Methods: A large internet-based national survey of people suffering from FM was developed by a national patient association (Fibromyalgie-SOS Association) on their website, in France in 2014. The survey included 103 qualitative and quantitative questions that were developed by 3 medical experts (including rheumatologists) and patients.
Results: The questionnaire was completed by 4516 people. Respondents were predominantly middleaged (48 yrs) females (93%), most of whom had FM symptoms duration for 12 years and a diagnosis for 5 years. Diagnosis was made by a rheumatologist in 54% of the cases. The symptoms were concordant with the OMERACT domains (chronic pain, fatigue stiffness and other FM-associated symptoms) as previously published by Bennett in 2007 (3). The mean FIQ (Fibromyalgia Impact Questionnaire) score was 51 (0–100). 55% were currently working but 65% of them have been on sick leave in the 12 previous months. FIQ was mostly impacted by injustice feeling (+4.5), part time job (+2.4) and low income - less than 1000 euros monthly (+2.3) (linear regression).
Somatic comorbidities were mostly osteoarthritis (49%). Psychological comorbidities were injustice feeling (77%), cognitive symptoms (62%), anxiety (52%) and depression (48%). Initiating factors were reported by 73% of them: physical (50%) and/or psychological (76%). Aggravating factors included excess of activities, conflicts, traumatism and displacement. Treatments were provided by general practitioner (85%), physiotherapist (63%), rheumatologist (54%) and osteopathic manual practitioner (41%). Treatment was prescribed in 76.6% of the patients, including paracetamol alone (51.4%), paracetamol and weak opioids (64%), strong opioids (20.1%), antidepressants (81.5%), antiepileptic agents (54.5%), nonsteroidals NSAIDs (53.8%), anxiolytics (52.4%) and steroids (12.8%).
Conclusions: This unique descriptive survey in a large population provides data on symptoms, emotional distress, prescribing habits and impact of FM on daily life and work. Results show that FM is altered by emotional (including injustice feeling) and socio-economic factors.
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OP0275 FIBROMYALGIA PREVALENCE AND IMPACT ON DISEASE ACTIVITY SCORES IN RHEUMATOID ARTHRITIS PATIENTS WHO ARE UNRESPONSIVE TO BIOLOGICAL TREATMENT

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Background: Rheumatoid arthritis (RA) treatment uses a treat-to-target strategy and disease assessment is based on disease activity scores (DAS) such as the DAS28 [1]. Biological drugs have proven highly effective for RA treatment in clinical studies[2], however, in real life settings, comorbidities such as fibromyalgia (FM) might influence treatment response assessed by DAS28.
Objectives: In this study we determined FM prevalence and the impact on disease activity scores in patients with RA undergoing biological treatment and if higher tender joint (TJC) correlates with lower pain threshold in patients with active RA who did not satisfy FM criteria.
Methods: We performed a cross sectional study on RA patients undergoing biological treatment who presented in our department for a 6 month period. DAS28 was calculated for all patients. FM diagnosis was considered positive if patients satisfied both the ACR 1990 and ACR 2010 FM Criteria. Pain pressure thresholds (PPT) were measured at the level of the medial knee joint line, mid sternum and middle of the tibia with a manual dolorimeter. Depression, Anxiety, Stress 21 scale (DASS21) and Health Assessment Questionnaire (HAQ) were applied to all patients.
Results: 112 patients were included, 84.8% women, mean age 55.6 (SD 11.6) with a mean disease duration of 14.5 (SD 8.5) years. Acording to DAS28ESR scores 54 (48.2%) had moderate disease activity and 26 (23.2%) had high disease activity. 17 (21.5%) of patients with DAS28ESR scores over 3.2 satisfied FM criteria. FRA and RA groups did not differ significantly concerning age, disease and biological treatment duration, seropositivity, BMI or DASS21 scores. FRA patients had significantly higher values for DAS28 ESR, DAS28 CRP, PGH and HAQ, but similar values for SJC, ESR and CRP compared to RA patients (Table 1). In RA patients without FM, TJC correlated significantly with number of trigger points (r=-0.3), PPT at knee (r=-0.4), sternum (r=-0.3) and tibial level (r=-0.2).
Conclusions: Fibromyalgia is present in a significant percent of patients who are unresponsive to biological treatment as assessed by DAS28 score. Subjective components of DAS28 are significantly higher in FRA compared to RA patients, suggesting that disease assessment should be performed using objective measures in these patients. In patients with active disease despite biological treatment whitout FM, lower pain thresholds are correlated with TJC, suggesting a possible involvement of central pain mechanisms.

Table 1. DAS28 components for RA and FRA patients

	RA (n=63), mean (SD)	FRA (n=17), mean (SD)	P value
PGH	49.9 (19.8)	68.8 (17.2)	<0.001
TJC	5 (3,9)	10 (8.5,17.5)	<0.001
SJC	2 (1,4)	2 (1,5)	0.8
ESR	27.5 (19)	32.8 (23)	0.4
CRP	8.8 (14.4)	12.8 (15.6)	0.2
DAS28 ESR	4.6 (1.08)	5.5 (1.05)	0.003
DAS28CRP	3.99 (1)	4.94 (1.09)	0.002
HAQ	1.2 (0.5)	1.7 (0.6)	0.002

PGH - patient global health, TJC -tender joint count, SJC - swollen joint count, ESR - erythrocyte sedimentation rate, CRP - C reactive protein.

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LB0001 INTRADISCAL GLUCOCORTICOID INJECTION FOR PATIENTS WITH CHRONIC LOW BACK PAIN ASSOCIATED WITH ACTIVE DISCOPATHY: A RANDOMIZED TRIAL

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Background: Active discopathy is associated with a specific phenotype of chronic low back pain (cLBP). Local inflammation has a role in active discopathy-associated symptoms (1).
Objectives: To assess the efficacy of a single glucocorticoid intradiscal injection (GC IDI) in cLBP patients with active discopathy.
Methods: We conducted a prospective, parallel-group, double-blind, randomized controlled study in 3 tertiary care centers in France. 135 cLBP patients with active discopathy on MRI were enrolled. They received a single GC IDI (25 mg prednisolone acetate) during discography (n=67) or discography alone (n=68). The primary outcome was the percentage of patients with LBP intensity in the previous 48 hr <40 on an 11-point numeric rating scale (NRS, 0 no pain - 100 maximal pain) at 1 month. The main secondary outcomes were LBP intensity and persisting active discopathy on MRI at 12 months post-intervention, and spine-specific limitations in activities, health-related quality of life, anxiety and depression, employment status and analgesics and non-steroidal anti-inflammatory drugs consumption at 1 and 12 months.
Results: All randomized patients were included in the primary efficacy analysis. At 1 month, the percentage of responders (LBP intensity <40) was higher in the GC IDI than control group (36/65 [55.4%] *vs* 21/63 [33.3%]; absolute risk difference [95% confidence interval] 22.1 [5.5;38.7]); p=0.009. In the sensitivity analysis, mean reduction [95% CI] in LBP intensity from baseline to 1 month was greater in the GC IDI group compared to the control group (-32.5 [-38.2;-26.8] *vs* -17.5 [-23.3;-11.7], respectively; absolute difference [95% CI] -15.0 [-22.9;-7.1], p<0.001).
At 1 month, the percentage of patients reporting an improvement in spine-specific limitations in activities was higher in the GC IDI than control group (55/65 [84.6%] *vs* 34/63 [54.0%]; absolute risk difference [95% CI] 30.5 [15.7; 45.2], p<0.001). The 2 groups did not differ in LBP intensity at 12 months and in most of the secondary outcomes at 1 and 12 months. 102/119 (85.7%) patients would agree to a second intervention. We found no cases of rapidly destructive disc disease or intervertebral disc calcifications.
Conclusions: In active discopathy-associated cLBP, a single GC IDI reduces LBP at 1 month post-intervention but not at 12 months.
Registration: ClinicalTrials.gov number NCT00804531 (First received: December 8, 2008. Last updated: June 23, 2016).
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