sample the presence of aortic root dilation and conduction disturbances (AVB, BBB, IVCD) had a statistically significant association. The principal limitations of this study are the small sample size and the retrospective nature in patient selection.

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FRI0198

WHICH FACTORS INFLUENCE PSYCHOLOGICAL WELL-BEING OF PATIENTS WITH AXIAL SPONDYLOARTHRITIS? – DATA FROM A CROSS-SECTIONAL SURVEY LINKED TO INSURANCE CLAIMS

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Background: Psychological well-being is considered an important determinant of quality of life. Importantly, well-being is related not only to medical factors, but also to social and economic factors.

Objectives: The aim of this study was to examine the psychological well-being of patients with axial spondyloarthritis (axSpA) and its determinants.

Methods: A stratified random sample of subjects with a diagnosis of axSpA (International Classification of Diseases, Tenth Revision, [ICD-10] code M45) was drawn from German health insurance data to whom a postal questionnaire was sent asking about disease-related, psychological, and lifestyle factors as well as socioeconomic status. Additional information to verify the axSpA diagnosis was collected. The psychological well-being was assessed by the World Health Organisation Well-Being Index (WHO-5), which is considered a sensitive and specific screening tool for depression. The following established cut-offs on the WHO-5 were applied: >50: good well-being, no depressive symptoms, 29–50: mild depressive symptoms, ≤28: moderate-to-severe depressive symptoms. Information on comorbidities, drug prescriptions and non-pharmacological treatment was retrieved from claims data and linked to the questionnaire data.

Results: A total of 1736 persons with a confirmed axSpA diagnosis were included; mean age was 55.8 years and 46.3% were female. We found a mean WHO-5 score of 44.70 in axSpA subjects, which is considerably below the WHO-5 score of 69.95 reported among the population in Germany aged 41 to 60 years.¹ Using the cut-offs on the WHO-5, 533 persons (31%) were found to have moderate-to-severe depressive symptoms, 479 (28%) had mild depressive symptoms, and 724 (42%) had a good well-being. Persons with moderate-to-severe depressive symptoms had higher disease burden of axSpA, lower household income and reported more often a lack of exercise and a perception of suffering from stress (table 1). Multivariable logistic regression revealed that higher disease activity of axSpA, higher level of functional impairment, lower income, self-reported stress and lack of exercise, and younger age were associated with moderate-to-severe depressive symptoms.

Abstract FRI0198 – Table 1. Main demographic, disease-related, lifestyle and socioeconomic characteristics of patients and axSpA.

	Total N=1736	no N=724 (42%)	mild N=479 (28%)	moderate/severe N=533 (31%)	P-value
Sex, female	46.3	41.0	50.6	49.7	0.0009
Age, years	55.8±0.1	57.4±0.4	54.1±0.5	55.1±0.4	<.0001
Symptom duration, years	25.2±0.3	26.6±0.5	23.9±0.6	24.3±0.6	0.0013
Duration since diagnosis, years	19.4±0.3	21.3±0.5	17.9±0.6	18±0.6	<.0001
In rheumatologic care, %	46.1	39.5	47.2	54.0	<.0001
HLA-B27 positive, %	86.0	87.4	83.5	86.6	0.2816
BASDAI, 0–10	4.5±0.1	3.3±0.1	4.8±0.1	5.8±0.1	<.0001
BASFI, 0–10	4.1±0.1	2.9±0.1	4.2±0.1	5.6±0.1	<.0001
Inflammatory bowel disease (ever, self-reported), %	8.8	6.9	6.2	13.9	<.0001
Uveitis (ever, self-reported), %	27.3	28.7	28	24.9	0.3181
Psoriasis (ever, self-reported), %	15.1	12.1	16.8	17.7	0.0152
Body Mass Index, kg/m ²	27±0.1	26.8±0.2	27±0.2	27.4±0.2	0.0872
Lack of exercise, %	24.4	19.0	25.3	30.8	<.0001
Suffering from stress, %	39.9	25.5	47.8	52.6	<.0001
Full-time employment, %	31.7	32.2	35.6	27.4	0.0187
Household income, €					
<1500	25.9	20.1	26.7	33.1	<.0001
1500–3200	56.0	55.0	58.3	55.2	
>3200	18.1	24.9	15.0	11.7	
Smoking, current, %	18.9	14.8	20.0	23.4	0.0006
Pharmacological treatment, %					
NSAIDs	59.7	50.9	63.4	68.6	<.0001
Non-opioid analgesics	22.6	18.2	20.6	30.3	<.0001
Opioids	16	9.4	16.5	24.4	<.0001
bDMARDs*	17.1	15.5	19.1	17.5	0.2520
csDMARDs**	11.7	10.6	10.5	14.4	0.0818
Glucocorticoids	18.3	15.6	17.5	22.8	0.0046
No pharmacological treatment, %	22.1	30.3	21.2	11.8	<.0001

Values are presented as mean ± standard error of the mean for continuous characteristics and as percentages otherwise. P-values were assessed using analyses of variance for continuous characteristics and Rao-Scott chi-square tests otherwise.

WHO-5, 5-item World Health Organization Well-Being Index; BASDAI, Bath Ankylosing Spondylitis Disease Activity Index; BASFI, Bath Ankylosing Spondylitis Functional Index; NSAIDs, Nonsteroidal Anti-inflammatory Drugs; csDMARDs, conventional synthetic Disease-Modifying Anti-Rheumatic Drugs; bDMARDs, biological Disease-Modifying Anti-Rheumatic Drugs.

* bDMARDs: 17.0% TNF blocker, 0.07% secukinumab, 0.06% tocilizumab, 0.06% ustekinumab, 0.05% abatacept.

** csDMARDs: 5.7% sulfasalazine, 5.6% methotrexate, 0.9% leflunomide, 0.6% azathioprine, 0.2% cyclosporin.

Conclusions: Moderate-to-severe depressive symptoms are frequent in patients with axSpA. They are associated with a high disease burden as well as sociodemographic factors. These findings highlight the need for the careful evaluation of depressive symptoms as a part of the management strategy for axSpA, helping to improve axSpA outcomes.

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FRI0199

FUNCTIONING CATEGORIES BY ASAS HEALTH INDEX IN PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS AND CONCOMITANT FIBROMYALGIA

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Background: Ankylosing spondylitis (AS) is a chronic rheumatic disease that characterised by prevalent inflammatory spinal involvement. Concomitant fibromyalgia (FM) can significantly modify this condition. In 2014, ASAS Health Index and Environmental Factors (ASAS H/EF) appeared as new tool to assess the health status of patients with spondyloarthritis, able to describe the total impairments, restrictions and functional limitation due to AS.¹

Objectives: The aim of this study was to evaluate the functional status of patients with active AS with concomitant FM by the functioning categories of ASAS HI.

Methods: The study included 72 patients with AS according to the modified New York criteria (1984) Fifty-nine were male (81.94%), average age 39.5±11.72 (M ±SD) years. FM was diagnosed by modified criteria of the American College of Rheumatology (2010) The disease activity we assessed by Ankylosing Spondylitis Disease Activity Score (ASDAS-ESR). We used Ukrainian version of ASAS HI/EF.² Functional categories were established as recommended.³ We categorised patients into 3 functioning categories: normal functioning (ASAS HI ≤4), moderate impairment of functioning (>4 and ≤8) and severe impairment of functioning (ASAS HI >8).

Results: Twenty patients met the criteria for FM (27.78%). Disease activity according to the ASDAS-ESR in patients with AS and AS with concomitant FM was almost the same: 3.58±0.84 and 3.98±0.91. However, ASAS HI in patients with AS and FM was significantly higher than in patients with AS (7.3±1.22 vs. 5.8±1.84).

According to ASAS HI we divided all patients into functioning categories. 10 of 52 patients with AS (19.23%) had normal functioning, 39 (75%) were classified as patients with moderate impairment of functioning and 3 (5.77%) had severe impairment of functioning. In the group AS +FM patients with normal function were not found, while others were distributed in a ratio of 2:1–13 (65%) patients with moderate and 7 (35%) with severe impairment of functioning. It was revealed relationship between ASAS HI and disease activity ($r=0.549$).

Conclusions: Concomitant FM impairs the functional status in patients with AS. High and very high disease activity in patients with AS is associated with functional disability according to ASAS HI functioning categories. ASAS HI is reliable and sensitive clinical tool for determining impairment of functioning in patients with AS.

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FRI0200

INSIGHT INTO THE QUALITY OF LIFE OF PATIENTS WITH ANKYLOSING SPONDYLITIS: REAL-WORLD DATA FROM A US-BASED LIFE IMPACT SURVEY

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Background: While severe pain and stiffness are common hallmarks of ankylosing spondylitis (AS), disease progression is slow and not always visible; however, the quality of life (QoL) of patients with AS is still significantly impacted.

Objectives: To assess patient-reported impact of AS on QoL in the physical, discomfort, social, and emotional domains among US patients with AS in a real-world setting.

Methods: Descriptive data on demographics and QoL were collected from a random sample of patients associated with the Spondylitis Association of America (SAA). QoL measures were based on the Evaluation of Ankylosing Spondylitis Quality of Life (EASi-QoL) questionnaire (scale, 0–80, with higher score indicating more severe impact).¹ Between July 7 and December 31, 2017, 820 interviews were conducted with SAA contacts, including 720 completed via web survey (from 7750 emails) and 100 via follow-up over the phone (from 10 784 phone calls made to 5000 unique numbers). Of 820 participants who completed the survey, 716 self-reported receiving a diagnosis of AS from their doctor and were included in this study. Participants were queried on the impact of AS on their QoL within the day of survey participation with regard to the physical domain, and within the past week prior to participation with regard to the discomfort, social, and emotional domains. A 3:1 (male to female) weighting was performed to reflect the known

clinical prevalence that men are three times more likely to have AS compared to women.

Results: The mean age of the 716 respondents was 55.5 years; 46.9% were male. The most common locations of pain reported were the lumbar spine (86.8%), neck (84.1%), and hip joint (80.2%). The mean total EASi-QoL score was 28.9; overall, 34.7%, 31.7%, and 34.7% of respondents, respectively, reported low (EASi-QoL score 0–17), medium,^{18–35} and high (≥36) impact of AS on QoL. Physical aspects of the disease contributed the most impact, with 41.9% of respondents reporting high impact of AS on the physical domain (EASi-QoL score ≥10). The proportion of respondents reporting high impact of AS (ie, the top 2 levels of impairment for each question) in the 4 QoL domains is shown in figure 1A. In several QoL aspects, AS impacts were reported more frequently by female vs male respondents, respectively, including lifting a child or heavy objects (43.2% vs 27.8%), worrying about the future (37.3% vs 23.5%), feeling tired or lacking in energy (46.4% vs 33.4%), sleep interference (32.7% vs 23.2%), trouble keeping physically active (35.9% vs 26.7%), standing for 30 min (34.9% vs 26.1%), and travelling by car or public transport (19.2% vs 10.5%). AS also impacted their lifestyle, as shown in figure 1B.

Abstract FRI0200 – Figure 1. (A) Proportion of respondents with AS reporting top two levels of impairment by their disease across 4 domains of disease, and (B) Patient-reported impact of AS on lifestyle. AS, ankylosing spondylitis.

Conclusions: Negative impacts in all QoL domains were reported, with a mean overall EASi-QoL score of 28.7. Gender differences were also pronounced in several aspects, including lifting a child or heavy objects, and worrying about the future. Incorporating subjective measures of disease via patient-reported outcomes should be considered with evaluation of disease progression.

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