-0.0049, P=0.447), and leave-one-out sensitivity analysis showed that removing any SNP would not change the overall result, suggesting this finding was available. Details of the results were shown in Figure 1.

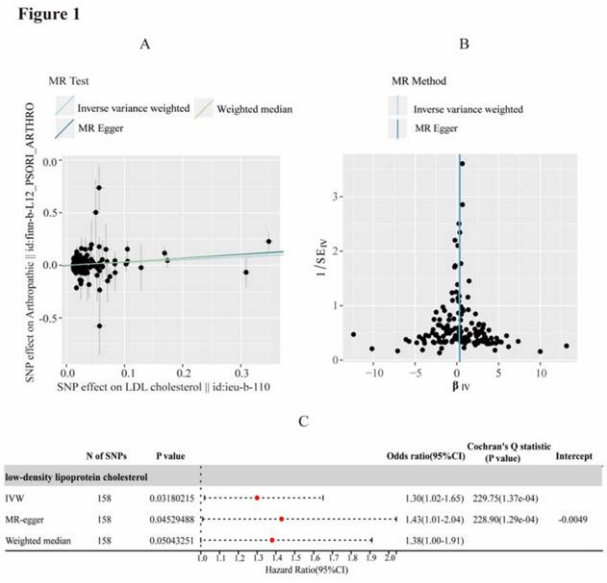


Figure 1. The causal associations between low-density lipoprotein cholesterol (LDL-C) and psoriatic arthritis (PsA) were evaluated by the odds ratio (OR) values of IVW, MR-Egger, and Weighted median. Scatter plot (A), funnel plot (B), and forest plot (C).

Conclusion: LDL-C was a hazard factor for PsA. Monitoring and lowering serum concentrations of LDL-C may make a difference in psoriasis treatment and slow down the process of PsA.

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AB1131 PATIENT ACCEPTABLE SYMPTOMS STATE IN PSORIATIC ARTHRITIS: DOES IT DIFFER BETWEEN SEXES?

Keywords: Psoriatic arthritis, Outcome measures, Patient reported outcomes

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Background: Patient Acceptable Symptoms State (PASS) is a dichotomous and feasible tool recently validated for Psoriatic Arthritis (PsA). It assesses if the patient accepts her/his disease status by using a simple question: "Think about all the ways your PsA has affected you during the last 48 hours. If you were to remain in the next few months as you were during the last 48 hours, would this be acceptable to you?". A negative answer ("no") denotes a disease status not acceptable for the patient. Due to the recent introduction of PASS in PsA, there are not data about its difference between sexes.

Objectives: To assess PASS differences in PsA based on sexes, characterizing the factors associated with an unacceptable disease state (PASS "no").

Methods: This is a cross sectional study. Patients were consecutively enrolled from January 2022 to December 2022, in two outpatient clinics devoted to PsA. All enrolled patients were adult and had a PsA diagnosis (for at least six months). We assessed PASS and its difference between sexes (χ^2 test). Moreover, we performed two logistic regression models to assess which factors were associated with PASS "no", in both sexes.

Results: Two-hundred and forty-five patients were enrolled. Female less accepted their disease status, compared with male patients, PASS "no" was 49.1% vs 23.5%, (p<0.001) (Table1). The factor associated with a higher probability to have an unacceptable symptoms state was a higher disease activity (Table 2), both for male and female. In particular, for male patients, when DAPSA increases of 1 point, the probability to have a state of PASS "no" increases of 31% (OR 1.31, CI 95% 1.16-1.47), independently by age, disease durations, BMI and BSA. The same result was confirmed for female patients, but with a stronger association: when DAPSA increases of 1 points the probability to have a state of PASS "no" increase of 101% (OR 2.01, CI 95% 1.45-2.77), independently by age, disease durations, BMI, BSA and fibromyalgia. Moreover, fibromyalgia in female patients was not associated with PASS "no".

Table 1 Clinical and demographic characteristics, grouped by sexes.

	All patients n. 245	Female n. 119	Male n. 126	p value
Age, mean (SD)	55 (12)	55 (12)	56 (13)	0.553
Disease duration (months), median (IQR)	94 (49-164)	94 (51-157)	94 (47-165)	0.650
BMI, mean (SD)	27.4 (5.01)	26.7 (5.28)	28.0 (4.68)	0.044
DAPSA, median (IQR)	10.2 (4.3-17.65)	13.45 (6.70-20.70)	7.29 (4-14.42)	<0.001
PASS "no", n. (%)	82/227 (36.1)	55/112 (49.1)	27/115 (23.5)	<0.001
Fibromyalgia, n. (%)	27 (11)	22 (18.5)	5 (4)	<0.001

BMI: Body Mass Index, DAPSA: Disease Activity for Psoriatic Arthritis; IQR: Inter Quartile range; PASS: Patient Acceptable Symptoms State; SD: Standard Deviation.

Table 2 Logistic regression analysis. Factors associated with PASS "no".

	PASS "no"	
Model 1*(male patients)	**OR (CI 95%)**	**p value**
DAPSA	1.31 (1.16-1.47)	<0.001
	PASS "no"	
Model 2*(female patients)	**OR (CI 95%)**	**p value**
DAPSA	2.01 (1.45-2.77)	<0.001
Fibromyalgia (yes)	1.34 (0.21-8.30)	0.715

*Both models were corrected for: age, disease duration, BMI and BSA.
All these predictors did not show any statistically significant association with PASS "no".

Conclusion: Female patients perceive their disease acceptable less than male. A higher disease activity (assessed by DAPSA), in particular for female patients, is the main factor to predict a state of non-acceptance of the disease.

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AB1132 PSYCHOMETRIC PROPERTIES OF SCREENING INSTRUMENTS FOR PSORIATIC ARTHRITIS

Keywords: Diagnostic tests, Psoriatic arthritis

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Background: There is a considerable delay in the diagnosis of psoriatic arthritis (PsA) and several screening tools have been proposed for fascilitating the diagnosis of PsA among patients with psoriasis.
Objectives: We aimed to identify all instruments that were developed for screening PsA among psoriasis patients, and to analyze the psychometric properties of these instruments.
Methods: A systematic literature search was conducted to identify all studies for developing and validating instruments that evaluate the presence of psoriatic arthritis among psoriasis patients. Psychometric properties of each instrument including construct validity, reproducibility, internal consistency, sensitivity to change and feasibility were extracted. Additionally, the reasons for false positivity and false negativity with each instrument were tabulated. Literature review and data extraction were performed by two independant reviewers and inconsistencies were resolved by a senior investigator. The systematic review protocol was registered in PROSPERO (CRD42021231734).
Results: The systematic review revealed 15 screening instruments that were evaluated in a total of 42 studies. Psychometric evaluation was available for only 5 of the instruments, assessed in 8 studies. Table shows the psychometric properties of these 5 instruments. Main reasons for false positivity were rheumatoid arthritis, osteoarthritis, mechanical pain and fibromiyalgia for PASE, PEST, CONTEST and EARP, and ankylosing spondylitis and osteoarthritis for PASQ. Main reasons for false negatives were axial involvement for ToPAS and PEST, peripheral involvement for SiPAT, PASE and PAQ, enthesal involvement for PEST, PASE and ToPAS. Among these instruments, EARP had low false negativity and high false positivity rates, while ToPAS II had both low false positivity and low false negativity compared to the other instruments.
Conclusion: Overall, the psychometric properties of PsA screening tools have not been adequately evaluated. There is an unmet need for studies evaluating and comparing psychometric properties of different screening tools in a large patient population, including patients with various PsA features such as enthesitis, axial and peripheral involvement.

Table.

Instrument	Number of studies	Internal consistency	Test-retest reliability	Construct Validity	Criterion validity	Interrater reliability	Sensitivity to change	Feasibility
PASE	6	good	good	good	Not provided	moderate	good	moderate
PEST	2	moderate	Not provided	Not provided	Not provided	Not provided	Not provided	Not provided
EARP	3	good	Not provided	Not provided	Not provided	Not provided	Not provided	good
TOPAS II	1	Not provided	Not provided	Not provided	Not provided	Not provided	Not provided	good
PsA-Disk	1	good	good	good	moderate	Not provided	Not provided	Not provided

REFERENCES: NIL.
Acknowledgements: NIL.
Disclosure of Interests: None Declared.
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AB1133 AXIAL PSORIATIC ARTHRITIS: ISOLATED ENTITY OR PHENOTYPE FORM ONLY

Keywords: Psoriatic arthritis, Spondyloarthritis

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Background: The latest literature data increasingly emphasizes the axial involvement of Psoriatic Arthritis (PsA). The clinical and radiographic characteristics suggest that it is a new entity compared to the axial involvement of Ankylosing Spondylitis (AS), while therapeutic advances and cytokine targets suggest that it is a clinical form only.
Objectives: The objective of our study is to compare the characteristics of patients with axial PsA (axPsA) and axial AS (axAS).
Methods: Patients≥18 years old, with axPsA or axAS, during registration in the prospective monocentric register, between August 2012 and August 2022. A rheumatological investigation including: clinical, laboratory and genetic assessments as well as imaging with conventional radiography of pelvic and spine was performed.
Results: Of 250 patients (58 PsA vs 192 AS) with axial involvement, isolated axPsA patients were older at diagnosis (age of diagnosis of axial involvement was 35.8 vs 29.4). Patients with isolated axPsA were more likely to have: Less clinical inflammatory back pain compared with patients with isolated axAS: less limited schöber index (10/14 vs 10/12), finger-to-ground distance often equal to 0 cm in axPsA, less contracture of the paravertebral muscles, less reduction in thoracic expansion (4 vs 2 cm). Less limitation of inguinal pain (hip flexion 100 vs 70), a higher dactylitis count ±SD (0.3±1.2 vs 0.1±0.8), more nail lesions which could suggest looking for an association between nail damage and the presence of dactylitis in PsA, less extensive skin psoriasis [PASI= 2-13] and less presence of uveitis (18.96% (11/58) vs 23,95% (46/192)). Human Leucocyte Antigen (HLAB27) positivity was negatively associated with isolated axPsA disease (20 vs 78%). AxPsA were less frequently had radiographic sacroiliitis with unilateral/asymmetric pattern [On the X-ray, the SI were either normal or slightly modified, deliberately asymmetrical, rarely grade 4, the syndesmophytes were most often asymmetrical, coarse and of lumbar location, the heels were affected in less severe involvement, most often represented by simple shielding] and average patients showed slight spinal/pelvic radiographic progression (OR: 0,14; 95% CI: 0,01, 0,58). Finally, AxPsA had lower BASDAI and HAQ scores (OR 0.10, 95% CI 0,01to 0.47/ OR 0.03, 95% CI 0,00 to 0.17) and lower PRO evaluation (PRO spine pain 39.65 vs 49.47% and PRO fatigue 50 vs 52.6%).
Conclusion: Isolated axial PsA and AS are uncommon, axPsA has different clinical and radiographical characteristics when compared to AS. AxPsA is largely independent of HLAB27, it was associated with distinct radiographic ax AS features, increased spinal progression and low grade radiographic sacroiliitis as well as lower disease activity and impact scores.
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AB1134 IMPACT OF INFLAMMATORY BOWEL DISEASE ON DAPSA REMISSION IN PATIENTS WITH PSORIATIC ARTHRITIS: A PROPENSITY SCORE-MATCHED RETROSPECTIVE ANALYSIS OF "CROSS" MULTIDISCIPLINARY PROJECT PATIENTS'.

Keywords: Psoriatic arthritis, Remission

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Background: Psoriatic Arthritis (PsA) is a chronic inflammatory disease and patients with PsA have an increased risk of developing inflammatory bowel disease (IBD) [1]. It's not clear whether the coexistence of IBDs in PsA patients on bDMARDs is associated with the achievement of clinical outcome.
Objectives: The aim of this study was to identify whether IBDs may impact on 12-month remission of articular disease assessed by Disease Activity Index for Psoriatic Arthritis (DAPSA) in PsA patients on monoclonal anti-TNFα or anti-IL12/23 therapy.
Methods: Patients with classified PsA according to CASPAR criteria with active skin psoriasis who underwent monoclonal anti-TNFα or anti IL12/23 treatment were retrospectively analyzed from January 2019 to May 2021 in our CROSS multidisciplinary outpatient's clinic. Clinical and demographic characteristics as disease severity indices (Disease Activity in Psoriatic Arthritis (DAPSA), Psoriasis Area and severity index (PASI), and Leeds Enthesitis Index LEI) were recorded. We identified those with IBDs (either Chron's disease or Ulcerative Colitis) and assess the intestinal disease activity by specific symptoms (abdominal pain, diarrhoea, intestinal bleeding) or instrumental findings. Propensity score-nearest-neighbour (1:1; caliper= 0,2) algorithm was used to provide two comparable groups. Paired t-Test was used to identify differences between outcome of interest at different follow-up periods and univariate and multivariable logistic regression models were run to identify predictors of DAPSA remission at 12-month follow-up.
Results: Of 123 patients with PsA on monoclonal bDMARDs therapy, the algorithm retrieved a sample of 74 patients (IBD group 37 patients, control group 37 patients)

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