The second aim is to identify the most frequent reasons for consultation and diagnoses, to assess the concordance between the two and to analyse the trend over time of the number of virtual consultations and their relationship with the different waves of the COVID 19 pandemic.

Methods: Retrospective observational study. The virtual consultations made from PC (47 centres) to Rheumatology during 2020 were analysed. They were carried out through a computer programme, using the "Andalusian Health Service Virtual Consultation Platform" tool. A specific agenda was established for virtual consultations. The reason for the referral and the rheumatologist's diagnosis were collected. The response given to the PC was divided into four models: NON-TRIBUTARY (not related to the speciality), DISCHARGE (a diagnosis and therapeutic response is concluded), APPOINTMENT FOR CONSULTATION and FOLLOW-UP (new contact is requested, completing the information). The reasons for consultation, diagnoses, time and type of response were analysed.

Results: 47 virtual consultations were carried out. 54.5% (n 298) were closed as DISCHARGE. 27.4% (n 150) were APPOINTMENT FOR CONSULTATION, and 17.7% (n 97) indicated FOLLOW-UP. Only 0.4% (n 2) were NOT TRIBUTARY.

The average response time was 2 days 15 hours and 56 min.

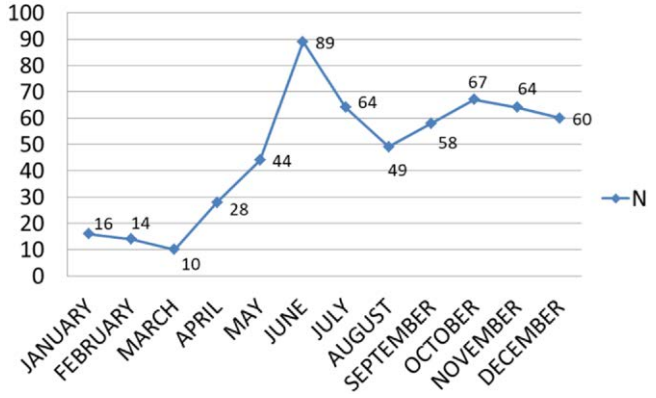
The most frequent reason for consultation was polyarthralgias (26.7%, n 146) and after the rheumatologist's assessment a diagnosis was established in 89% of them. Inflammatory arthropathy accounted for 30.8% (n 45), osteoarthritis for 19.9% (n 29), fibromyalgia for 12.3% (n 18), polymyalgia rheumatica (PMR) for 6.9% (n 10), osteoporosis for 2.7% (n 4) and connective tissue disease for 2.1% (n 3).

Another frequent reason for consultation was osteoporosis (13.5% n 74), of which 85.1% (n 63) had a confirmed diagnosis and/or need for revision.

A diagnosis could be made via telematics in 89.6% of the consultations. 15.5% were osteoporosis (n 85), 14.9% osteoarthritis (n 81), 10.5% soft tissue injuries, 8.8% mechanical/nonspecific pain (n 47), 7.1% rheumatoid arthritis (n 39), 6.5% fibromyalgia (n 34), 6.2% connective tissue disease (n 34), 5.7% PMR (n 31), 4.9% suspected spondyloarthritis (n 26), 4.2% psoriatic arthritis (n 23) and 4.2% microcrystalline arthritis (n 23).

27.4% (n 150) of the virtual consultations were required for assessment in a face-to-face appointment. We analysed the distribution over time (Figure 1). In the COVID 19 confinement phase (14 March - 21 June), the number of consultations increased, peaking in June, a behaviour that has persisted in the other mobility phases (October/November).

Figure 1. ANNUAL PROGRESS OF VIRTUAL CONSULTATIONS TO RHEUMATOLOGY



Conclusion: More than half of the virtual consultations carried out were resolved without face-to-face assessment, with a diagnosis being established in almost 90%. It is an effective tool for rapid access to Rheumatology, detecting pathology requiring preferential attention, with a face-to-face appointment, as well as for the early diagnosis of inflammatory arthropathy, which was detected in a quarter of the consultations, as well as for the diagnosis and follow-up of osteoporosis. Virtual consultation facilitates a quick response, playing an even more relevant role in the current SARS CoV-2 pandemic situation.

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POS1481-HPR SEXUAL EXPERIENCE IN MALE PATIENTS WITH ANKYLOSING SPONDYLITIS: RESULTS FROM A CROSS-SECTIONAL STUDY OF 113 PATIENTS

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Background: The expression and experience of sexuality is a key part of an individual self-identity[1], so it is essential for both healthy individuals and patients. Patients with ankylosing spondylitis (AS) may be susceptible to sexual issues due to disease activity, dysfunction and comorbid emotional problems. However, sexuality, especially sexual experience, are rarely paid attention in patients with AS.

Objectives: Our study aims to assess sexual experience in male patients with AS, and analyze the factors affecting sexual experience.

Methods: This is a cross-sectional study. A total of 113 patients with AS and 46 healthy people were investigated, matched according to age and body mass index. The Sexual Experience Questionnaire is used to assess male sexual experience. Linear regression analysis is used to explore the contributions of clinical variables to worse sexual experience.

Results: There is a significant difference in the total sexual experience score between AS patients and healthy controls (41.92±8.83 vs 46.98±8.10, *P*=0.0013). Also, patients with AS have a worse score in all dimensions of sexual experience, including erectile function, individual satisfaction and couple satisfaction, comparing to healthy people. In the regression model after controlling for the effects of age, disease duration and body mass index, disease activity (BASDAI), function (BASFI), mobility (BASMI, chest expansion and finger-floor distance), health index (ASAS HI), sleep quality (PSQI) and psychological status (HADS, HADS-A and HADS-D) are significant determinants of sexual experience, including erectile function (except for chest expansion), individual satisfaction (except for BASMI) and couple satisfaction (except for BASMI). See Table 1 for details.

Table 1. Multivariable regression analysis of association between sexual experience and clinical outcomes

Independent	Sexual experience total score		Erectile function		Individual satisfaction		Couple satisfaction	
	β (95%CI)	*P*	β (95%CI)	*P*	β (95%CI)	*P*	β (95%CI)	*P*
Pain total	-0.09 (-0.25,0.28 0.07)		-0.27 (-0.58, 0.073 0.03)		-0.51 (-0.91, 0.014 -0.10		-0.15 (-0.32, 0.077 0.02)	
BASDAI	1.35 (-2.24, 0.003 -0.45)		-0.42 (-0.75, 0.014 -0.09)		-0.72 (-1.16, 0.001 -0.28)		-0.21 (-0.40, 0.028 -0.02)	
BASFI	-1.80 (-2.59, <0.001 -1.01)		-0.62 (-0.91, <0.001 -0.32)		-0.89 (-1.28, <0.001 -0.50)		-0.30 (-0.47, 0.001 -0.13)	
BASMI	-1.04 (-2.01, 0.036 -0.07)		-0.47 (-0.82, 0.008 -0.12)		-0.48 (-0.96, 0.051 0.001)		-0.09 (-0.29, 0.413 0.12)	
Chest expansion	1.60 (0.24, 2.96)	0.021	0.50 (-0.004,0.052 0.99)		0.74 (0.07, 1.42)	0.032	0.36 (0.08, 0.64)	0.011
Finger-floor distance	-0.20 (-0.33,0.003 -0.07)		-0.07 (-0.11, 0.009 -0.02)		-0.10 (-0.17, 0.003 -0.03)		-0.04 (-0.06, 0.011 -0.01)	
ASAS HI	-1.27 (-1.64, <0.001 -0.91)		-0.42 (-0.55, <0.001 -0.28)		-0.62 (-0.80, <0.001 -0.43)		-0.24 (-0.32, <0.001 -0.16)	
PSQI	-0.60 (-1.11, 0.021 -0.09)		-0.19 (-0.38, 0.045 -0.004)		-0.28 (-0.54, 0.03 -0.03)		-0.13 (-0.23, 0.019 -0.02)	
HADS	-0.53 (-0.76,<0.001 -0.29)		-0.18 (-0.27, <0.001 -0.09)		-0.24 (-0.36, <0.001 -0.13)		-0.10 (-0.15, <0.001 -0.05)	
HADS-A	-0.86 (-1.30, <0.001 -0.42)		-0.28 (-0.44, 0.001 -0.12)		-0.42 (-0.63, <0.001 -0.20)		-0.17 (-0.26, <0.001 -0.07)	
HADS-D	-0.99 (-1.45, <0.001 -0.53)		-0.35 (-0.52, <0.001 -0.19)		-0.44 (-0.67, <0.001 -0.21)		-0.20 (-0.29, <0.001 -0.10)	

Conclusion: Worse sexual experience is associated with increased disease activity, decreased function, poor mobility, decreased health index, poor sleep quality and psychological status. Therefore, special attention to worse sexual experience in patients with AS is essential to assess disease-related suffering and develop new patient management strategies.

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POS1482-HPR PAIN CATASTROPHIZING IS ASSOCIATED WITH RESIDUAL PAIN AFTER REACHING IMPROVED CONDITIONS OF SWOLLEN/TENDER JOINTS AND SERUM C-REACTIVE PROTEIN LEVEL

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