td>
<td>0.094</td>
<td>10</td>
<td>0.108</td>
<td>1.1 (0.8-1.7)</td>
</tr>
<tr>
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<td>69</td>
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<td>4</td>
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<tr>
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<tr>
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<td>1.2 (0.9-1.6)</td>
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<tr>
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<td>10</td>
<td>0.038</td>
<td>-</td>
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<td>-</td>
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<tr>
<td>GG</td>
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<td>0.447</td>
<td>155</td>
<td>0.583</td>
<td>1.7 (1.3-2.2)</td>
</tr>
</tbody>
</table>

Disclosure statement: All authors have declared no conflicts of interest.

OP41. ACHIEVING MINIMAL DISEASE ACTIVITY CRITERIA WITH ANTI-TNF THERAPY IN PSORIATIC ARTHRITIS CAN PREVENT PROGRESSIVE JOINT DAMAGE

Laura C. Coates and Philip S. Helliwell
LIMM, Section of Musculoskeletal Disease, University of Leeds, Leeds, UK

Results: At the baseline, physical function in both groups was similar. Immediately after the intervention, participants who undertook ESCAPE-knee pain reported better physical function than participants who remained on usual care remained unchanged.

Physical function of participants who undertook the ESCAPE-knee pain program improved at each assessment compared with baseline value, i.e. mean WOMAC-func decreased, (post-rehabilitation WOMAC-func -5.49 (95% CI -7.78, -3.19; P < 0.0001); 6-month WOMAC-func -4.44 (-6.54, -2.33; P < 0.0001); 12-month WOMAC-func -3.10 (-5.64, -0.76; P < 0.0001)). However, declined over time becoming more similar to the usual care values.

Conclusions: ESCAPE-knee pain is an exercise-based rehabilitation programme for chronic knee pain that has sustained improvement in physical function for up to 2½ years after completing the programme. Models of care should be developed that will sustain for longer the initial improvement in physical functioning.

Disclosure statement: C.D. Wyeth and Abbott - Honoraria for presentations, Wyeth, Abbott and Schering-Plough - Department grant, ultrasound machine and training, research nurse and biologics database clerk. All other authors have declared no conflicts of interest.
Background: Minimal disease activity (MDA) is defined by OMERACT as “that state of disease activity deemed a useful target of treatment by both the patient and physician, given current treatment possibilities and limitations” and criteria for psoriatic arthritis (PsA) have been developed. The aim was to investigate if achieving MDA could improve radiological outcome.

Methods: The study was an analysis of most patients in the phase III infliximab studies. In both, patients with active PsA were treated with infliximab 5 mg/kg or placebo. Patients were given double blind therapy for 16 weeks (IMPACT) or 24 weeks (IMPACT2) followed by open-label treatment. Patients were classified as MDA if they fulfilled 5 of 7 from: tender joint count < 1; swollen joint count < 1; psoriasis activity and severity index < 1 or body surface area < 3; patient pain visual analogue score (VAS) ≤ 15; patient global disease activity (VAS) ≤ 20; health assessment questionnaire ≤ 0.5; tender entheseal points < 1. Radiological progression was assessed using modified PsA Sharp-van der Heijde (S-vdH) scores for the hands and feet. All analysis is on an intention-to-treat basis.

Results: In IMPACT1, data were available for 63 patients. Of those receiving infliximab, 48% (15/31) achieved MDA at week 16 compared with 3% (1/32) on placebo (P = 0.012). At week 24, all patients were on infliximab, 27 of 64 (42%) were in MDA. At week 52, 86% of those patients who achieved MDA showed no progression of radiological disease (increase in S-vdH score ≤ 0), compared with 67% of those who did not achieve MDA (P = 0.012). At week 104, numbers were greatly reduced and 12/37 (30%) were in MDA. All patients who achieved MDA at week 104 showed no progression of radiological disease compared with 58% of those who did not achieve MDA (P = 0.03). In IMPACT2 data were available on 157 patients. Of those receiving infliximab, 52% (40/77) achieved MDA at week 24 compared with 21% (17/80) on placebo (P < 0.001). At week 52, when all patients were on infliximab, 63 of 157 (40%) were in MDA. At week 52, 78% of those patients who achieved MDA showed no progression of radiological disease, compared with 57% of those who did not achieve MDA (P = 0.009). Cumulative probability plots of changes in S-vdH score through week 54 show that the curve for patients consistently in MDA (at week 24 and 52) lies to the right of the control curve indicating a smaller amount of radiographic progression per patient in MDA patients.

Conclusions: Patients with active PsA who achieve MDA with effective therapy have a significant reduction in radiographic progression over 2 years (mSASSS). At a similar rate and frequency as pts from a historical cohort of AS pts without treatment with TNF antagonists. We may occur. Good long-term outcomes depend on early diagnosis and treatment. The National Ankylosing Spondylitis Society (NASS) therefore surveyed the experience of its members in this regard.

Methods: 1000 members of NASS who lived in the UK and joined between 1 June 2006 and 1 June 2009 were sent a questionnaire, which asked about the intervals between onset of symptoms, contact with GPs and specialists and institution of effective treatment. 324 (32.4%) individuals (64% male) returned complete responses. They were aged 17 to 78 years (mean: 45 years); 126 (39%) were aged less than 30 years. Disease activity was measured using the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI).

Results: The age at onset of symptoms ranged from 7 to 69 (mean: 27) years. The interval between the onset of symptoms and the first consultation with a GP ranged from less than 2 weeks to more than 10 years (mean: 20 weeks). 113 (35%) of individuals waited for more than 5 years.

Table: Clinical responses and disease activity during up to 4 years of adalimumab treatment

<table>
<thead>
<tr>
<th>Week</th>
<th>NY</th>
<th>P</th>
<th>NY</th>
<th>P</th>
<th>NY</th>
<th>P</th>
<th>NY</th>
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<td>12</td>
<td>60.7</td>
<td>58.0</td>
<td>24.1</td>
<td>24.0</td>
<td>3.3</td>
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<td>20.0</td>
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<td>2.8</td>
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<td>3.3</td>
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<td>75.7</td>
<td>81.6</td>
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<td>4.7</td>
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<td>156</td>
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<td>41.9</td>
<td>43.2</td>
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<td>41.7</td>
<td>38.6</td>
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<td>4.5</td>
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<td>0.6</td>
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<tr>
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<td>81.6</td>
<td>82.1</td>
<td>43.4</td>
<td>43.6</td>
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<td>2.1</td>
<td>4.2</td>
<td>4.5</td>
<td>0.5</td>
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</table>

OP43. ANKYLOSING SPONDYLITIS: TIME FROM ONSET TO EFFECTIVE TREATMENT

Jane Skerrett1, Ingrid van der Weide1, Julie Barlow2 and Andrew Keat3
1National Ankylosing Spondylitis Society, Richmond, UK; 2Coventry University, Coventry; 3Rheumatology, Northwick Park Hospital, Harrow, UK

Background: Many patients with ankylosing spondylitis (AS) experience long delays before the diagnosis is made and treatment started. During this irreversible physical and/or social damage may occur. Good long-term outcomes depend on early diagnosis and treatment.

Methods: 1000 members of NASS who lived in the UK and joined between 1 June 2006 and 1 June 2009 were sent a questionnaire, which asked about the intervals between onset of symptoms, contact with GPs and specialists and institution of effective treatment. 324 (32.4%) individuals (64% male) returned complete responses. They were aged 17 to 78 years (mean: 45 years); 126 (39%) were aged less than 30 years. Disease activity was measured using the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI).

Results: The age at onset of symptoms ranged from 7 to 69 (mean: 27) years. The interval between the onset of symptoms and the first consultation with a GP ranged from less than 2 weeks to more than 10 years (mean: 20 weeks). 113 (35%) of individuals waited for more than 5 years.
than 1 year before consulting their GP. The time from first consultation 
with the GP to referral to a specialist ranged from less than 2 weeks to 
more than 10 years (mean: 62 weeks). 153 (47%) were referred 
more than 1 year after the first GP consultation. Initially, 72 (22%) 
were referred to an orthopaedic surgeon, 14 (4%) to a physiotherapist 
and 202 (62%) to a rheumatologist. Respondents waited, on 
average, 9 weeks to see a specialist but 103 (32%) waited more than 
3 months.

For 120 (37%) individuals the diagnosis of AS was made by 
the first specialist. 100 (31%) saw three or more specialists before 
a diagnosis of AS was made and 101 (31%) waited more than 2 years 
from the first specialist consultation before a diagnosis of AS was 
confirmed.

After seeing a specialist, 119 (37%) reported that, within 6 months, 
treatment had controlled their symptoms but 57 (18%) reported that 
symptoms were still not adequately controlled. 179 (55%) recorded a 
current BASDI score of 4 or higher.

Overall the average interval between the onset of symptoms and 
receipt of effective treatment was 157 weeks, of which 91 weeks 
elapsed between symptom onset and the first consultation with a 
specialist.

Conclusions: The average time to receive effective treatment 
in this group was 3 years but even 6 months after seeing a specialist 
most patients still had clearly active disease. Most people with 
AS in the UK wait too long to receive effective treatment. There is an 
urgent need to shorten both the early and later stages of the 
AS pathway.

Disclosure statement: A.K., Abbott - research grant, honoraria, 
Schering-Plough - honoraria, research support, Wyeth - honoraria, 
Pfizer - speaker fees. J.S., Abbott - Unrestricted grant to NASS 
for this study. All other authors have declared no conflicts of 
interest.

OP44. GOLIMUBAM, A NEW, HUMAN, TNF-α ANTIBODY, 
ADMINISTERED SUBCUTANEOUSLY EVERY 4 WEEKS IN 
PSORIATIC ARTHRITIS PATIENTS: 104-WEEK EFFICACY AND 
SAFETY RESULTS OF THE RANDOMIZED, PLACEBO-
CONTROLLED GO-REVEAL STUDY

Dafna Gladman1, Arthur Kavanaugh2, 
Chandrabhusan Chattopadhyay3, Philip Mease4, Gerald 
G. Krueger5, Julie Zrubek6, Anna Beutler7, Benjamin Hsu8, 
Surekha Mudrudvarya9, Michael Mack2, Iain B. McInnes10, on behalf 
of the and GO-REVEAL Investigators9

1Toronto Western Hospital, Toronto, ON, Canada; 2University 
of California San Diego, La Jolla, CA, USA; 3Wrightington Hospital, 
Wigan, UK; 4Swedish Hospital Clinical Research Center, Seattle, WA, 
USA; 5University of Utah Health Sciences Center, Salt Lake City, UT, 
USA; 6Centocor Research and Development, Inc., Malvern, PA; 
7University of Glasgow, Glasgow, UK

Background: Golimubam (GLM), a new human anti-tumor necrosis 
factor (TNF) monoclonal antibody, has shown efficacy in psoriatic arthritis 
(PsA).

Methods: To assess long-term efficacy and safety of GLM in PsA, PsA 
pts with ≥3 swollen and ≥3 tender joints and psoriasis were 
randomized to SC PBO or GLM (50 or 100 mg) q 4 weeks. At week 
16, pts with less than 10% improvement in swollen and 
tender joints entered early escape (EE). All pts received GLM from 
week 24 through week 104. Investigators could dose-escalate 
pts receiving GLM 50 mg to 100 mg based on clinical judgement 
after all pts reached week 52. Results are provided through 
week 104.

Results: 405 pts with active PsA were randomized (113 PBO, 146 
GLM 50 mg, 146 GLM 100 mg). GLM was significantly better than PBO 
in improving signs and symptoms of PsA at week 24 and efficacy was 
maintained through week 52. At week 104, the percentage of pts with 
ACR20 for more than one year after the first GP consultation. Initially, 72 (22%) 
were referred to an orthopaedic surgeon, 14 (4%) to a physiotherapist 
and 202 (62%) to a rheumatologist. Respondents waited, on 
average, 9 weeks to see a specialist but 103 (32%) waited more than 
3 months.

For 120 (37%) individuals the diagnosis of AS was made by 
the first specialist. 100 (31%) saw three or more specialists before 
a diagnosis of AS was made and 101 (31%) waited more than 2 years 
from the first specialist consultation before a diagnosis of AS was 
confirmed.

After seeing a specialist, 119 (37%) reported that, within 6 months, 
treatment had controlled their symptoms but 57 (18%) reported that 
symptoms were still not adequately controlled. 179 (55%) recorded a 
current BASDI score of 4 or higher.

Overall the average interval between the onset of symptoms and 
receipt of effective treatment was 157 weeks, of which 91 weeks 
elapsed between symptom onset and the first consultation with a 
specialist.

Conclusions: The average time to receive effective treatment 
in this group was 3 years but even 6 months after seeing a specialist 
most patients still had clearly active disease. Most people with 
AS in the UK wait too long to receive effective treatment. There is an 
urgent need to shorten both the early and later stages of the 
AS pathway.

Disclosure statement: A.K., Abbott - research grant, honoraria, 
Schering-Plough - honoraria, research support, Wyeth - honoraria, 
Pfizer - speaker fees. J.S., Abbott - Unrestricted grant to NASS 
for this study. All other authors have declared no conflicts of 
interest.

OP45. INFLUENCE OF BASELINE INFLAMMATION 
AND OLGARTHRITIS VS POLYARTHRITIS ON PSORIASIS 
RESPONSE TO ETANECERT THERAPY IN SUBJECTS WITH 
BOTH PSORIASIS AND PSORIATIC ARTHRITIS

Bruce Kirkham1, Oliver Fitzgerald2, Debbie Robertson3, 
Joanne Estokaj4, Joanne Foehl5, Charles Molta6 and 
Bruce Freundlich7

1Guy’s and St. Thomas’s Hospital, London, UK; 2University College 
Dublin School of Medicine and Medical Science, Dublin, Ireland; 
3Pfizer Inc, Collegeville, PA, USA

Background: The objective of this post hoc analysis was to explore 
the relations of baseline joint disease and baseline inflammation on 
response to therapy in psoriatic arthritis subjects.

Methods: Subjects diagnosed with both psoriasis and psoriatic 
arthritis from a large clinical trial (N = 752) received either etanercept 
(ETN) 50 mg twice weekly for 12 weeks or ETN 50 mg once weekly 
for 12 weeks in blinded fashion; all subjects then received open-label 
ETN 50 mg once weekly for an additional 12 weeks. Subjects were 
included in this post hoc analysis only if they had > 1 swollen joint 
at baseline and evaluable CRP (n = 611). Subjects were grouped by 
baseline arthritis activity (2-3 swollen joints; n = 138) or polyarthritis 
(>3 swollen joints, n = 473) and by baseline C-reactive protein 
(CRP) normal (< 9 mg/L; n = 392) or high (> 9 mg/L; n = 219).

Results: Baseline CRP and arthritis categories were analysed in ANCOVA 
models (adjusted for treatment, baseline Psoriasis Activity and 
Severity Index [PASI] and interactions) as predictors of absolute 
PASI, PASI change from baseline and PASI % improvement from 
baseline at week 24.

Conclusions: ANCOVA models showed no significance for oligoarthritis 
vs polyarthritis but did show significance for CRP (P < 0.005). Greater 
differences between normal vs high CRP groups at week 24 were seen 
in least square means for absolute PASI (3.57 vs 4.75; P = 0.0037), 
change from baseline in PASI (-15.83 vs -14.65; P = 0.0037) and PASI 
% improvement from baseline (80.57% vs 74.25%; P = 0.0031). For 
PASI % improvement from baseline, a significant arthritis-by-CRP 
interaction was also identified (P = 0.0370).

Conclusions: In this population of subjects with both psoriasis 
and psoriatic arthritis, baseline oligoarthritis vs polyarthritis was 
unrelated to skin disease response after 24 weeks of etanercept 
therapy. Baseline inflammation as measured by CRP appeared to 
be predictive of improvement in skin disease alone and in inter-
action with baseline joint disease category. However, clinically 
meaningful improvement was seen in both the high and normal CRP 
groups.
Background: Controlled trials with 25 mg biw of ETN in subjects with AS have demonstrated significant efficacy in comparison with placebo. Currently ETN 25mg biw is approved for AS in the USA and European Union. ETN at higher doses has been evaluated in severe psoriasis demonstrating that at 12 weeks, patients who received 50 mg biw had a significantly better clinical response than those who received 25 mg biw. There are no studies in AS that evaluate the efficacy of ETN at higher doses than those currently used. The present study was designed to evaluate the effect of ETN 50 mg biw vs 50 mg qw in patients with AS and previous failure to standard therapies.

Methods: 12 week, double-blind, randomized, multicentric study in AS patients with maintained inflammatory activity, who have failed to respond to conventional therapy.

Results: 108 patients randomized in Group A: 50 mg biw and Group B: 50 mg qw (54 patients per group). Homogenous groups, mainly white males, mean age of 41.4 years, mean disease duration of 7.1 years.

Efficacy: At week 2, 60.8% of the patients with 50 mg biw reached ASAS20 and 75.5% of the patients with 50 mg qw achieved partial remission.

The proportion of patients with BASDAI 50 at week 2 was 52.9% in patients with 50 mg biw and 43.4% in patients with 50 mg qw; and at week 12, 66.7% in patients with 50 mg biw and 55.1% in patients with 50 mg qw.

An improvement in mean BASFI and lineal BASMI changes from baseline was observed at week 2 for both treatment groups and continued improving until week 12.

Safety: There were 101 adverse events (AEs): 86.1% mild, 8.9% moderate and 5% severe, with similar proportions between both groups. The most reported AEs were injection site reactions, respiratory infections and increased transaminases. There were no cases of tuberculosis, demyelinating disease, opportunistic infections, deaths, life-threatening events or unexpected AEs.

Conclusions: This study confirms that it is not necessary a double dose of ETN to achieve early excellent efficacy results in patients with AS. At week 12, both regimens are equally efficacious and safe.