Figure 2. IPAQ level

1-low physical activity, not reaching health-enhancing levels of physical activity (HEPA), 2-moderate physical activity, reaching HEPA, 3-high physical activity, surpasses HEPA

to record information regarding their use of glucocorticoids during the "last 7 days" and during the "last 6 months." We retrieved 132 questionnaires (of whom 6 were discarded as incomplete). All data was analyzed using SPSS Statistics v22. **Results:** Of the 126 patients (mean age 74.9 ± 7.7 years), 59% were female. The mean duration of disease was 22.5 ± 19.1 months in patients with GCA and 32.9 ± 29.9 months in those with GCA and polymyalgia rheumatica (PMR). The mean daily number of medications taken was 9.2 ± 5.2 (range: 1 - 30); the mean number of types of daily tablets taken was 5.0 ± 2.1 (range: 1 - 10). The mean daily number of glucocorticoid tablets taken was 3.2 ± 2.6 (range: 0 - 12), with a mean daily dose of 11.1 ± 10.3 mg (range: 0 - 60 mg). Overall, in the last 7 days, 22% and in last 6 months, 40% of patients were not following their original recommended steroid regimens (Table 1). The total mean glucocorticoid dose in the "last 7 days" group ($n=81$) was 77.8 ± 70.1 mg/week (11.1 ± 10.1 mg/day) whilst the total mean glucocorticoid dose in the "last 6 month" group ($n=45$) was 1782.0 ± 1543.3 mg/6 month (9.9 ± 8.6 mg/day). Most respondents stated their glucocorticoid non-adherence was due to medical advice; other reasons included forgetting, fear of side effects, or confusion about different preparations of prescribed glucocorticoids. The presence of PMR did not influence glucocorticoid adherence.

Table 1. Glucocorticoid used compared to original regimen in GCA

	Last 7 days (%)	Last 6 months (%)
Higher than prescribed	16	22
Lower than prescribed	6	18
Same as prescribed	78	60

Conclusion: There is significant variation in the use of glucocorticoids compared to the original starting regimen in patients with GCA, with or without PMR. However, the amount of the discrepancy is small. The commonest reason for non-adherence was medical advice received from either primary or secondary care.

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Disclosure of Interests: HAIRUL HADI ARIFF: None declared, Abid Awisat: None declared, JACK ARNOLD: None declared, Hudaifa Al Ani: None declared, Lorraine O'Neill: None declared, Mar Pujades Rodriguez: None declared, Raashid Luqmani Grant/research support from: Arthritis UK, the Medical Research Council, the University of California San Francisco/Oxford Invention Fund, the Canadian Institutes of Health Research, The Vasculitis Foundation, GSK, Consultant of: GSK, Medpace, MedImmune, Roche

DOI: 10.1136/annrheumdis-2020-eular.283

SAT0620-HPR INACTIVITY BEHAVIOR AND EXERCISE BARRIERS IN PATIENTS WITH BEHÇET'S DISEASE

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Background: Behçet's Disease (BD) is a chronic, inflammatory, rheumatic disease that is characterized by mucocutaneous lesions and can be seen major organ involvement such as eyes, musculoskeletal system, gastrointestinal system and central nervous system. Impaired quality of life, aerobic capacity, respiratory function and life satisfaction, sleep disorders, depression, anxiety and fatigue are seen commonly in BD patients like the other rheumatic diseases. Considering that regular physical activity effects survival for patients and healthy people, it is important to determine the factors affecting physical activity level and exercise barriers.

Objectives: The aim of this study is to investigate physical activity level and exercise barriers in patients with BD.

Methods: 45 patients were included in the study. Physical activity level, exercise barriers, fatigue, depression, pain, quality of life and aerobic capacity were evaluated with International Physical Activity Questionnaire (IPAQ), Exercise Barriers and Benefits Scale (EBBS), Fatigue Severity Scale (FSS), Beck Depression Inventory (BDI), Visual Analog Scale (VAS), Behçet's Disease Quality of Life Questionnaire (BDQoL) and 6 minutes walk test, respectively. Spearman's Correlation Coefficient were used to investigate the relationships between exercise barriers and other parameters.

Results: IPAQ demonstrated that 22 (48.8%) of the patients had low level physical activity. Additionally, physical activity levels significantly correlated with both exercise barriers ($\rho = -0.345$) and exercise benefits ($\rho = 0.320$) ($p < 0.05$). BDQoL scores also correlated significantly with exercise barrier scores ($\rho = 0.338$), ($p < 0.05$). No significant relationships were observed for other parameters.

Conclusion: Exercise and physical activity are of great importance because of its positive contribution to the musculoskeletal system for BD patients' rehabilitation. Thinking of negative effects of physical inactivity, patients with Behçet disease should be encouraged to exercise. Also, reasons of physical inactivity should be investigated and treated.

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.3573

SAT0621-HPR EVALUATION OF THE SOCIAL IMPACT OF THE DISEASE IN PATIENTS WITH RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, AND SYSTEMIC LUPUS ERYTHEMATOSUS.

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Background:

Objectives: To describe the impact of the disease on patients with rheumatoid arthritis (RA), systemic lupus erythematosus (SLE) or ankylosing spondylitis (EA) on the social health of people who suffer from it.

Methods: Cross section of a consecutive sampling of patients with AS, RA or SLE. Selection criteria: age ≥ 18 years with AS (ASAS criteria), AR (EULAR / ACR 2010 criteria) and SLE (ACR-EULAR criteria) able to understand and willing to perform the questionnaires. Protocol: All patients who attended a consultation between October and December 2019 were offered to participate in the study. After their approval and verification of the inclusion criteria, they conducted a battery of PROMIS platform questionnaires focused on assessing their social health. Likewise, data on their disease, comorbidities and socio-labor profile were collected. All participants signed an informed consent and the study was approved by the CEIC of the referral hospital.

Main outcomes: The variables collected by the questionnaires evaluate social health in several areas: mobility, depression, satisfaction with social relationships, social isolation, company, ability to participate in social activities, emotional support, instrumental support and support through information. Statistical analysis: Descriptive, bivariate analysis using t-student, ANOVA and χ^2 , followed by multivariate linear regression (RLM) (Vd: ability to participate in continuous social activities 7-35).

Results: 151 patients participated: 50 with RA (90% women, mean age 55.12 ± 13.64 years), 51 with AS (51% women, 52.59 ± 12.15 years) and 50 patients with SLE (96% women, mean age 47.14 ± 11.3 years). The most frequent comorbidities were: arthritis, visual impairment, anxiety and depression (table 1). These results present a greater tendency to depression and anxiety patients of SLE. No significant differences were observed in most of the social questionnaires analyzed between groups (table 2), except in a worse mobility in patients with RA and AD compared to SLE ($p = 0.017$). About half of the patients in all groups had depression (43%) and reduced mobility (63.6%). All groups are satisfied with their social role 128 (85.3%), have the capacity to participate in social activities 140 (94%) and feel accompanied 147 (97.4%). On the contrary, the social isolation figure is 42 (28%). Social isolation implies an affectation of the serious social role in patients who claim to be accompanied, so it is not secondary to loneliness or lack of family support.

In the multivariate analysis it was observed that the independent variables that were associated with the ability to participate in social activities were satisfaction with social relations ($\beta = 0.349$ [$p < 0.001$]), mobility ($\beta = 0.309$ [$p < 0.001$]), depression ($\beta = -0.186$ [$p < 0.011$]) and social isolation ($\beta = -0.195$ [$p = 0.001$]). This model would explain 32% of the variability in the ability to participate in social activities. ($R^2 = 0.32$).

Conclusion: The predictors of the ability to participate in social activities in patients with RA, AD and SLE were: depression, mobility deficit, social isolation and satisfaction with social activities. Patients with RA, AD and SLE present similar data, so there are no differences due to pathologies in the social role, highlighting that they have a good social support and despite this there is social isolation being able to be associated with the deficit in mobility and high rates of depression.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.845

SAT0622-HPR SAFETY IN PATIENTS WITH RHEUMATOID ARTHRITIS IN BIOLOGICAL TREATMENT OVER 65 YEARS OF AGE

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Background: A bias has been described with the lowest prescription of biologic treatments (bDMARD) in patients with rheumatoid arthritis (RA) in the elderly, despite presenting activity rates comparable to young population and higher risk of functional disability. This could be due to concerns about co-morbidities and polypharmacy.

Objectives: 1) To define the characteristics of patients with RA ≥ 65 years and bDMARD to follow up in the Day Hospital of University Assistance Complex of León during the last year. 2) To record the incidence rate (IT) and ratio of incidence rates (RDI) of infections, neoplasms and cardiovascular events (CD) during the course of your therapy.

Methods: Observational, retrospective study of patients diagnosed with RA according to ACR 1987 and/or ACR 2010 criteria in intravenous biological treatment during 2019 with ≥ 65 .

Results: 40 patients with an average age at diagnosis of 55.9 ± 15.76 years were included, 67.5% of them were women. The average duration of the disease was 17.65 ± 13.15 years. 40% had a history of smoking, 35% hypertension, 20% dyslipemia and 20% diabetes mellitus. A 97.5% were positive FRRA, 57% positive ACPA, 37.5% nodular and 65% erosive. As for pre-treatment, 70% had been with conventional (cDMARD) $\geq$ bDMARD (Methotrexate (MTX) (92.5%) and Leflunomide (60%)). The mean dose of prednisone was 8.79 ± 10.14 mg/day. The incidence rate of infections was 1.5%, and neoplasms and CD were 0.75% per person-years. The age at the beginning of the first bDMARD was 67.45 ± 8 years, the second ($n=20$) 67.98 ± 6.64 and the third ($n=7$) 71.79 ± 7.49 . The first biological was a 52.5% anti-TNF, 5% anti-CTLA4, 30% anti-CD20 and 12.5% antiIL6 (25% monotherapy and combined with MTX 57.5%). The second was 30% anti-TNF, 25% antiCTLA4, 15% antiIL6 and 30% antiCD20 (50% in monotherapy and 40% methotrexate); with the third anti-TNF 42.85%, antiCTLA4 14.29%, antiIL6 14.29% and antiCD20 28.57% (42.86% in monotherapy and 42.46 with methotrexate). The mean doses of prednisone were 6.08 ± 6.82 , 4.38 ± 7.21 and 6.95 ± 5.94 mg/day respectively. The IT of bDMARD infections were 8.81%, 19.81% and 7.4% person-years; of neoplasia 1.04%, 0 and 0; and EC 3.63%, 0 and 1.85 person-years. The RTIs with first, second and third biological infections were: 5.88, 13.25, 4.95; with neoplasms 1.38; with EC 1.38, 0 and 0.69. The mean total accumulated corticosteroid dose was 17.69 ± 15.01 mg/day.

Conclusion: 1) Patients over 65 years old receiving bDMARD in our Day Hospital in 2019 were long-standing RA with aggression data, who had not responded to ≥ 2 cDMARD and required medium-high doses of prednisone.

2) In our sample there is a link between incidence of infection and the introduction of biological therapy, which is maintained with the increasing age of our

patients, and it is not so clear with neoplasms and CD. These data are consistent with the existing literature^{1,2,3}.

3) Larger, comparative studies with RA under 65 years are needed, but it is reasonable to conclude that if bDMARD is required, elderly patients could be a high-risk group for infections, requiring special monitoring and follow-up.

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.5260

SAT0623-HPR THE LIVED EXPERIENCES OF COGNITIVE DYSFUNCTION IN ADULTS WITH FIBROMYALGIA: A QUALITATIVE SYSTEMATIC REVIEW

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Background: Adults with fibromyalgia frequently report symptoms of cognitive dysfunction, often referred to as fibrofog. However primary research exploring cognitive dysfunction in the lives of adults with fibromyalgia is very limited (Kravitz and Katz, 2015).

Objectives: The aim of this review was to (i) synthesise the qualitative literature on the lived experiences of cognitive dysfunction in adults with fibromyalgia, (ii) develop common themes through thematic analysis and (iii) identify knowledge gaps to inform future research and clinical practice in this area.

Methods: Seven electronic databases (MEDLINE, Embase, CINAHL, PsycINFO, Amed, Scopus and OpenGrey), reference lists of key articles and two high impact qualitative journals were searched from 1990 to November 2018. Articles were eligible for inclusion if they reported primary qualitative data exploring the experiences of cognitive dysfunction in adults with fibromyalgia. Included studies were appraised using the Critical Appraisal Skills Programme (CASP) qualitative checklist and extracted data analysed using narrative synthesis. SD conducted critical appraisal and data extraction on all included studies. FC, JL and ED reviewed five papers each. All papers were reviewed by two co-authors. Of the 1413 records identified, 15 studies were selected for inclusion.

Results: These studies included 208 women and 22 men with fibromyalgia, aged 18 to 72 years and representing seven different countries. Duration of diagnosis was four months to 34 years. Fourteen studies used interviews and one used focus groups. None of the included studies focussed exclusively on cognitive function in adults with fibromyalgia. Three studies identified themes specific to cognitive dysfunction and fibromyalgia symptoms. The remaining 12 studies presented relevant data intertwined with the overall lived experiences of fibromyalgia.

Cognitive dysfunction, as a part of fibromyalgia, was often unpredictable. Problems with memory and concentration that were most commonly reported were emotionally distressing and affected functional and vocational activities. Participants found communication effortful, with a negative impact on work, leisure and social activities. Stress, fear and worry around perceived cognitive changes were commonly expressed. Lost employment or changed work roles and relationships, due to cognitive difficulties, had negative impacts for many participants. The terms cognitive dysfunction and fibrofog were used interchangeably within the studies, but lacked common definition. This introduced uncertainty around whether participants and authors were describing the same phenomenon.

Conclusion: Adults with fibromyalgia experience unpredictable and emotionally impactful difficulties related to cognitive dysfunction. Functional impact was broad-reaching, particularly around work ability and lost employment opportunities. It is unclear how cognitive symptoms in fibromyalgia related to co-morbid symptoms such as pain, fatigue and poor sleep. Further research focusing on the full impact of cognitive function on the lives of adults with fibromyalgia is recommended to inform clinical practice. Research to establish clarity of definition of the terms cognitive dysfunction and fibrofog within fibromyalgia is highly recommended.

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