are monitored for serum uric acid less than twice per year. But 79% of patients claim to be satisfied with their current treatment and do not expect better management of their disease.

Conclusion: The results of the survey demonstrate that gout patients in Europe are diagnosed late, their disease is not well controlled and not regularly monitored. It seems that their doctors are not aware of the pain and impact of gout on their patients' quality of life as patients are not telling them about it. Nevertheless, most of the patients feel their current treatment is the best they can get. There is a clear need to educate patients and their doctors about adequate management of gout.

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OP0158-HPR THE BARRIERS AND FACILITATORS TO REQUESTING AND RECEIVING PSYCHOLOGICAL SUPPORT FOR PEOPLE WITH RHEUMATOID ARTHRITIS AND ADULTS WITH JUVENILE IDIOPATHIC ARTHRITIS

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Background: UK guidelines¹⁻³ state that psychological interventions should be offered to people with rheumatoid arthritis (RA) to help them adjust. Although rheumatology units recognise that providing psychological support is part of their role, 3 in 4 rate their overall provision as inadequate.⁴ The reasons being a lack of time, a lack of trained clinicians and available training and the costs of delivering this type of service. However, little is known about the barriers to requesting psychological support from the patient perspective.

Objectives: To establish the full range of barriers and facilitators to requesting psychological support.

Methods: The 2018 National Rheumatoid Arthritis Society (NRAS) 'Emotional Health and Well-being Matters' survey was designed by patients and researchers. This included a questionnaire designed to capture the barriers to accessing psychological support, using an established theoretical framework.⁵ The questionnaire consisted of 41 items covering a range of barriers, with responses on a 5-point Likert scale. Participants were recruited by NRAS via their social media platforms, membership and non-membership lists through direct mail and in newsletters and the NRAS HealthUnlocked forum. The survey was open from May-July 2018. Recruitment was those diagnosed with RA and AJIA, aged 18 years and over and living in the UK.

Results: A final sample of 1650 participants took part in the survey, 97% of the sample had RA and 3% AJIA. 1 in 5 people with RA and 1 in 10 with AJIA were unlikely or extremely unlikely to seek psychological or emotional support in the future, even if they felt they needed it. The most frequently reported barriers to requesting psychological support from their healthcare team were (i) lack of optimism about their future with RA or AJIA (ii) not knowing what support they can access (iii) finding it difficult to talk about their emotions and asking for help (iv) believing healthcare professionals lack the time and ability to help them (v) believing that discussing emotions and providing psychological support is not on their healthcare team's agenda, evidenced by a focus on physical rather than psychological health in consultations and (vi) never or rarely being asked about their emotions.

Conclusion: Exploring the potential barriers to requesting psychological support has given us unique insight into the complex journey of receiving psychological support. To overcome the most influential barriers steps need to be taken to encourage hope for the future, empower patients with RA and AJIA to talk about their emotions and instigate these discussions with their healthcare team, as well as providing more information and guidance about what support they can access and from where.

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OP0159 THE EFFECT OF HIGH-INTENSITY RESISTANCE TRAINING AND VITAMIN D SUPPLEMENTATION ON MUSCLE STRENGTH IN PATIENTS WITH KNEE OSTEOARTHRITIS: A RANDOMIZED CONTROLLED TRIAL

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Background: Exercise therapy is the cornerstone of knee osteoarthritis (OA) management. In particular muscle strengthening exercise, targeting the characteristic loss of muscle strength present in knee OA, is a key factor for the beneficial effects reported for exercise therapy. The optimal training intensity for resistance training in patients with knee OA, however, is not known to date. Besides resistance training, vitamin D supplementation in patients with vitamin deficiency may optimize muscle strength.

Objectives: To assess (i) whether high-intensity resistance training leads to greater improvements in muscle strength compared to moderate-intensity resistance training in patients with knee OA; and (ii) whether vitamin D supplementation in combination with strength training leads to greater improvements in muscle strength compared to placebo in combination with strength training in patients with knee OA and vitamin D deficiency (25 (OH)D level > 15 nmol/L and < 50 nmol/L (in winter) or < 70 nmol/L (in summer)).

Methods: In a randomized controlled trial, 177 patients with a clinical diagnosis of knee OA were included. All patients were randomly allocated to a high-intensity (70-80% of the Repetition Maximum (1RM)) or a moderate-intensity (40-50% of the 1RM) resistance training program of 12 weeks. Both groups were supervised by a physical therapist twice a week and performed home exercises once a week. In addition, 50 out of 177 patients had vitamin D deficiency and received supplementation of vitamin D (1200 IU vitamin D3 per day) or placebo in the 12 weeks prior to and during the resistance training program. The primary outcome measure was isokinetic (60 °/s) upper leg muscle strength (Nm/kg). In addition, the estimated 1 RM for leg press, leg curl and hip abduction were used as measures for muscle strength. Other outcome measures included severity of knee pain (NRS), self-reported and performance based activity limitations (WOMAC physical functioning (WOMAC), Get-up-and-go-test (GUG)). Measurements were performed by a blinded assessor prior to the exercise program (T0), directly after the program (T12) and at 6 months follow-up (T36). Additionally, for patients with vitamin D deficiency, measurements were also taken prior to vitamin supplementation or placebo (T-12).

Results: Both the high-intensity group and moderate-intensity group improved in upper leg muscle strength over time. No significant differences between groups were found for isokinetic upper leg muscle strength ($p = 0.646$) (see figure 1). However, when measured by the estimated 1 RM, significant differences were found between groups in favor of the high-intensity group ($p = 0.001$) (see figure 1). No between-group differences were found on pain ($p = 0.885$), or on self-reported and performance-based activity limitations (WOMAC $p = 0.968$; GUG $p = 0.800$), although both groups improved (see figure 1). An unexpected finding was that, in the (small sample of) patients with vitamin D deficiency, the placebo group showed significant greater isokinetic upper leg muscle strength over time compared to the vitamin D group ($p = 0.001$).

Conclusion: No differences between groups were found for isokinetic upper leg muscle strength. With the estimated 1 RM as a measure of muscle strength, high-