anxiety and depression subscales of HADS, respectively, strong and moderately strong, in the positive direction ($r=0.618$ $p<0.001$ and $r=0.572$ $p<0.001$). A statistically significant, strong correlation was found between the BETY and HAQ scores in the positive direction ($r=0.650$ $p<0.001$) (table 2). It was observed that patients showed depression characteristics according to HADS cut-off values (>7).

Abstract OP0138 – Table 1 Characteristics of patients

n=352	Min-Max	X±SD
Age (year)	19–75	46,01±11,6
Height (cm)	130–190	162,54±8,42
Weight (kg)	40–125	73,19±14,9
BMI (kg/m ²)	15,21–52,76	27,8±5,8
HADS-A	0–21	8,71±5,1
HADS-D	0–21	7,49±4,6
HADS-T	0–42	16,20±8,9
HAQ	0–53	12,21±10,4
BETY	2–120	62,65±26,3

X: Mean, SD: Standard Deviation BMI: Body Mass Index

Abstract OP0138 – Table 2 Correlations

n=352		HADS-anx	HADS-dep	HAQ
BETY	r	,618*	,572*	,650**
	p	,000	,000	,000

*: Pearson Correlation Test **: Spearman Correlation Test $p<0,05$

Conclusions: It was concluded that the cognitive functions of patients with rheumatic diseases were affected by anxiety-depression levels and daily living activities. Therefore, when the patient changes his/her cognition about his/her illness, it is thought that anxiety and depression levels may change positively. It was decided that the cognitive functions of the patients should be emphasised in the assessment of rheumatic patients.

REFERENCES:

- Anyfanti P, Gavrilaki E, Pyrasopoulou A, Triantafyllou G, Triantafyllou A, Chatzimichailidou S, et al. Depression, anxiety, and quality of life in a large cohort of patients with rheumatic diseases: Common, yet undertreated. *Clinical rheumatology* 2016;35(3):733–9.
- Booth J, Moseley GL, Schiltenswolf M, Cashin A, Davies M, Hubscher M. Exercise for chronic musculoskeletal pain: A biopsychosocial approach. *Musculoskeletal Care* 2017;15(4):413–21.
- Ünal E, Arin G, Karaca Nb, Kiraz S, Akdoğan A, Kalyoncu U, et al. Romatizmalı hastalar için bir yaşam kalitesi ölçeinin geliştirilmesi: Madde havuzunun oluşturulması. *Journal of Exercise Therapy and Rehabilitation* 2017;4(2):67–75.

Disclosure of Interest: None declared

DOI: 10.1136/annrhumdis-2018-eular.7123

OP0139 CHARACTERISTICS OF DIFFICULT-TO-TREAT RHEUMATOID ARTHRITIS: RESULTS OF AN INTERNATIONAL SURVEY

N.M.T. Roodenrijs¹, M.J.H. de Hair¹, J.W.G. Jacobs¹, P.M.J. Welsing¹, D. M. F. M. van der Heijde², J.M. van Laar¹, G. Nagy³, on behalf of the Task Force Difficult-to-Treat RA. ¹Department of Rheumatology and Clinical Immunology, University Medical Center Utrecht, Utrecht; ²Department of Rheumatology, Leiden University Medical Center, Leiden, Netherlands; ³Department of Genetics, Cell- and Immunobiology and Department of Rheumatology, 3rd Department of Internal Medicine, Semmelweis University, Budapest, Hungary

Background: The EULAR and ACR recommendations regarding rheumatoid arthritis (RA) mainly focus on early phases of the disease and on pharmacological management. Nevertheless, some patients remain symptomatic despite treatment according to the current recommendations, which makes them difficult-to-treat.¹ The estimated prevalence of difficult-to-treat RA is around 5%–20%. A difficult-to-treat RA classification needs to be defined to enable creation of recommendations on its comprehensive management.

Objectives: To compose a definition of difficult-to-treat RA and to explore items on its comprehensive management not covered by the current EULAR RA management recommendations.

Methods: An online survey was distributed among rheumatologists (in training). It consisted of 9 questions regarding the background of the respondents, aspects to be included in the definition of difficult-to-treat RA and missing items on its comprehensive management in the current EULAR management recommendations. Multiple-choice questions were used to assess the necessity of incorporating the following items into the definition: the disease activity level, e.g. the disease activity score assessing 28 joints (DAS28-ESR), presence of fatigue, number of disease-modifying anti-rheumatic drugs (DMARDs) that failed and the inability to reduce oral glucocorticoid (GC) treatment. Optional open questions were used to identify additional features for the definition of difficult-to-treat RA and to collect items on its comprehensive management not covered by the current EULAR recommendations.

Results: 390 rheumatologists (a few of them in training) from 31 countries completed the survey between July and December 2017 (figure 1a). 50% of the respondents would include signs suggestive of active disease or a DAS28-ESR score >3.2 in the definition (figure 1b) and 41% fatigue. The most selected option for the number and category of DMARDs that had to have been used to be included in the definition was 1) Failure to ≥ 2 conventional synthetic DMARDs and (Boolean) 2) ≥ 2 biological or targeted synthetic DMARDs with different mechanisms of action (figure 1c). 89% suggested including inability to taper oral GCs below 5 or 10 mg. Over 400 responses to open questions were submitted, of which a selection is listed in table 1.

Abstract OP0139 – Table 1 Most frequent answers to the open questions

Please define any additional features and suggested criteria for difficult-to-treat RA	Please mention any clinically relevant situations which are not covered by the current EULAR RA recommendations
Time span with active disease despite treatment	Treatment adherence
Rapidly progressive erosions despite treatment	Persistent chronic pain without objective inflammatory signs
Adverse events to multiple agents	Coping problems
Comorbidities, e.g. fibromyalgia	Extra-articular manifestations

Abstract OP0139 – Figure 1 a) origin and number of respondents, b) what should be the definition for not well-controlled disease in the definition of difficult-to-treat RA? c) which and how many anti-rheumatic drugs should at least be tried with insufficient effect (failed) for the definition of difficult-to-treat RA?

Conclusions: This survey shows that difficult-to-treat RA is seen as a heterogeneous condition; next to signs of active disease, failure to DMARDs and inability to taper GCs may be included in the definition. The large number of respondents and of responses with regard to items not covered by the current EULAR RA management recommendations underscore the need for recommendations on comprehensive management of difficult-to-treat RA.

REFERENCE:

- de Hair MJH, Jacobs JWG, Schoneveld JLM, van Laar JM. Difficult-to-treat rheumatoid arthritis: An area of unmet clinical need. *Rheumatology* 2017. [Available from] doi:10.1093/rheumatology/kex349

Disclosure of Interest: N. Roodenrijs: None declared, M. de Hair: None declared, J. Jacobs: None declared, P. Welsing: None declared, D. van der Heijde: None declared, J. van Laar Grant/research support from: JMWL received fees from Arthrogeen, MSD, Pfizer, Eli Lilly, and BMS and research grants from Astra Zeneca, Roche-Genentech, G. Nagy: None declared

DOI: 10.1136/annrhumdis-2018-eular.2669