analyse the association between these physical functioning measures and the assessment of affect and life satisfaction.

Results: We found independent associations of the objective measures but not the subjective assessments of physical activity with positive affect and satisfaction with life (both, $p < 0.01$ and adjusted $R^2 > 0.06$) and of sedentary time with positive affect ($p < 0.02$ and adjusted $R^2 > 0.03$). Moreover, we observed consistent and independent associations of both the objective and subjective dimensions of physical fitness with all the components of subjective well-being (all, $p < 0.01$ and adjusted R^2 ranged from 0.02 to 0.05).

Conclusions: Both objective and subjective measures of physical activity and sedentary behaviour independently impact affect and subjective well-being. Strategies to enhance both dimensions of physical fitness may be a promising approach for improving the subjective well-being in fibromyalgia.

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FRI0711-HPR KINESIOPHOBIA IN ADULT PATIENTS WITH FAMILIAL MEDITERRANEAN FEVER: ASSOCIATION WITH PHYSICAL ACTIVITY, DEPRESSION AND ANXIETY

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Background: Familial Mediterranean fever (FMF) characterized by pain and inflammation with fever which requires a lifelong treatment¹. All of this causes psychosocial influences and also causes kinesiophobia, which is defined as avoidance of physical activity and fear of repetition of the pain. As it may affect the levels of physical activity and functional capacity, it is important to identify factors related to kinesiophobia in patients with FMF.

Objectives: The aim of this study was to investigate the existence of kinesiophobia and related factors such as depression, anxiety and physical activity in adult patients with FMF.

Methods: 38 subjects with FMF (15 male) from Society of Behçet & FMF Diseases included in the study. The demographic characteristics of the participants were recorded. The 'Tampa Scale for Kinesiophobia (TSK)²', 'International Physical Activity Questionnaire (IPAQ)³', 'Hospital Anxiety and Depression Scale (HADS)⁴' and 'Fatigue Severity Scale (FSS)⁵' were used to assess associated factors.

Results: Demographic and disease characteristics of the participants were presented in the table 1. Only 9 subjects reported regular exercise. 86% of the subjects had a score over 37 in TSK representing high kinesiophobia⁶. TSK scores were positively correlated with HAD-D ($r=0.530$; $p=0.001$) and FSS ($r=0.340$; $p=0.035$). On the other hand, age, disease duration, body mass index, HAD-A and IPAQ scores were not correlated with TSK. Gender or exercise routine had no effect on TSK.

Table 1 Demographic and disease characteristics

	Mean±Std	Min.	Max.
Age (year)	37.05±8.71	19	57
Disease duration (years)	13.11±11.14	1	46
BMI (kg/cm ²)	24.5±4.43	16.65	38.05
IPAQ	6942.5 ±2520.4	3018	14580
TSK	44.16±5.06	33	54
HAD-A	9.84±4.43	2	20
HAD-D	8.82±4.70	1	20
FSS	56.45±13.05	23	70

Conclusions: Kinesiophobia is very common and associated with depression and fatigue in patients with FMF. Limited number of participants reported regular exercise habit which should be added to treatment programs to increase physical activity and functional capacity in patients with FMF.

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FRI0712-HPR THE EXPERIENCE OF PATIENTS WITH DIFFERENT CHRONIC DISEASES WITH HEALTH CARE. A SURVEY WITH THE IEXPAC INSTRUMENT

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Background: Insights from patients are important for health care planning

Objectives: In this study we describe the perception of patients with 4 different chronic conditions with health care in Spain through the IEXPAC scale ("Instrument to Evaluate the Experience of Patients with Chronic diseases"), a scale developed and validated in Spain.

Methods: The IEXPAC scale (<http://www.iemac.es/iepac/>) was developed and validated in Spain by health care professional and social organizations, experts in quality of health care and chronic patients. The scale is structured in 12 items with Likert responses from "always" to "never", yields a score from 0 (worst experience) to 10 (best experience), and identifies aspects of health care needing improvement. A survey was handed to patients needing care in at least two different levels (i.e. primary care and hospital) and with one of the following chronic conditions A) Rheumatic diseases, B) Inflammatory bowel disease (IBD), C) Human immunodeficiency virus infection (HIV) and D) Diabetes mellitus (DM) plus cardiovascular or renal chronic disease. Patients completed the survey at home and responded by pre-paid mail.

Results: 2474 patients received the survey, 1618 (65.4%) returned it (359 with rheumatic disease, 341 with IBD, 467 with HIV infection, 451 with DM, mean age 56 years, 41% women). Only 6.1% were affiliated to a patients association. Patients declared a median of 8 visits (IQR 25–75: 4–15) to primary care or specialty clinics in the last year and 29% had visited an emergency room. In the last 3 years 48% had been hospitalized. Up to 61% reported to search for information on diseases, therapies, lifestyle or diet in webpages, general or social media. Responses to the IEXPAC items (percentages that responded "mostly" + "always" to each item) are displayed in the table. In general, these % were higher in HIV patients, which represents a better experience with health care. In some items, patients with rheumatic diseases scored lower (table 1). Mean IEXPAC score was 6.0 (SD1.8) and was higher in HIV patients (table 1). Worst scores were seen in items related to access or guidance for getting reliable information on health and on social resources, contact with other patients and follow-up after hospital discharge.