11th question					
Yes always	33.3	14.8	<0.001	51.4	42.9
(%)					0.198
Yes often (%)	25.9	18.5		25.7	22.9
Yes	25.9	37		11.4	20
sometimes					
(%)					
Yes rarely (%)	9.3	20.4		5.7	8.6
No never (%)	5.6	9.3		5.7	5.7

Conclusion: It was concluded that BETY as a biopsychosocial exercise approach is effective in reducing fatigue and improving the pain coping skill as well as the biopsychosocial status of rheumatic patients. BETY should be kept in mind for further studies in terms of biopsychosocial aspects of pain coping, fatigue, etc.

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FRI0719-HPR AN EVALUATION OF A FIBROMYALGIA EXERCISE PROGRAMME DELIVERED IN THE UNITED KINGDOM NATIONAL HEALTH SERVICE

Jennifer Pearson^{1,2}, Michael Lloyd³, Michael Bisset⁴, Sandra Derham⁵, Julie Russell², Shea Palmer¹. ¹University of the West of England, Glenside Campus, Department of Allied Health Professions, Bristol, United Kingdom; ²Royal National Hospital For Rheumatic Diseases, Rheumatology Therapy Department, Bath, United Kingdom; ³Leeds Community Healthcare NHS Trust, North West Recovery Hub, Leeds, United Kingdom; ⁴University of Huddersfield, Department of Allied Health Professions, Sport and Exercise, Huddersfield, United Kingdom; ⁵Royal National Hospital For Rheumatic Diseases, Rheumatology Therapy Department, Bath, United Kingdom

Background: Fibromyalgia (FM) is a complex long-term condition affecting up to 5.4% of the UK population¹. It is associated with chronic widespread pain, fatigue, stiffness, sleep problems, memory and concentration difficulties, and irritable bowel syndrome². FM guidelines recommend exercise as a core treatment for the management of FM symptoms³. Evidence shows exercise interventions are effective for people with FM, reducing pain and improving function and muscle strength⁴.

Objectives: This study aimed to evaluate the effectiveness of introducing a FM exercise group programme within a United Kingdom National Health Service hospital setting.

Methods: A pre and post evaluation was conducted. People with FM attending a rheumatology therapy department were invited to take part in a FM group exercise programme (60 minutes, once per week, seven weeks). To improve adherence, the exercise programmes were individualised based upon patients' preferences for aerobic or resistance exercise or both. Pre and post Revised Fibromyalgia Impact Questionnaire (FIQR), self-efficacy scale and sit-to-stand in 30 seconds outcome data were collected. Data were analysed using parametric paired samples t-tests and standardised effect size (Cohen's d).

Results: A total of n=20 patients completed the exercise programme (n=3 non-completers had higher baseline FIQR scores). Of the 20 completers the mean age was 49.9 years; n=19 were women; n=2 had a concomitant diagnosis of Joint Hypermobility Syndrome and n=1 had Inflammatory Arthritis. The results demonstrated statistically significant improvements across all outcome measures. There were large standardised effect sizes: self-efficacy d=0.93 (95% Confidence Interval (CI) 1.56, 0.26), FIQR d=-1.00 (-0.32, -1.64), sit to stand in 30 seconds d=0.76 (0.07, 0.75).

Conclusion: An exercise programme for patients affect by FM can be successfully delivered in a hospital setting. Those who completed the programme saw large improvements in pain, self-efficacy and sit to stand. However, further research is needed to confirm the findings of this uncontrolled study.

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FRI0720-HPR DEVELOPMENT AND VALIDATION OF A SELF-ADMINISTRATED QUESTIONNAIRE MEASURING ESSENTIAL KNOWLEDGE FOR PATIENTS WITH RHEUMATOID ARTHRITIS: THE RHEUMATOID ARTHRITIS ASSESSMENT KNOWLEDGE QUESTIONNAIRE (RAKE)

Malory Rodere¹, Bruno Pereira¹, Martin Soubrier¹, Sonia Tropé², Françoise Fayet¹, Jean David Cohen³, Muriel Piperno⁴, Beatrice Pallot Prades⁵, Sophie Pouplin⁶, Pascal Coquerelle⁷, Laurent Grange⁸, Christelle Sordet⁹, Laure Gossec¹⁰, Catherine Beauvais¹¹. ¹University Hospital, Clermont-Ferrand, France; ²ANDAR, Montpellier, France; ³University Hospital, Montpellier, France; ⁴University Hospital, Lyon, France; ⁵University Hospital, Saint Etienne, France; ⁶University Hospital, Rouen, France; ⁷University Hospital, Béthunes, France; ⁸University Hospital, Grenoble Alpes, France; ⁹University Hospital, Strasbourg, France; ¹⁰Pitié-Salpêtrière Hospital, Sorbonne university, Paris, France; ¹¹Saint Antoine University Hospital, APHP, Paris, France

Background: Improving knowledge and skills is recommended for patients with rheumatoid arthritis (RA) to enhance self-management. Measuring knowledge is also part of the educative approach. However, the available Knowledge questionnaires (KQs) (ref 1,2) needed to be updated according to recent recommendations for RA management and the patients' needs (ref 3).

Objectives: To develop and validate a new KQ in RA.

Methods: 4 steps. Step1. Selection of knowledge considered essential for patients with RA through Delphi rounds by a working group of rheumatologists, health professionals (HPs) and patients leading to a list of consensual items (ref3). Step2. Two rheumatologists and a rheumatology nurse constructed the first version of the KQ, each question of the KQ referring to a selected item on the list. The formulation was then amended by the working group. A new version was elaborated during a face-to-face meeting of 3 HPs and one patient. Step 3. The KQ was submitted to ten patients for cognitive debriefing, comments were analysed and a the final version was elaborated. Step 4. Multicentric validation in 11 rheumatology departments: acceptability was measured by the rates of missing data per item, reproducibility and sensitivity to change were assessed respectively by test/retest at a 2 weeks interval (Lin's concordance correlation coefficient) and by testing the KQ before and after patient education sessions. The sample size estimation and statistical analyses were conducted according to COSMIN recommendations, especially concerning thresholds of metrological indexes.

Results: Step1 obtained 45 knowledge items, 32 considered essential and 13 considered useful, selected respectively by more than 2/3 and more than 50% of participants to the Delphi rounds, leading to the RAKE: a 45-items questionnaire, with a 32-items short form. The RAKE contains 6 knowledge domains: disease knowledge (10 items), pharmacological treatment (14), non-pharmacological treatment (7), comorbidities (1), self-care for pain and fatigue (5), adaptative skills to psychosocial and professional issues and health care system (8). The validation included 130 patients, 108 (83%) women, mean age 56.4±12.10 years, median disease duration 9 years [4; 23]. The missing data rate per item was <0.05. The RAKE's internal validity (Kuder-Richardson) was 0.90. Reproducibility (in 72 patients) was 0.86 [0.80; 0.92]. Sensitivity to change was measured in 54 patients. A statistically significant difference in total knowledge score was observed between the two assessment times: 30.1±7.4 vs. 37.7±5.7 (p<0.001), representing an effect size >1.1 [0.7; 1.6]. The RAKE's