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.

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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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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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