Table 1. Laboratory results of the FMF and the control group

Variables	FMF patients (n=54)	Control (n=28)	P value
Omentin, pg/mL	108.05(19.97-343.22)	199.5(42.98-339.41)	0.03
SAA, ng/mL	3.7 (1.18-22.75)	1.31(0.95-3.16)	<0.001
ESR, mm/h	15(2-68)	12(7-17)	<0.001
CRP, mg/L	12(1-194)	2.5(1-8)	<0.001

Variables were given as median (IQR).

Calculated using Mann-Whitney U test for non-normal distribution.

FMF=Familial Mediterranean fever, SAA=serum amyloid A, ESR=erythrocyte sedimentation rate, CRP=C-reactive protein, IQR=interquartile range.

Table 2. Laboratory results of FMF patients with and without colchicine resistance

Variables	With resistance (n=16)	Without resistance (n=38)	P value
Omentin, pg/mL	76.64(19.77-224.33)	186.47(28.41-343.21)	0.006
SAA, ng/mL	3.69(1.18-22.75)	3.77(1.18-21.49)	0.784
ESR, mm/h	25.5(2-68)	15(2-60)	0.835
CRP, mg/L	11(1-67)	19(1-194)	0.111

Variables were given as median (IQR).

Calculated using Mann-Whitney U test for non-normal distribution.

FMF=Familial Mediterranean fever, SAA=serum amyloid A, ESR=erythrocyte sedimentation rate, CRP=C-reactive protein, IQR=interquartile range.FOM

Conclusion: FMF patients with colchicine resistance are associated with decreased omentin concentrations, probably mediated by inflammation-driven mechanisms.

References:

- [1] Yue J, Chen J, Wu Q, Liu X, Li M, Li Z, Gao Y. Serum levels of omentin-1 association with early diagnosis, lesion volume and severity of acute ischemic stroke. *Cytokine*. 2018;111:518–522.

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SAT0514 FATIGUE IN FAMILIAL MEDITERRANEAN FEVER

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Background: Fatigue is an important and common symptom in rheumatologic diseases. It causes disability and worsens patients quality of life. Familial Mediterranean Fever (FMF) is a hereditary autoinflammatory disease characterized by recurrent episodes of fever and serositis. Mutations in the MEFV gene that encodes pyrin protein are responsible for the disease. Most frequent mutation is M694V and FMF patients with M694V/M694V genotype have more severe disease.

Objectives: The aim of this study is to investigate fatigue and its impact on quality of life of FMF patients who are attack-free for more than one year.

Methods: Seventy-seven FMF patients and 70 age and sex matched healthy controls were enrolled in the study. Fatigue severity scale (FSS) was used to evaluate fatigue level. Disease severity was evaluated via FMF disease severity score. Short form-36 (SF-36) was used to evaluate the quality of life of the participants and Beck depression inventory (BDI) was used to evaluate depression.

Results: No statistically significant difference was found when FMF group and healthy controls were compared for demographic variables and laboratory markers (complete blood count, erythrocyte sedimentation rate, c-reactive protein levels, liver and kidney function tests). All of the subscale scores of SF-36 were lower in FMF group when compared with the control group. BDI and FSS scores were higher in the FMF group.(Table 1)

Table 2. Correlation of fatigue, depression, disease severity and duration with quality of life in FMF patients

	Physical functioning	Social functioning	Role Physical	Role emotional	Mental health	Vitality	Pain	General health
FMF disease severity scale	r= -0,223	r= -0,319**	r= -0,313**	r= -0,184	r= -0,124	r= -0,188	r= -0,191	r= -0,351**
Beck Depression Inventory	r= -0,418**	r= -0,554**	r= -0,461**	r= -0,470**	r= -0,660**	r= -0,594**	r= -0,308**	r= -0,576**
Fatigue severity scale	r= -0,391**	r= -0,426**	r= -0,475**	r= -0,324**	r= -0,650**	r= -0,739**	r= -0,410**	r= -0,521**
Disease duration	r= -0,40**	r= -0,218	r= -0,232*	r= -0,287*	r= -0,026	r= -0,211	r= -0,189	r= -0,109

** p<0.01

*P<0.05

Table 1. Comparison of FMF and control groups for fatigue, depression and quality of life

	FMF group (n: 77) median(min-max)	Control group (n: 70) Median (min-max)	p
Fatigue severity scale (FSS)	31(27-47)	28 (24-37)	p<0.05
Beck depression inventory (BDI)	15 (0-35)	12 (0-19)	p<0.05
SF-36 Physical functioning	80.00(25.00-100.00)	95.00 (50.00-100.00)	p<0.01
SF-36 Social functioning	55.50 (40.00-88.80)	77.70 (22.20-88.80)	p<0.01
SF-36 Role physical	25.00 (0.00-100.00)	100.00 (0.00-100.00)	p<0.01
SF-36 Role emotional	33.30 (0.00-100.00)	100.00 (0.00-100.00)	p<0.01
SF-36 Mental health	56.00 (24.00-88.00)	72.00 (24.00-100.00)	p<0.01
SF-36 Pain	55.50 (0.00-100.00)	77.70 (33.30-100.00)	p<0.01
SF-36 Vitality	45.00 (15.00-95.00)	65.00 (5.00-100.00)	p<0.01
Sf-36 General health	40.00 (5.00-92.00)	67.00 (20.00-100.00)	p<0.01

Twenty-three of FMF patients had M694V/M694V genotype and those patients had higher disease severity scores (p<0.01), higher FSS (p<0.01) and higher BDI scores (p<0.05) when compared with other FMF patients. Regarding the quality of life, patients with M694V/M694V genotype had lower scores in social functioning, role physical, role emotional and pain subscales of SF-36. In the correlation analysis depression and fatigue were found to be the major determinants of quality of life in FMF. Disease severity or duration were not strongly correlated with the SF-36 scores (Table 2).

Conclusion: Despite being attack-free for more than one year, FMF patients had poor quality of life and fatigue when compared with the healthy controls. The quality of life in FMF patients, whose attacks are well controlled, is mainly determined by fatigue and depression rather than disease severity.

References:

- [1] Duruoz MT, Unal C, Karaali Bingul D, Ulutatar F. Fatigue in Familial Mediterranean fever and its relations with other clinical parameters. *Rheum Int* 2018;38:75-81.

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SAT0515 COMPLEX HYPERMOBILITY EHLERS-DANLOS SYNDROME (HEDS): MAPPING THE PATIENT'S JOURNEY OVER 40 MONTHS IN A TERTIARY REFERRAL CENTRE

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Background: Ehlers-Danlos Syndromes are heritable connective tissue disorders. They are multisystemic and patients can present with several symptoms such as joint pain and instability, visceral and autonomic dysfunction, as well as significant psychosocial sequelae. Managing this cohort of young patients is usually challenging as many patients present late due to delayed diagnosis, often with several complications, problems with mobility and opioid use. Furthermore, there is often a prolonged lack of coordinated healthcare and access to social care services. A recent parliamentary debate in the U.K. highlighted that hEDS services are excluded from specialist Rheumatology commissioning services. In order to ascertain the relevance and utility of specialist services in this population, we conducted this study.

Objectives: The objective of this study was to map the patient experience following a referral to the specialist clinic in order to assess the need for an integrated, multidisciplinary approach to treating patients with hypermobility EDS.

Methods: We retrospectively reviewed the records of 50 patients with the diagnosis of hypermobility EDS who were seen in a specialist hypermobility clinic at University College Hospital UCLH between January 2016 and March 2016. Relevant data was collected regarding their medical care in our hospital up to October 2019.

Results: The median age was 37 (range 21-59). We had 10 males and 40 females. The diagnosis of hypermobility EDS was based on the 1997 criteria as these patients were seen prior to the 2017 classification. Overall, the study yielded 6 key themes: 1. All patients experienced chronic pain, with 36% reporting use of opioids for pain management. 2. Patients were referred to multiple