Background: Land and water-based exercise intervention programs have demonstrated positive effects on fibromyalgia symptoms. However, research comparing the efficacy of both protocols is limited.

Objectives: The aim of this study was to assess the effect of two exercise interventions (land- and water-based) and a subsequent detraining period on fatigue in women with fibromyalgia.

Methods: Among the 272 participants initially randomised, a total of 161 women (age: 50.7±7.7) completed all the assessments with an attendance of at least 70% (land-based n=50, water-based n=44, control n=67). The intervention groups trained 3 non-consecutive days/week (60 min/sess) during 24 weeks. Each session involved exercises to improve cardiorespiratory fitness, muscle strength, and flexibility. Four dimensions of fatigue were assessed using the Multidimensional Fatigue Inventory. Participants were evaluated at baseline (pre-test), at the end of the intervention (post-test) and following a detraining period of 12 weeks (re-test).

Results: The land-based exercise group reduced general fatigue (mean difference: -1.17; 95% confidence interval: -2.30 to -0.03; P=0.04) and physical fatigue (-2.48; -3.80 to -1.16; P<0.001) compared to the control group. The water-based exercise intervention group reduced physical fatigue compared to the control group (-1.61; -3.04 to -0.19; P=0.02). No significant reductions were observed in other dimensions of fatigue in the intervention group compared to the control group and no differences between intervention groups were observed (all comparisons, P>0.05).

Conclusion: Twenty-four weeks of land or water-based exercise were both effective in reducing physical fatigue of women with fibromyalgia. Furthermore, land-based exercise led to additional reductions in general fatigue. Reductions in fatigue were not sustained after the detraining period in any of the intervention groups (all comparisons, P>0.05).

Disclosure of Interests: None declared.

DOI: 10.1136/annrheumdis-2020-eular.5576

FR0649-HPR HYDROXYCHLOROQUINE PRESCRIBING AND OPHTHALMOLOGICAL SCREENING WITHIN RHEUMATOLOGY DEPARTMENTS IN THE NORTH-WEST OF THE UNITED KINGDOM: A PROSPECTIVE REGIONAL AUDIT


Background: Hydroxychloroquine (HCQ) is widely used in the management of rheumatoid arthritis and connective tissue disease. The prevalence of retinopathy in patients taking long-term HCQ is approximately 7.5%, increasing to 20-50% after 20 years of therapy. Hydroxychloroquine prescribed at ≤5mg/kg poses a toxicity risk of <1% up to five years and <2% up to ten years, but increases sharply to almost 20% after 20 years. Risk factors for retinopathy include doses >5mg/kg/day, concomitant tamoxifen or chloroquine use and renal impairment.

Methods: A retrospective cohort study including all patients taking HCQ at a major university hospital in the Copenhagen region of Denmark from February 2015 to January 2017. Patients were randomised electronically. Jointly examined by a blinded ophthalmologist. Patients in the OOCs group had no scheduled appointments but were allowed to book acute appointments with their contact ophthalmologist within 5 days and had access to nurse-led consultations without pre-booking, and a nurse-led telephone helpline. Appointments for the control group were scheduled according to routine procedures. Outcome measures were collected at baseline year 1 and year 2. Clinical parameters: DAS28, CRP, VAS pain, 28-tender and swollen joint count (28-TJC and 28-SJC), HAQ score and radiographs of hands and feet. Psychological parameters: VAS patient satisfaction (Pt satisfact) and quality of life (EQ-SD).

Results: Of 282 patients, 266 completed the first year, 239 the second year. Patient characteristics (OOCs/controls): age: 61.4±10.5/59.9±12.2 years, females 77/77%, ACPA positive 66/65%, treatment with synthetic DMARDs 67/65% and/or biologics 33/35%. Clinical and psychological parameters are shown in Table 1. OOCs at year one and two was comparable to traditional scheduled routine procedures regarding clinical and psychological outcome measures. Radiographic progression was detected in 2.9% (4/138) and 2.1% (3/140) of the OOCs and control group, respectively (p=0.69; Chi-squared test).

Table 1. Outcome measures in patients with RA randomised to on demand Open Outpatient Clinic System (OOCs) or traditional follow-up (control group) in a rheumatology outpatient clinic. Results are shown as means±SD.

<table>
<thead>
<tr>
<th>OOCs</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>Baseline</td>
</tr>
<tr>
<td>Visits</td>
<td>3.3±1.2</td>
</tr>
<tr>
<td>Phone calls</td>
<td>10.2±7.2</td>
</tr>
<tr>
<td>DAS28</td>
<td>1.6±1.5</td>
</tr>
<tr>
<td>CRP</td>
<td>2.1±4.2</td>
</tr>
<tr>
<td>VAS pain</td>
<td>27±25</td>
</tr>
<tr>
<td>HAQ-score</td>
<td>0.6±0.6</td>
</tr>
<tr>
<td>Polyclinic</td>
<td>0.6±0.2</td>
</tr>
<tr>
<td>Pt satisfact</td>
<td>88±21</td>
</tr>
</tbody>
</table>

Conclusion: The patient self-controlled outpatient follow-up system (OOCs) was associated with fewer visits, but more phone calls to the nurse, and was comparable with traditional scheduled routine procedures regarding clinical, psychological and radiographic outcomes after two years. Thus, organisation of outpatient care according to OOCs may be applied to strengthen patient-centred care in patients with RA.

Disclosure of Interests: René Panduro Poggenborg Speakers bureau: Novartis, Ole Rintek Madsen: None declared, Lene Dreyer: None declared, Annette Hansen Consultant of: AbbVie, Speakers bureau: Eli Lilly.

DOI: 10.1136/annrheumdis-2020-eular.1184

References:

Acknowledgments: This study was supported by the Spanish Ministry of Economy and Competitiveness (I+D+I DEP2010-15639; I+D+i DEP2013-40908-R) and the Spanish Ministry of Education, Culture and Sport (FPUE15/00002).

 disclosed.


Disclosure of Interests: None declared.
HPR Epidemiology and public health (including prevention).

**FR00650-HPR**  SEXUAL DYSFUNCTION IN WOMEN WITH SYSTEMIC LUPUS ERYSHEMATOSUS

G. V. Espasa1, L. Gonzalez Lucero1, Y. Soria Curi1, A. L. Barbablia1, S. M. Mazza1, M. L. Leguizamine1, M. Pera1, H. R. Sueldo1, M. C. Bertolaccini1, M. Santana1, L. M. Galindo1, V. I. Bellomio1, *Hospital Angel C. Padilla, San Miguel de Tucumán, Argentina*

**Background:** Sexual dysfunction is the alteration in one or several phases of sexual activity (desire, excitement, plateau, orgasm and resolution), which can culminate in frustration, pain and a decrease in the frequency of sexual intercourse. There are few studies that associate sexual dysfunction with Systemic Lupus Erythematosus (SLE) due to the difficulty in assessing it and its multifactorial cause.

**Objectives:** Determine the frequency of sexual dysfunction and analyze associated factors in patients with SLE.

**Methods:** A descriptive cross-sectional study was conducted. We included patients who attended the Rheumatology unit between May and July 2019; over 18 years of age, with a diagnosis of SLE according to the ACR 1997 and / or SLICC 2012 criteria, and healthy patients matched by age as control. Demographic and disease-related variables were studied. The DASS-21 (Depression Anxiety Stress Scale) scale that evaluates depression, anxiety and stress, and the Female Sexual Function Index (FSFI) that assesses 6 domains (desire, excitement, lubrication, orgasms, satisfaction and pain) were applied with a cut-off point ≤ 26.5 to define sexual dysfunction. Women over 50 years old, with secondary Sjogren’s syndrome, menopause, severe depression and illiterate patients were excluded.

**Results:** Of the 94 randomized patients, 89 completed study: 44 in the conventional monitoring arm and 45 in the connected monitoring arm. The total number of physical visits between baseline and 6 months was significantly lower in the “connected monitoring” group (0.42 vs 0.58 versus 1.93 ± 0.55; p<0.05). No differences between groups were observed in the clinical and functional scores. A better quality of life for SF-12 subscores (Role-Physical, Social-Functioning and Role-Emotional) were found in the “connected monitoring” group.

**Conclusion:** According to our results, a connected monitoring reduces the number of physical visits while maintaining a tight control of disease activity and improving quality of life in patients with RA starting a new treatment.

**References:**

