two months of antiviral treatment, she developed symmetrical polyarthritis, with pain and edema in the wrists, elbows, shoulders and metacarpophalangeal joints, associated with prolonged morning stiffness. The musculoskeletal examination was notable for active synovitis of the proximal phalangeal joints, metacarpophalangeal joints, wrists, elbows. Distal interphalangeal joints were spared. She had no musculoskeletal symptoms prior to antiviral therapy. Review of systems was otherwise unremarkable. X-ray showed no remarkable findings. Ultrasonography of the hands revealed diffuse synovitis as well as tenosynovitis of the ulnar extensor tendons in both wrists. Laboratory results revealed a normal C-reactive protein, elevated liver enzymes: ALAT (alanine-aminotransferase) 119, ASAT (aspartate-aminotransferase) 66, Gamma-GT 203 and undetectable cryoglobulins. Anti-CCP was 21 IU/ml (negative < 20 IU/ml), antinuclear antibodies were positive 1280 (negative < 160), rheumatoid factor was 192 (normal < 30 IU/ml).

A diagnosis of rheumatoid arthritis (RA) was made on the basis of clinical and ultra-sonographic evidence as well as Rheumatoid Factor (RF) and anti-cyclic citrullinated peptide (anti-CCP) antibody positivity. Moreover, an autoimmune thyroiditis was found that evolved into hypothyroidism treated with thyroxine.

Results: The patient developed a sustained virological response as evidenced by persistent undetectable HCV RNA and normal aminotransferase activities. Upon completion of a 12-week course of antiviral therapy, The rheumatoid syndrome disappeared after cessation of IFN therapy. By that time, antinuclear antibodies were in a titre of 1 /180, rheumatoid factor and Anti-CCP were negative.

Conclusion: The present case suggests that biological agents, affecting the cytokine network, may work as triggering factors for the development of RA in previously predisposed individuals. Screening for RF and anti-CCP may be considered before treating with IFN. In addition, a close surveillance for the occurrence of autoimmune phenomena during and after treatment should be worthy, for early diagnosis and adequate clinical management.

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.2286

THURSDAY, 04 JUNE 2020

HPR Measuring health (development and measurement properties of PROs, tests, devices)

THU0607-HPR

COMPARISON OF THE PATIENT REPORTED PHYSICAL ACTIVITY LEVEL ACCORDING TO KINESIOPHOBIA PRESENCE IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS

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Background: Many factors such as poor functional or emotional status might play a role in participating physical activity for people with rheumatic diseases. There is a lack for evidence regarding to the effect of kinesiophobia presence on the physical activity levels of axSpA patients.

Objectives: The primary objective was to compare the patient reported physical activity levels in axSpA patients with kinesiophobia and those without. Evaluating disease related and physical characteristics, quality of life and emotional status according to presence of kinesiophobia were also aimed.

Methods: One-hundred forty-eight consecutive axSpA patient were allocated to Kinesiophobia+ group (n: 90, 66% males) or Kinesiophobia- group (n: 58, 64% males). The presence of kinesiophobia was defined as having a score of >37 in Tampa Scale for Kinesiophobia. All patients were evaluated regarding to physical characteristics (age, body-mass index), functional status (Bath Ankylosing Spondylitis Functional Index), disease activity (Bath Ankylosing Spondylitis Disease Activity Index), spinal mobility (Bath Ankylosing Spondylitis Metrology Index), patient reported physical activity (International Physical Activity Questionnaire Short Form), emotional status (Hospital Anxiety and Depression Scale), and quality of life (Assessment of SpondyloArthritis International Society Health Index).

Results: Physical characteristics and spinal mobility were similar in patients with and without kinesiophobia (p>0.05, Table). Disease activity, function, quality of life, depression and anxiety scores were poorer in Kinesiophobia+ group compared to Kinesiophobia- group (p<0.05, Table). Patient reported physical activity level was found to be lower in patients with kinesiophobia (p<0.05, Table).

Table. Comparison of groups according to kinesiophobia presence

	Kinesiophobia+ Group (n: 90)	Kinesiophobia- Group (n: 58)	p*
	Median (IQR 25/75)	Median (IQR 25/75)	
Physical Characteristics			
Age (years)	41.0 (37.0/52.0)	44.0 (36.0/53.0)	0.850
Body-Mass Index (kg/m ²)	26.8 (24.6/30.1)	26.0 (22.7/29.0)	0.364
Disease Related Characteristics			
BASDAI (score)	2.7 (1.3/4.6)	1.8 (0.6/3.5)	0.036
BASMI (score)	3.3 (1.9/5.0)	2.7 (1.6/3.5)	0.114
BASFI (score)	2.5 (1.2/4.4)	1.2 (0.5/2.7)	0.003
Patient Reported Physical Activity Level			
IPAQ (MET/week)	505.5 (169.0/1653.0)	858.0 (330.0/2772.0)	0.042
Quality of Life			
ASAS-HI (score)	7.0 (5.0/9.1)	4.0 (2.0/7.9)	0.001
Emotional Status			
HAD Anxiety (score)	7.0 (4.0/9.0)	5.0 (3.0/8.0)	0.006
HAD Depression (score)	7.0 (4.0/10.0)	3.0 (1.0/7.0)	0.001
Fear of Movement			
TAMPA (score)	41.0 (39.0/44.0)	34.0 (31.0/36.0)	p<0.001

*Mann-Whitney U Test, IQR 25/75: Interquartile range 25/75, BASDAI: Bath Ankylosing Spondylitis Disease Activity Index, BASMI: Bath Ankylosing Spondylitis Metrology Index, BASFI: Bath Ankylosing Spondylitis Functional Index, IPAQ: International Physical Activity Questionnaire Short Form, HAD: Hospital Anxiety and Depression Scale, ASAS-HI: Assessment of SpondyloArthritis International Society Health Index, TAMPA: The Tampa Scale for Kinesiophobia, p<0.05.

Conclusion: It seems that the presence of kinesiophobia may have a negative impact on patient reported physical activity level, and disease related parameters. However, it is also possible that kinesiophobia might occur as result of poor disease activity or disability. Strategies such as patient education should be included in axSpA management for preventing kinesiophobia development or improving kinesiophobia related consequences.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.4130

THU0608-HPR

VALIDITY OF SIX MINUTE STEPPER TEST IN EVALUATION OF FUNCTIONAL EXERCISE CAPACITY IN PATIENTS WITH ANKYLOSING SPONDYLITIS

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Background: In most patients with ankylosing spondylitis (AS), exercise capacity decreases due to pulmonary dysfunction, chest wall restriction and peripheral muscle weakness. The six-minute walk test (6MWT) is a validated simple field, hence frequently used to evaluate exercise capacity. However, 6MWT has some limitations, especially the fact that it requires a corridor of at least 30 meters long to perform this test which can limit its use in some centers. Shorter corridors force patients to turn more frequently, slowing down the pace of walking that reduces potential walking distance. To overcome technical and spatial limitations, 6-minute stepper test (6MST) has been proposed to evaluate exercise capacity. In the literature 6MST has been suggested for a variety of diseases. Since, it requires only a limited amount of space and equipment and is feasible, easy to perform, well tolerated.

Objectives: In the literature, there is no study in which 6MST is used to evaluate exercise capacities of patients with AS. Therefore, the aim of this study was to evaluate validity of 6MST in AS population in comparison to 6MWT.

Methods: 6MWT and 6MST were performed in 51 patients with AS (52.26±13.33 years, 30F/21M). Demographic and clinical characteristics were recorded. Functional exercise capacity was evaluated using 6MWT and 6MST. The total distance of 6MWT was compared to the total number of steps of 6MST. Before, during and after 6MWT and 6MST, heart rate (HR), oxygen saturation (SpO₂), breathing frequency (BF), blood pressure (BP), dyspnea and fatigue were assessed using modified Borg scale.

Results: The number of steps on the 6MST was significantly correlated with the distance of the 6MWT (r=0.61, p<0.0001). Dyspnea (p=0.04) and leg fatigue (p<0.0001) was significantly higher in 6MST than in 6MWT. HR, SpO₂, BF, BP and fatigue were similar in both 6MST and 6MWT.