using the Paykel's Interview for Recent Life Events. Pain was assessed using a visual analogue scale (VAS). The Fibromyalgia Impact Questionnaire (FIQ) was also used.

**Results:** Seventy-seven patients were originally screened, but seven were excluded because of current depressive episode or having a ZSDS of ≥60 or categorized as minimizers of childhood maltreatment at CTQ. The final analysis therefore involved 70 patients, all Caucasians: 30 with PMF and 40 with RA+FM. All patients with PMF and 38 (85%) of the 40 with AR+FM were treated for FM symptoms (antidepressants, pregabalin). The lifetime rates of MDD were significantly higher in PMF vs AR+FM (76.7 % and 40% respectively, p <0.003), as well as the rate of PD (50 % and 15% respectively, p <0.003), whereas there was no difference in PTSD rates. The PMF patients reported significantly higher levels of physical (p=0.020) and sexual abuse (p=0.011) and physical neglect (p<0.001), whereas there was no between-group difference in the levels of emotional abuse (p=0.912) and neglect (p=0.542); consistently, the proportion of sexually abused (p=0.005) or physically neglected patients was also higher in the PMF group (p=0.023). The rates of emotional neglect were high in both groups, without any significant difference between them. The vast majority of AR+FM patients (90%) said that only event occurring in the year preceding the onset of FM was RA, whereas the PMF patients mainly reported non-physical events (36%, particularly the ending of a relationship, or working or financial problems) or no event at all (40%), (p<0.001). Binary logistic regression used to identify the factors predicting association of PMF/RA+FM status, showed an association with lifetime major depression, life events preceding the development of FM, and BMI (p<0.05 at all).

**Conclusion:** PMF and SMF differ in psychiatric co-morbidities and environmental adversities, suggesting that the putative common pathogenetic condition of FM may develop through different pathways.

**References:**

**Disclosure of Interests:** None

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**THU0456**

**THE “JOINT CRITERIA” FOR FIBROMYALGIA DIAGNOSIS IN RHEUMATOID ARTHRITIS PATIENTS: RELIABILITY COMPARED TO THE 2010 ACR CLASSIFICATION CRITERIA FOR FIBROMYALGIA**

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**Background:** A significant proportion of rheumatoid arthritis (RA) patients have concomitant fibromyalgia (FM) (1). Associated FM diagnosis in RA patients can determine worse treatment outcomes compared to patients without FM (1). A difference between tender joint count (TJC) and swollen joint count (SJC) ≥7, also named the “joint criteria” was proposed as being diagnostic for FM in patients with RA. The “joint criteria” were validated against the 1990 ACR Classification Criteria for FM and are easy to apply to patients with RA (2). Since then, the 2010 ACR Classification criteria for FM, which include somatic symptoms besides pain sensitivity, were developed and validated.

**Objectives:** We aimed to determine the reliability of the joint criteria for fibromyalgia in RA compared to the ACR 2010 Classification Criteria for FM and to compare RA patients diagnosed with FM (FRA) to those without FM in terms of clinical variables.

**Methods:** We performed a cross-sectional study on RA patients who presented in our department during a 3 months period. Tender joint count (TJC) and swollen joint count (SJC), patient global assessment of disease activity (PGA) were determined. DAS28 scores were calculated using CRP. We applied the 2010 ACR Classification Criteria and the joint criteria for FM diagnosis. Kappa agreement coefficient was used to determine the reliability of the joint criteria against the 2010 ACR Classification Criteria for FM in patients with RA. Differences between groups were assessed using Mann-Whitney U test for numerical data or Chi square test for ordinal data.

**Results:** We included 100 consecutive RA patients, 84% female, with a mean age of 57.3(12) years and mean disease duration of 14(9) years. Twenty-four patients (24%) had associated FM according to the ACR 2010 Classification Criteria and 22 (22%) patients satisfied the joint criteria for associated FM. The level of agreement between the joint criteria and the ACR 2010 classification criteria for FM was kappα=0.86, p< 0.001, with a sensitivity of 70% and a specificity of 93%. FRA patients had similar demographic and disease characteristics compared to RA patients. Patients with FRA according to the joint criteria had significantly higher PGA, DAS28, and HAQ scores, but similar CRP values and SJC compared to RA patients (Table 1).

**Table 1 Demographic and clinical data of FRA and RA patients**

<table>
<thead>
<tr>
<th>Variable</th>
<th>FRA (n=22)</th>
<th>RA (n=78)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>60 (10.7)</td>
<td>59 (12.2)</td>
<td>0.093</td>
</tr>
<tr>
<td>Disease Duration (years)</td>
<td>13.3 (13)</td>
<td>12.2 (7.5)</td>
<td>0.589</td>
</tr>
<tr>
<td>ACPA seropositivity(%)</td>
<td>69</td>
<td>55</td>
<td>0.1</td>
</tr>
<tr>
<td>SJC</td>
<td>2(4)</td>
<td>2(4)</td>
<td>0.7</td>
</tr>
<tr>
<td>CRP (g/dl)</td>
<td>12.8(14.2)</td>
<td>8.1(13.7)</td>
<td>0.06</td>
</tr>
<tr>
<td>DAS28CRP</td>
<td>4.17</td>
<td>3.5(12)</td>
<td>0.009</td>
</tr>
<tr>
<td>HAQ</td>
<td>1.75(0.5)</td>
<td>1(0.7)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>PGA (mm)</td>
<td>70(11)</td>
<td>44(23)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Data are expressed as mean (SD) or median (IQR)

**Disclosure of Interests:** None

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**THU0457**

**LONGLITUDE ASSOCIATION OF SEDENTARY TIME AND PHYSICAL ACTIVITY WITH SLEEP QUALITY IN WOMEN WITH FIBROMYALGIA: THE AL-ÁNDALUS PROJECT**

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**Background:** Sleep disturbances are common in fibromyalgia, and influences quality of life. Recent literature has suggested that non-pharmacological treatments (e.g., physical exercise and cognitive behavioural therapy) may help to improve sleep quality (SQ) and the management of fibromyalgia1. In this regard, sedentary time (ST) and physical activity (PA) intensity levels could play a role on SQ in this population2. However, evidence is scarce and mainly based on cross-sectional data.

**Objectives:** This study aimed to examine the longitudinal associations (2- and 5-year follow-up) of ST and PA intensity levels with SQ in women with fibromyalgia.

**Methods:** In this prospective cohort study, women diagnosed with fibromyalgia (age: 51±7.6 years) with complete data were included at baseline (n=409), at 2-year follow-up (n=214) and at 5-year follow-up (n=218). Sedentary time and PA intensity levels (light and moderate-to-vigorous [MVPA]) were assessed using triaxial accelerometers worn for consecutive 7 days. The percentage of time spent in different behaviours was calculated (e.g., (ST/accelerometer wear time) × 100). The SQ global score was calculated as a sum of all components (score
High Prevalence of Joint Hypermobility in Inflammatory Bowel Disease Patients with Pain Unresponsive to Bowel-Targeted Therapy in Al-Ándalus Project

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Background: Musculoskeletal manifestations occur in 20-50% of patients (pts) with inflammatory bowel disease (IBD). A substantial number of patients complain of non-inflammatory musculoskeletal pain.

Objectives: To assess the incidence of joint hypermobility (JHM), benign joint hypermobility syndrome (BJHS) among patients with inflammatory bowel disease (IBD) examined in the inter-disciplinary rheumatology service at a tertiary referral center and the impact on IBD manifestations and disease activity.

Methods: Medical records of 180 consecutive IBD pts referred to the inter-disciplinary clinic were retrospectively reviewed. Data regarding age, gender, diagnosis, disease duration, clinical and laboratory features, previous and current therapy, Harvey-Brandshaw Index were entered into a database and analyzed.

Results: Forty-six patients (mean(SD) age 36.2(12.4), disease duration 13.9(6.8) years) out of 180 IBD patients (mean(SD) age 40.4(14.3), disease duration 15.7(8.1) years) fulfilled the criteria for JHM. Twelve patients had active inflammatory joint disease (2 with axial involvement, 10 with peripheral joint disease and 2 with axial and peripheral joint involvement). The other 32 answered both major criteria for BJHS. The median Beighton scoring was 7 (range 5-9). Most of them were on biological treatment. Patients with JHM suffered frequently of arthralgia and abdominal pain, in spite of endoscopic remission and normal levels of calprotectin and inflammatory markers (p=0.02, r=0.17). JHM and BJHS were associated with poorer outcome (p=0.004, r=0.2). In a multiple logistic regression analysis, only JHM reached borderline significance for predicting worse outcome by 2.5x.

Conclusion: Joint and abdominal pain did not improve with immunomodulatory therapy in IBD patients with JHM. JHM may have a negative impact on achievement of clinical remission, in a significant subset of IBD patients. Rheumatologists and gastroenterologists should be aware of this.

Disclosure of Interests: None declared. This work was supported by the Spanish Ministry of Economy and Competitiveness (I+D+i DEP2010-15639; I+D+i DEP2013-40906-R) and the Spanish Ministry of Education, Culture and Sport (FPUI5/00002).

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Physiological Fitness and Quality of Life in Women with Fibromyalgia: Longitudinal Analyses from the Al-Ándalus Project

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Background: Optimizing the highly deteriorated quality of life (QoL) of patients with fibromyalgia is one of the main goals in the management of the disease. Physical fitness has been identified as a powerful marker of health that is positively related to QoL in this population, although previous evidence is mainly based on cross-sectional data.

Objectives: This study aimed to examine the longitudinal associations (2- and 5-year follow-up) between physical fitness and QoL in women with fibromyalgia.

Methods: In this prospective cohort study, women diagnosed with fibromyalgia (age: 51±7 years) filled with completed data were included at baseline (n=441), at 2-year follow-up (n=220) and at 5-year follow-up (n=227). The Senior Fitness Tests battery was used to assess physical fitness components and a standardized global fitness index was calculated. The eight dimensions plus the two physical and mental component summaries of the Short-Form health survey-36 questionnaire were used to assess QoL. To examine whether changes in fitness predicted QoL at follow-up, multiple linear regression models were built. The bidirectionality of the associations (whether changes in QoL predicted fitness at follow-up) was also tested. Outcome values at baseline and age, fat percentage, analgesic consumption, educational level, and occupational status at follow-up were entered as potential confounders in all analyses.

Results: Changes in fitness were associated with physical function (β=0.160), physical role (β=0.275), bodily pain (β=0.271), general health (β=0.144), and health?