Conclusion: Patients following Open-Access welcome the flexibility and involvement in disease control. However, patients need relevant information to be able to act adequately to the new patient role. Interacting with both rheumatologists and nurses, combined with sufficient time for dialogue, broaden patients' perspective, make opportunities for action visible, and contribute to patient's ability to participate in the managing of their own condition.

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THU0708-HPR CORRELATIONS BETWEEN FATIGUE AND PATIENT REPORTED OUTCOME IN PEOPLE WITH INFLAMMATORY ARTHRITIS

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Background: Fatigue is one of the most common symptoms of people with inflammatory arthritis (IA) and often rated as high as or higher than pain. However, it remains unexplored how fatigue is associated with patient related outcomes (PRO) such as work impairment, quality of life, sleep, depression, physical functioning and pain.

Objectives: To explore fatigue and to analyze possible correlations between fatigue and PROs in people with rheumatoid arthritis (RA), psoriatic arthritis (PsA) and axial spondyloarthritis (axSpA).

Methods: A cross-sectional study. People ≥ 18 years with a confirmed diagnosis of RA, PsA or axSpA were consecutively recruited for the study over a 6-month period via routine visits to outpatient rheumatology clinics in two hospitals departments. Trained study nurses collected information on informed consent, diagnosis, medical treatment and disease activity status. Fatigue was evaluated by a self-completed questionnaire using the FACIT-Fatigue sub-scale. The questionnaire also included the following PRO scales: Work Productivity and Activity Impairment scale (WPAI), EuroQol (EQ-5D), Medical Outcomes Study Sleep Scale (MOS), Major Depression Inventory (MDI), and Health Assessment Questionnaire (HAQ) on quality of life and pain. Data was analyzed in SAS. Correlations were assessed by a) Pearson correlation coefficients and b) raw and adjusted linear regressions.

Results: In total 633 persons were invited and 487 (77%) (mean age=53.5, SD 14.5) were included (62% women). The mean fatigue score (range 0-52; lower = more fatigued) was 34.3 (SD 11.1) and there was no statistically significant difference between mean fatigue in the three diagnostic groups ($p=0.08$). Altogether 61% expressed that they were suffering from fatigue (i.e. had a FACIT-Fatigue sub-scale ≤ 39). Women generally had a lower overall fatigue score (mean=33.3, SD 11.1) than men (mean=36.0, SD 11.0). Fatigue did not differ between age groups ($p=0.33$). Those who had changed medical treatment within 0-12 months (21.1%) suffered more from fatigue than those with unchanged treatment (mean=30.1, SD 11.7 vs. mean=35.4, SD 10.7, $p<0.0001$). The average disease activity as indicated by DAS28, BASDAI and BASFI showed low disease activity in the cohort. Current medical treatment (csDMARDs and/or bDMARDs or none) was not associated with severity of fatigue ($p=0.85$). Fatigue correlated with all PROs (Pearson correlation coefficients, all p -values <0.0001) (Table 1). Increased work impairment, sleep problems, depression, and pain were all associated with increased fatigue, whereas decreased quality of life and physical functioning were associated with increased fatigue (raw and adjusted linear regressions). The associations did not change significantly after additional adjustment

for socioeconomic factors. Analyses stratified on type of disease did not differ significantly from the primary non-stratified analysis.

Table 1. Pearson correlations between fatigue (measured by FACIT-F) and PROs

	Pearson correlation coefficient	p-value	N
Work impairment (WPAI)	-0.6359	<0.0001	280
QoL (EQ-5D)	0.7010	<0.0001	487
Sleep (MOS sleep scale)	0.7009	<0.0001	481
Depression (MDI)	-0.7502	<0.0001	483
Physical Functioning (HAQ)	-0.3789	<0.0001	483
Pain (VA)	-0.6118	<0.0001	482

Note: Pearson correlation coefficients range from -1 to 1. A Pearson correlation coefficient of more than 0.80 or less than -0.80 indicates a strong correlation, a coefficient of 0.40 to 0.80 or -0.40 to -0.80 indicates a moderate correlation, and a coefficient below 0.40 or more than -0.40 indicates a weak correlation

Conclusion: Despite the study cohort represents a stable group with low disease activity, fatigue was a frequently expressed symptom across diagnoses. There was a significant correlation between fatigue and the other PROs why fatigue cannot be seen as a single problem, but rather a symptom that broadly affects people living with inflammatory arthritis.

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THU0709-HPR PERSONS WITH POLYMYOSITIS AND DERMATOMYOSITIS EXPERIENCE REDUCED WORK ABILITY AND QUALITY OF LIFE

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Background: A recent study have described that persons with Polymyositis (PM) and Dermatomyositis (DM) experience reduced work ability (1). Information about whether the reduced work ability affect quality of life is lacking.

Objectives: To describe self-rated work ability with two different assessment and quality of life in persons with PM and DM. To investigate correlations between self-rated work ability and quality of life

Methods: Participants were identified through the Swedish Myositis Network registry (SweMyoNet). Of 78 possible participants, 48 agreed to participate in this study. The median (IQR) age were 57 (45-61) years with a median disease duration of 6 (2-14) years. Fifty-three percent of the participants were women. Seventy-seven percent were working, and the remaining were on sick-leave.

Self-rated work ability was measured by the questionnaire Work Ability Index (WAI) and the Work Ability Score (WAS) which is a single item question. Quality of life by the SF-36.

Results: Self-rated work ability measured by WAI in persons with PM and DM varied between poor work ability and good work ability. The median value of the group was 34 which indicates less good work ability.

Self-rated work ability measured by WAS varied between poor work ability and good work ability. The median of the total group indicates less good work ability.

There was a strong correlation between self-rated work ability measured by WAI and WAS (r_s 0,879 $p=0,01$).

Quality of life measured by SF-36 were rated lower in persons with PM and DM when compared to the general population in dimensions; Physical Function, Role-Physical, General Health, Vitality and Social function ($p\leq 0.02$).

There were moderate to high correlations between self-rated work ability measured by both WAI and WAS, and all dimensions of SF-36 ($p<0.01$)

Conclusion: Persons with PM and DM self-rated their work ability as poor and the quality of life were significantly reduced when compared to the general population. The measures WAI and WAS correlates highly with each other and revealed comparable results indicating that WAS may work as well as WAI as a screening tool to identify reduced work ability. The WAS may also be more feasible with just one single question to use in clinical practice. Our results indicate the importance to measure self-rated work ability in persons with PM and DM in clinical practice.