at least 10 hours was required. The VO_2 max measured with a graded maximal exercise test was used to determine the CRF. Pearson correlation coefficients were calculated for the associations between the different measures of physical activity and VO_2 max. For the variables that were associated, linear regression analysis was carried out, with pain and disease activity as possible confounders.

Results: Thirteen females and five males were included in the study. The mean age was 66.5 (± 15.0) years. Only 22% of the patients met public health physical activity guidelines for the minimal amount of 150 minutes a week. The mean step count was 6237 (± 2297) steps per day and mean moderate-to-vigorous physical activity time was 16.50 (± 23.56) minutes per day. The median VO_2 max was 16.23 [4.63] $\text{ml}\cdot\text{kg}^{-1}\cdot\text{min}^{-1}$, which is under the standard. Pearson correlations showed a significant positive association for step count with VO_2 max. No associations were found for sedentary, light, and moderate-to-vigorous physical activity with VO_2 max. The significant association between step count and VO_2 max ($p = 0.01$) was not confounded by disease severity and pain.

Discussion: Since better CRF protects against CVD, increasing daily step count may be a simple way to reduce the risk of CVD in patients with RA and high CV risk. However, these results need to be confirmed in a larger study group. Future research should investigate if improving daily step count will lead to better CRF levels and ultimately will lead to a reduction in CV risk in patients with RA and high CV risk.

Conclusion: Physical activity levels of patients with RA and high CV risk do not meet public health requirements for physical activity criteria and the VO_2 max was under the standard. Step count is positively associated with CRF.

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HPR Patients' perspectives, functioning and health (descriptive: qualitative or quantitative)

AB1321-HPR

DEVELOPING A SELF-MANAGEMENT INTERVENTION TO MANAGE JOINT HYPERMOBILITY SYNDROME AND EHLERS-DANLOS SYNDROME HYPERMOBILITY TYPE: AN ANALYSIS INFORMED BY BEHAVIOUR CHANGE THEORY

S. Bennett¹, N. Walsh¹, T. Moss¹, S. Palmer¹. ¹University of the West of England - UWE Bristol, Faculty of Health and Applied Sciences, Stoke Gifford, United Kingdom

Background: Joint Hypermobility Syndrome (JHS) and Ehlers-Danlos Syndrome Hypermobility Type (EDS-HT) are heritable disorders of connective tissue that can cause joint instability and pain and are associated with increased anxiety and depression. There is currently little UK guidance for supporting patients with JHS/EDS-HT¹. The analysis presented here used the Behaviour Change Wheel (made up of the Theoretical Domains Framework (TDF) and Capability, Opportunity, Motivation and Behaviour (COM-B) model²) to identify possible intervention options to improve self-management in people with JHS/EDS-HT.

Objectives: To determine recommendations for the components of a behaviour change intervention for people with JHS or EDS-HT.

Methods: Data from: 1) A systematic review and thematic synthesis of the literature examining adults' lived experiences of JHS/EDS³ and 2) A thematic analysis of interview data where UK adults with JHS/EDS-HT ($n=17$, 14 women, 3 men) discussed the psychosocial impact of the condition on their lives⁴, were mapped onto the TDF and COM-B in a behavioural analysis. A modified Nominal Group Technique focus group ($n=9$, all women) explored which interventions identified by the TDF/COM-B mapping exercise were most important to them.

Results: Participants prioritised a range of potential self-management interventions, including:

Education: Participants wanted greater support to improve their knowledge of JHS/EDS-HT, including self-help strategies for coping with injury, fatigue and overexertion, and how to evaluate information about their condition.

Training: In activity pacing, assertiveness and communication skills, and what to expect during pregnancy, when symptoms of JHS/EDS-HT can worsen.

Environmental restructuring and enablement: Support from occupational therapists to maintain independence at home. Enablement of access to CBT, mindfulness and emotional support.

Modelled behaviour: Positive first-person narratives that address how other patients with JHS/EDS-HT have coped with anxiety, depression, distress, fear, frustration and feelings of loss.

Conclusion: This study is the first to apply theoretically-informed approaches to the management of JHS/EDS-HT. Through a modified nominal group technique, potential behaviour change interventions for addressing barriers to self-management have been prioritised. Discussion with participants indicated poor access to psychological support, occupational therapy and a lack of knowledge of JHS/EDS-HT. Future research with healthcare professional and patient stakeholder groups will further evaluate which intervention options would be most acceptable and feasible for the management of JHS/EDS-HT.

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AB1322-HPR

NON-INFECTIOUS ACUTE INFLAMMATORY ARTHRITIS IN JOINT ARTHROPLASTY

L. Berbel Arcobé¹, L. Gomez Garcia², M. C. Bernaus Johnson³, F. Angles Crespo³, S. Martinez Pardo¹, L. Font Vizcarra³. ¹Mútua Terrassa University Hospital, Rheumatology, Terrassa, Spain; ²Mútua Terrassa University Hospital, Internal Medicine, Terrassa, Spain; ³Mútua Terrassa University Hospital, Orthopaedic Surgery and Traumatology, Terrassa, Spain

Background: Acute inflammatory arthritis (AIA) in a native knee joint is a common pathology with a well-defined differential diagnosis which includes crystal-induced arthritis. Presenting symptoms in a knee joint arthroplasty (KJA) can mimic a periprosthetic hematogenous infection (PHI). There are few studies in current literature that describe possible causes of non-infectious arthritis in KJA. PHI requires, in most cases, an urgent combined surgical and antibiotic (AB) treatment. Describing and studying other possible diagnoses that may resemble PHI in a KJA is mandatory in order to minimize diagnostic errors and avoid unnecessary treatments.

Objectives: To analyze the characteristics of AIA in KJA with negative cultures in patients with an initial diagnosis suspicion of PHI.

Methods: A retrospective case series was conducted at a tertiary-level hospital including all patients diagnosed with an AIA in KJA with negative cultures from January 2012 to December 2019. Demographic data, clinical presentation, management and outcomes were recorded and analyzed.

Results: A total of 11 cases in 9 patients were included (6 females and 3 males) with a median age of 69 years at the time of diagnosis. All patients had risk factors for AIA (6 had chondrocalcinosis (CC), 2 hyperuricemia and 1 psoriasis). However, crystal deposits in synovial fluid (SF) for none of the patients had been previously found.

The median time from the index surgery to clinical presentation was 6 months, and from initial clinical presentation signs to referral was 24 hours. All cases presented with pain and swelling and 5 presented with erythema. Median body temperature on admission was 37.2°C. All patients presented with no acute distress. Initial blood tests showed a median white blood cell count and CRP of 11.160/mm³ and 90mg/L, respectively. Blood and SF cultures were taken for all cases. The median white blood cell count in SF was 75.883/mm³.

Three cases had received AB treatment during a median of 6 days prior to microbiological sampling. After initial sampling, 6 cases received AB prior to surgery, 1 received AB after surgery, 1 received only AB and 3 were treated only with NSAIDs. In all cases, surgical treatment consisted in radical surgical debridement and polyethylene insert exchange.

Further blood and SF tests were performed 4 days after admission. The mean decrease for systemic white blood cell count, CRP and synovial leukocyte count was 46%, 58% and 56%, respectively. All cultures were negative and crystal deposits were not identified for any of the samples.

The median duration of symptoms was 127 days with a good outcome. 6 patients received AB for a median of 69 days.

Conclusion: Non-infectious AIA in KJA is a rare entity that should be accounted for the differential diagnosis of periprosthetic joint infection. The initial diagnosis

of infection could not be confirmed, although three patients had taken AB before sampling. It is important for physicians to have a suspicion for non-infectious arthritis, especially in patients with clinical and blood test result dissociation, radiological CC, medical history of hyperuricemia or psoriasis, in order to avoid unnecessary AB and surgical treatment.

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AB1323-HPR A QUALITATIVE EXPLORATION OF THE PERSONAL FINANCIAL TOLL OF ARTHRITIS

D. Berkovic¹, D. Ayton¹, A. M. Briggs², I. Ackerman¹. ¹Monash University, Melbourne, Australia; ²Curtin University, Melbourne, Australia

Background: The financial experience faced by working-age people with arthritis includes living below the poverty line for many (1). Financial distress amongst people with arthritis is known to contribute to poorer health outcomes, including high psychological distress and more severe pain (2). Despite the demonstrated societal cost of arthritis care and management, the personal costs borne by the individual are not well understood in different health systems (3).

Objectives: To explore the perceived financial impacts of living with arthritis amongst working-age individuals aged 18 – 50 years in Australia.

Methods: A qualitative descriptive study design was used. Participants with inflammatory arthritis or osteoarthritis were recruited from the community, including urban and rural settings. An interview schedule was developed, informed by existing literature (4), which was piloted prior to data collection. Deductive and inductive coding techniques were used to identify financial-related themes arising from the data.

Results: Semi-structured interviews were conducted with 21 younger people (90% female) with a mix of arthritis conditions including rheumatoid arthritis, psoriatic arthritis, osteoarthritis, and ankylosing spondylitis. Four themes were identified: direct arthritis-attributable medical costs, indirect arthritis-attributable costs, insurance and pension costs, and broader financial impacts on the family. Non-subsidised costs were frequently referenced by participants as burdensome, and existed even within the publically-funded healthcare system. Financial distress was characterised by participants as chronic, onerous for the entire family, and associated with exacerbation of physical symptoms.

Conclusion: People with arthritis and of working age experience significant arthritis-attributable financial burden and related distress. Financial concerns should be actively identified and considered within shared clinical decision making, in order to provide more patient-centred care for these individuals.

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AB1324-HPR INVESTIGATION OF THE RELATIONSHIP BETWEEN SOCIAL APPEARANCE ANXIETY AND DISEASE DURATION, SELF-ESTEEM, ANXIETY AND DEPRESSION IN RHEUMATOLOGICAL DISEASES- PRELIMINARY STUDY

S. Y. Cetin¹, A. Ayan², A. Buyuk³, T. Can Akman⁴. ¹Akdeniz University, Department of Physiotherapy and Rehabilitation, Antalya, Turkey; ²Antalya Training and Research Hospital, Rheumatology, Antalya, Turkey; ³Akdeniz University, Physiotherapy and Rehabilitation, Antalya, Turkey; ⁴Pamukkale University, Physiotherapy and Rehabilitation, Denizli, Turkey

Background: Appearance anxiety means discomfort in social interactions due to changes in appearance. Also this anxiety; it is the fear of being evaluated negatively and worry about the changes in appearance, and it is not only apparent. Body image is the emotions, thoughts and perceptions of the individual about his or her own body and directly affects self-esteem. The Social Appearance Anxiety Scale (SAAS) was developed to assess social appearance anxiety, and this

scale was found to be a valid and reliable scale in scleroderma (SSc) patients. It was also thought to be related to the severity of the disease. The literature shows that appearance concerns are strongly related to depression in patients with rheumatic disease and should be evaluated routinely.

Objectives: The first aim of the study is to determine the level of social appearance anxiety in rheumatology patients, and our last goal is to investigation of the relationship between social appearance anxiety and disease duration, self-esteem, depression and anxiety.

Methods: 129 rheumatology patients with a mean age of 42.96 ± 11.33 years (51 men, 78 women) were included in the study. 55% of patients were ankylosing spondylitis (AS), 15.5% of patients were sjögren syndrome (SS), 11.6% of patients were rheumatoid arthritis (RA), 7.8% of patients were fibromyalgia syndrome (FMS), 6.2% of patients were SSc, 2.3% of patients were Behçet's disease (BD) and 1.6% were diagnosed with psoriatic arthritis (PsA). The Social Appearance Anxiety Scale (SAAS) was used to evaluate patients' social appearance anxiety, the Rosenberg Self-Esteem Scale (RSES) was used to evaluate self-esteem, and the Hospital Anxiety and Depression Scale (HADS) was used to evaluate depression and anxiety.

Results: The disease duration was found to be 6.82 ± 5.22 years. The SAAS average was found to be 43.23 ± 20.53 points. It was found that the SAAS values of patients with PsA and SSc were higher than patients with AS, RA, FMS, SS, BD. A moderate positive correlation was found between SAAS and disease duration, depression and anxiety (p: 0.048, r: 0.545; p: 0.007, r: 0.638; p: 0.014, r: 0.749, respectively).

Conclusion: As a result of the study, it was observed that rheumatology patients had moderate and high level social appearance anxiety. We thought that they have a higher level of social appearance anxiety because of skin involvement in patients with PsA and SSc. In addition, as a result of the study, we found that as the social appearance anxiety increased, disease duration, depression and anxiety increased. According to this study, in which the preliminary results are given, we thought that it is necessary to determine patients' appearance anxiety in routine evaluation and to reduce social appearance anxiety by collaboration with multidisciplinary areas in rheumatological diseases.

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AB1325-HPR THE TRANSITION FROM PEDIATRIC TO ADULT RHEUMATOLOGY OF 347 PATIENTS AT A SINGLE CENTER

S. Ugurlu¹, B. H. Egeli¹, A. Adrovic¹, K. Barut¹, S. Sahin¹, M. Yildiz¹, O. Kasapcopur¹, H. Ozdogan¹. ¹Istanbul University- Cerrahpasa, Istanbul, Turkey

Background: Pediatric to adult rheumatology transition can be a challenge for both the patient and the clinician, especially in rheumatology as it includes chronic diseases with close follow-up.

Objectives: The objective of this study is to understand our tertiary rheumatology center patient demographic transitioning from pediatric to adult rheumatology in order to design prospective studies enhancing the evidence of transition recommendations.

Methods: Patients included in this study are regularly followed-up in our adult rheumatology clinic and were regularly followed up in our pediatric rheumatology clinic in the past. They were all diagnosed with a rheumatologic condition receiving treatment. The patient files were assessed to have a better understanding of their demographic, disease and treatment information.

Results: Our cohort includes 347 patients diagnosed with a variety of conditions that are Familial Mediterranean Fever (FMF) (n=216), Juvenile Idiopathic Arthritis (JIA) (n=56), Juvenile Spondyloarthritis (jSPA) (n=39), Systemic Lupus Erythematosus (SLE) (n=20), Behçet's Disease (n=7) and the rest of the rheumatologic conditions with less than 5 patients each. The mean age of the patients during transition, mean age of diagnosis, and follow-up duration are 21.34 ± 1.7 , 10.4 ± 4.18 , and 10.82 ± 4.4 in respective order. The treatment regimens the patients received are summarized in Table 1.