SAT0626-HPR

EXPLORING THE RELATION BETWEEN PAIN AND ACTIVITY AND PARTICIPATION BASED ON ICF IN CHILDREN AND ADOLESCENTS WITH JUVENIL IDIOPATIK ARTRIT: A PILOT STUDY

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Background: Functional limitation and inactivation are the most important problems in children with Juvenil Idiopatik Artrit (JIA).

Objectives: The aim of this study was to link and allocate items of Childhood Health Assessment Questionnaire (CHAQ) with activity and participation based on International Classification of Functioning, Disability and Health (ICF). The other aim was to examine the relationship between the pain and activity and participation determined on the basis of CHAQ with Juvenil Idiopatik Artrit (JIA).

Methods: Thirty-seven children and adolescents (26 girls, 11 boys, mean age=11.75±4.04 years) were included. The mean BMI of the participants was 19.61±4.52 kg / cm². Inclusion criteria: To be diagnosed with JIA according to ILAR classification. Being in the 6-18 age range. To be stable in drug use for at least 3 months or longer. Exclusion criteria: The presence of another disease. Intraarticular steroid injection or surgery in any joint in last 3 months. Evaluations were made by the same pediatric rheumatologist and physiotherapist (PT) by face to face interview method. Pain was evaluated by use of Numeric Rating Scale (NRS) (0=no, 10=worst) and disability by CHAQ. As CHAQ score increases, disability increases. CHAQ has 8 categories. The highest score for any question determines the score for that category. The items of CHAQ were linked with ICF codes and allocated with the ICF components by three PT. Original scoring of CHAQ allocated to ICF components was used in order to calculate scores of activity and participation in accordance with clinical data for 37 JIA. The 20th item in the "Reach" category is not included in the calculation as it contains the body function component of ICF. The data was analyzed using Pearson's correlation coefficient.

Results: Mean score of NRS was 3.52±2.34. Mean activity and participation score of CHAQ was 0.51±0.58, 0.70±1.10, respectively. Based on expert distinction, activity and participation categories of ICF were covered 24 and 5 items of CHAQ, respectively. Pain had moderate correlation with activity (r=0.595; p=0.002) and participation (r=0.604; p=0.001) for CHAQ. Activity had high correlation with participation (r=0.702; p=0.000).

Conclusion: Pain in children and adolescents with JIA is an important parameter affecting activity and participation. Pain should be evaluated in all aspects due to the limitation of both activity and participation. CHAQ largely contains the activity component of ICF. The development of new questionnaire is needed to assess the participation of JIA children and adolescents in more detail.

References:

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Table 1. Linking and allocating items of CHAQ

Items	ICF Code	ICF Component
DRESSING & GROOMING Dress, including tying shoelaces and doing buttons?	d5402	A
Shampoo his/her hair?	d5100	A
Remove socks?	d5403	A
Cut fingernails?	d520	A
ARISING Stand up from a low chair or floor?	d4103	A
Get in and out of bed or stand up in crib?	d4100	A
EATING Cut his /her own meat?	d550	A
Lift a cup or glass to mouth?	d4402	A
Open a new cereal box?	d440	A
WALKING Walk outdoors on flat ground?	d450	A
Climb up five steps?	d4551	A
HYGIENE Wash and dry entire body?	d510	A
Take a tub bath?	d4410	A
Get on and off the toilet or potty chair?	d4103	A
Brush teeth?	d5201	A
Comb/brush hair?	d5202	A
REACH Reach and get down a heavy object from just above his/her head?	d4452	A
Bend down to pick up clothing or a piece of paper from the floor?	d4105	A
Pull on a sweater over his/her head?	d5400	A
Turn neck to look back over shoulder?	b7101	Body Function
GRIP Write or scribble with pen or pencil?	d170	A
Open car doors?	d4450	A
Open jars which have been previously opened?	d4453	A
Turn faucets on and off?	d4402	A

Table 1. Linking and allocating items of CHAQ

Items	ICF Code	ICF Component
Push open a door when he/she to turn a door knob?	d4453	A
ACTIVITIES Run errands and shop?	d6200	P
Get in and out of car or toy car or school?	d4702	P
Ride bike or tricycle?	d4750	P
Do household chores	d6402	P
Run and play?	d9201	P

A:Activity, P:Participation

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SAT0627-HPR

SEXUAL QUALITY OF LIFE IN 39 FEMALE PATIENTS WITH IDIOPATHIC INFLAMMATORY MYOPATHIES

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Background: Symptoms related to idiopathic inflammatory myopathies (IIM) such as weakness of skeletal muscles, pulmonary and articular involvement may have a negative impact on all aspects of life including sexual life.

Objectives: To assess sexual functioning in female IIM patients compared to age-/sex-matched healthy controls (HC) and to analyze the potential impact of clinical features on sexual health.

Methods: In total, 39 women (29 currently have a partner) with IIM [mean age: 54.7, disease duration: 11.8 years, dermatomyositis (DM, 19)/ polymyositis (PM, 16)/ necrotizing myopathy (IMNM, 3)/ inclusion body myositis (IBM, 1)] and 39 healthy controls (30 currently have a partner, mean age: 54.7 years) without rheumatic diseases filled in 11 well-established and validated questionnaires assessing sexual function (FSFI, SFQ28, BISFW), quality of sexual life (SQoL-F), pelvic floor function (PISQ-12, PFIQ-7), fatigue (FIS, MAF), physical activity (HAP), and depression (BDI-II). A standard laboratory testing was performed. Data are presented as mean ± SEM.

Results: Patients with IIM reported significantly higher prevalence and greater severity of sexual dysfunction (FSFI, BISFW, SFQ28) and worse sexual quality of life (SQoL-F) compared to HC (table 1). Worse scores in IIM patients were associated with increased inflammation [CRP: FSFI (r=-0.378, p=0.0190), SFQ-28 Satisfaction domain (r=-0.346, p=0.0356), SQoL-F (r=-0.331, p=0.0479), greater muscle weakness of m. gluteus maximus/ m. gluteus medius/ m. iliopsoas [FSFI: (r=0.426, p=0.0368), (r=0.370, p=0.0368), (r=0.394, p=0.0252), SQoL-F (r=0.504, p=0.0044), (r=0.421, p=0.0204), (r=0.462, p=0.0100)], greater fatigue [FIS: FSFI (r=-0.358, p=0.0154), BISFW (r=-0.415, p=0.0084), SQoL-F (r=-0.327, p=0.0481)], more severe depression [BDI-II: FSFI Arousal domain (r=-0.357, p=0.0299)], deteriorated quality of life [HAQ: BISFW (r=-0.464, p=0.0033)], and worse ability to perform physical activities [HAP: FSFI (r=0.405, p=0.0105), BISFW (r=0.480, p=0.0019)]. No associations were found with disease duration, prednisone dose or serum levels of muscle enzymes.

Table 1.

Questionnaire: score range (meaning)	IIM (n=39)	HC (n=39)	p-value
FSFI: Female Sexual Function Index: 2(worst)-36(best)	15.7±2.1	20.7±2.0	p=0.0421
BISFW: Brief Index of Sexual Function for Women: -16 (worst)-75(best)	14.6±2.8	24.5±3.0	p=0.0134
SFQ28 Desire domain: Sexual Function Questionnaire: 5(worst)-31(best)	11.7±1.0	14.7±1.0	p=0.0457
PISQ-12: Pelvic Organ Prolapse/Urinary Incontinence Sexual Questionnaire short form: 0(best)-48(worst)	14.9±0.8	10.1±1.0	p=0.0005
SQoL-F: Sexual Quality of Life Questionnaire – Female: 0(worst)-100(best)	31.8±5.1	80.7±2.5	p<0.0001
PFIQ7: Pelvic Floor Distress Inventory Questionnaire – short form 7: 0(best)-300(worst)	24.7±6.3	10.1±2.7	p=0.0820
FIS: Fatigue Impact Scale: 0(best)-160(worst)	55.3±5.5	33.2±4.3	p=0.0025
MAF: Multidimensional Assessment of Fatigue Scale: 1(best)-50(worst)	22.0±2.0	15.7±1.4	p=0.0021
BDI-II: Beck's Depression Inventory II: 0(best)-63(worst)	12.8±1.5	6.6±0.9	p=0.0013
HAP: Human Activity Profile – adjusted activity score: 0(worst)-94(best)	51.0±3.5	80.2±1.6	p<0.0001
HAQ: Health Assessment Questionnaire: 0(best)-3(worst)	1.1±0.1	0.1±0.1	p<0.0001

Conclusion: Women with IIM reported significantly impaired sexual function and sexual quality of life compared to age-matched healthy controls. Worse scores in IIM were associated with disease activity, physical activity, fatigue, depression and quality of life.

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SAT0628-HPR "IT IS THE NEVER ENDING QUEST, HOW TO MOTIVATE PEOPLE" – HEALTH PROFESSIONALS' PERSPECTIVES ON SUPPORTING PHYSICAL ACTIVITY MAINTENANCE IN THOSE LIVING WITH AXIAL SPONDYLOARTHRITIS

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Background: Physical activity (PA) has been identified as a primary treatment option for people living with axial spondyloarthritis (axSpA) [1]. Yet, people living with axSpA can find it difficult to maintain PA at levels required to gain the evidenced benefits [2]. Intensive rehabilitation programmes harness the benefits of physical activity, but little is known about how to support PA maintenance when patients return to everyday life. The perspectives of health professionals involved in rehabilitation programmes can provide important and rich insights into how people living with axSpA could be helped to maintain their PA.

Objectives: To explore health professionals' experiences of supporting PA maintenance during and after a rehabilitation programme for those living with axial spondyloarthritis.

Methods: A qualitative study was conducted using semi-structured interviews. Nine health professionals (i.e., 4 physiotherapists; 1 clinical nurse specialist; 1 rheumatology SpR; 1 psychologist; 1 occupational therapist; and 1 podiatrist) who contribute to a rehabilitation programme were recruited from the Royal National Hospital for Rheumatic Diseases in Bath, UK (M time contributing to course = 6.79 yrs, range 1-19.25 yrs; contact time over course range = 1 to 45 hrs). Interviews were audio recorded, transcribed verbatim, and a thematic analysis employed [3].

Results: Maintaining a physically active lifestyle is a challenge for those living with axSpA and is an issue that is currently not being addressed. Health professionals' perspectives on supporting PA maintenance was illustrated through four main themes: (1) Social environment (group dynamic, importance of others with the same condition, immersion of the disease, external peer groups); (2) Re-framing (education, ownership, exercise off the pedestal, combating fear, routine and habit); (3) PA support (enjoyment and interest, PA as flexible, encouragement and importance, balance and realistic expectations, internal and external feedback); and (4) Challenges for health professionals (training, resources, knowledge of transition process to everyday life, difficulty motivating). The reasons why people engage in PA play a key role within each of these themes.

Conclusion: Results emphasize the current lack of support for the maintenance of PA and the complexities and challenges involved in maintaining PA for people living with axSpA. Interventions to support PA maintenance should pay particular attention to the importance of socially supportive environments, the need for enjoyment, and the use of internal and external feedback. The challenges faced by health professionals in motivating those living with axSpA to engage in PA regularly suggests a need for more training opportunities in motivation and health behaviour change.

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SAT0629-HPR FACTORS ASSOCIATED WITH USE OF BIOLOGICAL THERAPIES FOR AXIAL SPONDYLOARTHRITIS IN CANADA. RESULTS FROM THE IMAS SURVEY.

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Background: Biologics have revolutionized the treatment of axial spondyloarthritis (axSpA). However, there is limited knowledge about factors associated with their use in Canada.

Objectives: To evaluate sociodemographic, healthcare and patient-reported outcomes (PROs) associated with the use of biologics in Canadian axSpA patients.

Methods: The International Map of Axial Spondyloarthritis (IMAS) is a cross-sectional online survey of non-selected patients with self-reported axSpA, conducted in 21 countries and endorsed by the Axial Spondyloarthritis International Federation (ASIF). IMAS captures the patients' perspective of the burden of axSpA. The Canadian adaptation included a review of the survey by an advisory board of axSpA patients and a national steering committee composed of the Canadian Spondylitis Association, rheumatologists and patients. Participants were recruited between August 2018 and February 2019. Sociodemographic and healthcare-related variables, as well as PROs (disease activity [BASDAI, 0–10], spinal stiffness [3–12], functional limitation [0–54] and psychological distress [GHQ-12]) were collected. Respondents were divided in 2 groups 1) biologic and 2) NSAIDs or no treatment, based on reported pharmacologic treatments. Statistical analyses were performed to assess associations between variables and biologic use (bivariate) and the relative weight of these associations (multivariate).

Results: 542 axSpA patients were recruited. Mean age was 44.3±13.9 years, 63.1% were female, 66.4% married and 81.0% educated to university/college level. 22.8% of patients lived >50 km from their rheumatologist. Mean BASDAI was 5.3±2.1 and mean GHQ-12 score (mental health) was 4.0±3.8. Nearly half (49.6%) were currently on a biologic. Reported incidence of side effects was lower for patients having biologics (42.5%) vs. a NSAIDs (53.7%) as part of their treatment armamentarium. Only 15.7% of patients had discontinued biologic therapy, the main reasons for withdrawal being physician recommendation (50%), side effects (50%) and personal choice (34%). Variables associated with biologic use included: membership of a patient support group (p<0.001), non-manual work (p=0.008), higher income level (p=0.039), having a combination of public and private insurance schemes (p<0.001) and diagnosis by a rheumatologist (p<0.001). Associated PROs were spinal stiffness (p=0.011) and diagnostic delay (p=0.030). In the multivariate analysis, all variables except income and diagnostic delay were associated with biologic use (Table 1).

Table 1. Analysis of sociodemographic and clinical variables in relation to pharmacologic treatment

Variable	Univariate linear regression		Multivariate stepwise linear regression	
	B	95% CI	B	95% CI
Income level	0.001	1.000–1.000	NA	NA
Employment—manual worker	–0.761	0.266–0.822	–0.838	0.228–0.820
Member of a patient support group	0.937	1.797–3.628	1.116	1.754–5.309
Health insurance scheme—combination	0.209	1.162–1.307	0.215	1.132–1.357
Diagnostic delay	0.009	0.993–1.026	NA	NA
Spinal Stiffness (3–12)	0.099	1.022–1.193	0.220	1.090–1.424
Diagnosed by rheumatologist	0.535	1.412–2.067	0.335	1.041–1.877

B, B coefficient; NA, [not applicable]

Conclusion: Canadian axSpA patients with greater social status, disease awareness, and insurance options are more likely to receive biologic therapy. Furthermore, Canadian physicians are more inclined to prescribe biologics to patients with increased spinal stiffness.

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