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SAT0701-HPR

SLE EXACERBATION PREDICTORS IN PATIENTS OF KRYGYZ NATIONALITY

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Background: Taken into account the wave-like multivariate flow of SLE, there are still difficulties in diagnosing conditions such as "remission" and "exacerbation". The questions of SLE "exacerbation" predictors and their influence on the further nature of the course and outcome of the disease remain little studied.

Objectives: Study of SLE exacerbations predictors in patients living in Kyrgyzstan.

Methods: The study included 150 (26.31%) Kyrgyz patients out of 570 with a reliable diagnosis of SLE, female (96%), young age (median - 34 [26; 44]), Kyrgyz nationality (89.33%), high - 61 (40.66%) and very high activity - 40 (26.67%), with the duration of SLE at 1 observation point from 7 months to 10 years, with dynamic observation from 1 year to 3 years.

To determine the gradation of the degree of reduction in glomerular filtration rate (GFR) and the severity of proteinuria in patients with lupus nephritis, used the classification of chronic kidney disease (CKD) according to KDIGO (2013).

The characteristic and frequency of SLE exacerbations were assessed by the SFI - R index: mild, moderate or severe.

Results: The results of the study showed that 84 (56%) Kyrgyz patients out of 150 had 192 SLE exacerbations by using the SFI index during 3 years of follow-up, with a frequency of 1 to 4 cases (2.82 ± 2.21) per patient. A mild exacerbation was observed predominantly in 1G3 patients (53.66%), manifested by skin - mucous syndrome - in 81 (78.64%) and lebile fever - in 22 (21.36%). A moderate exacerbation was noted in 48 (25%) patients in the form of polyserositis - in 18 (37.5%), articulations - in 16 (33.33%) and nephritis with minimal urinary syndrome - in 14 (29.17%) of them. Severe exacerbation was recorded in 41 (21.35%) patients, manifested mainly by kidney damage - in 28 (68.29%), lungs - in 4 (9.76%), central nervous system - in 4 (9.76%) and hematological disorders - in 5 (12.19%).

Severe exacerbations of the kidneys were characterized by nephritis with CKD C1 A1 in 6, CKD C1 A3 in 6, with CKD C2 A3 in 6, severe nephritis with CKD C3a A3 in 3, CKD C3b A3 in 2 and nephritis with nephrotic syndrome in 5 patients.

SLE exacerbations in most cases resulted from self-withdrawal of glucocorticoid and cytostatic therapy in 44 (52.38%) and activation of the pathological process in 35 (41.67%) patients and in 5 (5.95%) of them were unknown.

Conclusion: On the background of careful dynamic monitoring of patients, predominantly mild SLE exacerbation was observed (53.66%), due to self-withdrawal of glucocorticoid and cytostatic therapy (52.38%).

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SAT0702-HPR

FREQUENCY OF INFECTION AND PREDICTIVE FACTORS IN PATIENTS WITH BIOLOGICAL THERAPY

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Background: infections represent an important cause of morbidity and mortality for patients with autoimmune inflammatory rheumatic diseases. CsDMARDS have a low risk of infection; however, exposure to glucocorticoids seems to be an important predictor of infection. Therapy with bDMARDs is associated with a higher rate of severe infections compared to csDMARD.

Objectives: to determine the prevalence and identify the predictive factors of infection in patients with autoimmune inflammatory rheumatic diseases with the use of biological therapy.

Methods: cross-sectional study, files of patients with autoimmune inflammatory rheumatic diseases were analyzed. Descriptive statistics were performed with mean, standard deviation and binary logistic regression to determine predictive factors of infection. We used SPSS software v. 21 (IL).

Results: 54 patients were included, 37% diagnosed with RA, followed by SLE 15%, psoriasis arthritis 9%, ankylosing spondylitis in 7%, Sjögren’s syndrome 5.6%. Fifty nine percent used glucocorticoids. Of the bDMARD the most used was Rituximab 65%, abatacept 25%, tocilizumab 5%, adalimumab 4%, etanercept 2% and infliximab 2%. The mean time of use was 28.8 ± 21.1 months. 54% had infection, mainly genitourinary 30%, pneumonia 15%, others as skin or gastrointestinal were presented with lower frequency, out of all infections only 12% required hospitalization (serious adverse events).

Not over and predictive factors for infection were found with the use of bDMARD, but adding this variable increased the risk of infection by 5%, however the use of concomitant therapy with mycophenolic acid was the most predictive risk for the presence of infection with an OR = 9,143 (95% CI 1.055 - 79.26) p = 0.045.

Conclusion: the patients on bDMARD presented a significant percentage of infections, in this study it was not shown that the use of biological therapy was a predictive factor for the risk of infections, but with the concomitant use of mycophenolic acid appears to increase the risk.

REFERENCES


Disclosure of Interests: None declared


SAT0703-HPR

THE HEALTH INEQUALITIES ASSOCIATED WITH SEVERE MENTAL ILLNESS IN PEOPLE WITH RHEUMATOID ARTHRITIS

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Background: People with conditions such as schizophrenia, schizoaffective disorder, bipolar disorder, personality disorder and depression with psychosis are vulnerable and face a number of health inequalities,1,2 including poorer healthcare. This may explain why those with a severe mental illness (SMI) die younger.3 In arthritis, people with psychotic disorders who are over 65 are less likely to receive nonsteroidal anti-inflammatory drugs (NSAIDS) and disease-modifying anti-rheumatic drugs (DMARDS) than those without a psychotic disorder.4 However, little is known about the prevalence of these conditions or whether disease outcomes differ to those in the broader rheumatoid arthritis (RA) population.

Objectives: To establish the proportion of people with RA who are living with a SMI and whether fatigue, pain, function and disease activity differs to that of the general RA population.

Methods: The 2018 National Rheumatoid Arthritis Society (NRAS) ‘Emo-
tional Health and Well-being Matters’ survey was designed by people with RA and researchers. This included a questionnaire designed to cap-
ture self-reported co-morbidities and measures of fatigue and pain using a 100-point visual analogue scale, quality of life (using the shortened Arthritis Impact Measurement Scale5), functional disability (using the Health Assessment Questionnaire6) and patient-based disease activity.7 Participants were recruited by NRAS via their social media platforms, membership and non-membership lists and in newsletters and the NRAS HealthUnlocked forum. The survey was open from May-July 2018. Recruitment was focused on those diagnosed with RA aged 18 years or over and living in the UK.

Results: A total of 1565 people with RA completed the survey, 2% (n=29) of whom reported having a diagnosis of SMI, the most common being bipolar disorder (n=12). After adjusting for age and gender, those
with RA and a SMI experienced significantly greater levels of pain (p=0.04), functional disability (p=0.01), along with poorer disease activity (p=0.03) and poorer quality of life (p=0.03) than those with RA, but without SMI. There was however, no significant difference in the receipt of DMARDS or NSAIDS between the two groups (p=0.12).

**Conclusion:** Prevalence rates of SMI are no greater in RA than the general population. Those with RA and a SMI do however experience significantly poorer clinical outcomes than people with RA but without SMI despite being in receipt of similar medications. Further research is needed to explore why these health inequalities exist and how best to ensure more positive outcomes for this vulnerable population.

**REFERENCES**


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or inflammatory parameters (ESR, CRP). Patients on sick-leave had more tender joints median (min-max) 9 (2-18) vs. 4 (0-20) and 3 (0-10), p=0.013. Workers reported higher intensity of pain, though not significant. Retired patients fulfilled MVP criteria to a higher rate (86%) than workers (42%) or patients with sick-leave (40%), p=0.010. The qualitative content analysis resulted in three categories. Reasons to being physically active in patients with RA is important to facilitate and support the patients. Joint pain seems to be an issue for patients with sick-leave. This could be associated to fear of movement and in this aspect these patients need to be supported. Time could be a limiting issue for working patients, which need to be highlighted and solved for these patients.

Conclusion: Knowledge of reasons to being physically active in patients with RA is important to facilitate and support the patients. Joint pain seems to be an issue for patients with sick-leave. This could be associated to fear of movement and in this aspect these patients need to be supported. Time could be a limiting issue for working patients, which need to be highlighted and solved for these patients.

Disclosure of Interests: None declared

SAT0706-HPR

THE RELATIONSHIP BETWEEN SUBJECTIVE AND OBJECTIVE METHODS FOR MEASURING PHYSICAL ACTIVITY STATUS OF AXIAL SPONDYLOARTHRITIS PATIENTS: QUESTIONNAIRE VERSUS ACCELEROMETER

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Background: Physical activity is getting more attention for the appropriate management of both disease itself and co-morbid conditions in patients with axial spondyloarthritis (axSpA). Many different tools are available for determining physical activity status. Although subjective tool such as questionnaires are quick and easy for gathering data, objective tools such as accelerometers might provide more accurate information.

Objectives: To investigate the relationship between a subjective physical activity questionnaire (International Physical Activity Questionnaire Short Form: IPAQ) and an accelerometer (Actigraph wGT3X-BT) for measuring physical activity status of axSpA patients.

Methods: Thirty-nine patients with axSpA (age 37.9±11.3 years, body mass index 26.9±5.3 kg/m², disease activity: 3.3±2.3 according to Bath Ankylosing Spondylitis Disease Activity Index, functional status: 2.9±2.8 according to Bath Ankylosing Spondylitis Functional Activity Index, 24 male) according to ASAS criteria were included to assess the subjective and objective physical activity status by using the Turkish version of IPAQ and an accelerometer (Actigraph wGT3X-BT), respectively. The accelerometer was worn by the patients on their waists at their first visit and it provides information about the light, moderate, vigorous physical activity times in minutes. On the seventh day when the accelerometer was removed, patients were asked to complete the IPAQ. The IPAQ inquires the physical activity performed previous week in minutes and categorizes into three sections as vigorous, moderate activity, and walking. The walking section in IPAQ was accepted as equal to light physical activity in Actigraph. The relationship between measurements was determined by using Spearman’s Rank Correlation Coefficient.

Results: No significant correlations were determined between subjective and objective methods (p>0.05), except the time spent during moderate physical activity (rho: 0.457, p<0.05). It was also observed that IPAQ was underestimated the physical activity times for all types of physical activity (Table 1).

Abstract Table 1. The correlations between objective and subjective physical activity measurements

<table>
<thead>
<tr>
<th>Objective Measurement</th>
<th>Subjective Measurement</th>
<th>Spearman’s Correlation</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Light Physical Activity (min)</td>
<td>2270.26±1016.70</td>
<td>331.03±552.75</td>
<td>-0.037</td>
</tr>
<tr>
<td>Moderate Physical Activity (min)</td>
<td>243.97±167.9</td>
<td>90.26±241.39</td>
<td>0.457</td>
</tr>
<tr>
<td>Vigorous Physical Activity (min)</td>
<td>7.23±18.61</td>
<td>248.72±848.93</td>
<td>0.184</td>
</tr>
<tr>
<td>Total Physical Activity (min)</td>
<td>2521.46±1094.40</td>
<td>670.00±1183.30</td>
<td>0.271</td>
</tr>
</tbody>
</table>

*: Actigraph wGT3X-BT, **: IPAQ - International Physical Activity Questionnaire Short Form, p<0.05.

Conclusion: According to our results, IPAQ short version may not be an appropriate tool for determining physical activity status in axSpA patients. It seems that we need disease specific tools in axSpA.

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SAT0707-HPR

PATIENT AND CLINICIAN PERSPECTIVES USED FOR SURVEY DEVELOPMENT TO INVESTIGATE THE NATURE, EXTENT AND IMPACT OF FOOT PROBLEMS IN PEOPLE WITH PSORIATIC ARTHRITIS

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Background: Despite recognition that hallmark features of psoriatic arthriti (PsA), such as enthesitis, are predominant and persistent in the foot and ankle [1], limited research has focused on the foot. Few published studies have used RA-specific outcome measures unlikely to capture the dermatological impact in PsA and there has been little incorporation of the patient perspective [1]. The importance of patient and clinician involvement as a central component of research design has been identified in PsA [2, 3], and provides a basis for defining what should be measured to represent comprehensively the experience of people with PsA-related foot problems and important domains of impact.

Objectives: To develop a survey based on the views of people with PsA and clinicians on foot problems, their impact and the foot care needs.

Methods: Interviews of people with PsA-related foot problems and focus groups with clinicians on their understanding of the patient experience were undertaken in Sydney, Australia and Auckland. New Zealand. A representative sample from public and private sector, from lower and higher socioeconomic geographical areas, as well as clinicians with different professional backgrounds was sought. Based on the themes from the qualitative interviews, previous research [1, 3] and clinical experience, survey items were generated by the research team using a consensus based approach. The survey was pre-tested using a 4-stage method that comprised; cognitive de-briefing of people with PsA, expert review panels of subject and survey design experts, cultural sensitivity assessment and pilot testing. All focus groups and interviews were audio-record, transcribed verbatim and survey items were revised based on comments made.

Results: The final 60-item self-administered survey was developed based on feedback from each of the 4-stages, which related to wording, comprehension, timescales, content, repetition, number of survey items and overall survey design. Key survey domains included demographic (10%) and socioeconomic data (10%), global disease information (18%), foot and ankle characteristics (18%), and the impact of foot problems on daily