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-identity¹, 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, 0.07)	0.07	-0.27 (-0.58, 0.03)	0.03	-0.51 (-0.91, 0.01)	0.04	-0.15 (-0.32, 0.02)	0.07
BASDAI	1.35 (-2.24, 0.003)	0.003	-0.42 (-0.75, 0.01)	0.01	-0.72 (-1.16, 0.001)	0.001	-0.21 (-0.40, 0.02)	0.02
BASFI	-1.80 (-2.59, <0.001)	<0.001	-0.62 (-0.91, <0.001)	<0.001	-0.89 (-1.28, <0.001)	<0.001	-0.30 (-0.47, 0.001)	0.001
BASMI	-1.04 (-2.01, 0.036)	0.036	-0.47 (-0.82, 0.008)	0.008	-0.48 (-0.96, 0.051)	0.051	-0.09 (-0.29, 0.12)	0.413
Chest expansion	1.60 (0.24, 0.021)	0.021	0.50 (-0.004, 0.052)	0.052	0.74 (0.07, 0.032)	0.032	0.36 (0.08, 0.64)	0.011
Finger-floor distance	-0.20 (-0.33, 0.003)	0.003	-0.07 (-0.11, 0.009)	0.009	-0.10 (-0.17, 0.003)	0.003	-0.04 (-0.06, 0.011)	0.011
ASAS HI	-1.27 (-1.64, <0.001)	<0.001	-0.42 (-0.55, <0.001)	<0.001	-0.62 (-0.80, <0.001)	<0.001	-0.24 (-0.32, <0.001)	<0.001
PSQI	-0.60 (-1.11, 0.021)	0.021	-0.19 (-0.38, 0.045)	0.045	-0.28 (-0.54, 0.03)	0.03	-0.13 (-0.23, 0.019)	0.019
HADS	-0.53 (-0.76, <0.001)	<0.001	-0.18 (-0.27, <0.001)	<0.001	-0.24 (-0.36, <0.001)	<0.001	-0.10 (-0.15, <0.001)	<0.001
HADS-A	-0.86 (-1.30, <0.001)	<0.001	-0.28 (-0.44, 0.001)	0.001	-0.42 (-0.63, <0.001)	<0.001	-0.17 (-0.26, <0.001)	<0.001
HADS-D	-0.99 (-1.45, <0.001)	<0.001	-0.35 (-0.52, <0.001)	<0.001	-0.44 (-0.67, <0.001)	<0.001	-0.20 (-0.29, <0.001)	<0.001

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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Background: It has long been recognized that immune-mediated inflammatory diseases, such as rheumatoid arthritis (RA), are prone to coexist with depression due to the effects of cytokines, and that these two illnesses lead to an elevation in patients' pain. However, we often encounter patients with RA who suffer from residual pain despite an improvement in disease activity and inflammation. The specific psychological factors associated with residual pain have not yet been clarified. In addition to the traditional psychological factors, such as depression and anxiety, we focused on pain catastrophizing due to the distortion of pain perception and explored its association with residual pain.

Objectives: To examine whether psychological factors, such as pain catastrophizing, depression, and anxiety, are associated with self-reported pain visual analogue scale (pain-VAS) scores in RA patients with 1 or less on 28joints- swollen/tender counts (SJC/TJC) and CRP.

Methods: This was a cross-sectional study of 290 RA outpatients (85% of whom were women) with scores of less than 1 on SJC, TJC, and CRP, with a median (IQR) age of 66 (57–73) years. The participants completed questionnaires, including pain VAS (0–100mm), Pain Catastrophizing Scale (PCS, 0–52 scale), and Hospital Depression and Anxiety Scale (HADS, 0–42 scale). Using linear regression analyses, we analysed whether PC (PCS ≥ 30), depression (HADS-D ≥ 11), and anxiety (HADS-A ≥ 11) (independent variables) were associated with pain VAS scores (dependent variable). After univariate regression analysis, multivariate analysis adjusted for confounding factors was performed.

Results: Patients reported a wide range of pain severity with a median (range) pain VAS score of 9 (0–96mm). The prevalence of anxiety and depression were 5.5% and 5.9%, respectively. Meanwhile, 24.1% of the patients experienced pain catastrophizing. Pain catastrophizing was associated with pain VAS scores in univariate and multivariate analyses (Table 1). The presence of anxiety and depression was not associated with pain VAS scores in any model. Multivariate analysis of other covariates showed that age, disease duration, and presence of SJC/TJC of joints other than the 28 joints were positively correlated with pain VAS scores.

Table 1. Univariate and multivariate regression analysis for independent variables associated with pain-VAS scores

independent variables	Univariate		Multivariate	
			Model 1*	Model 2**
Pain catastrophizing	Estimate	3.7	4.1	3.6
	95%CI	0.7 to 6.6	1.1 to 7.0	0.5 to 6.6
	p-value	0.015	0.006	0.021
Anxiety	Estimate	3.7	4.4	0.5
	95%CI	-1.9 to 9.2	-1.0 to 9.9	-3.5 to 7.9
	p value	0.198	0.108	0.453
Depression	Estimate	3.5	4.2	3.9
	95%CI	-1.9 to 8.9	-1.1 to 9.5	-1.9 to 8.7
	p-value	0.204	0.119	0.210

The covariates in multivariate analysis are as follows: age, sex, body mass index, disease duration, Steinbrocker's Stage, prednisolone dosage, biologic agents use, and presence of swollen joint counts/tender joint counts of joints other than the 28 joints. *Model 1: each psychological independent variable and the above covariates. **Model 2: all psychological independent variables and the above covariates.

Conclusion: Pain catastrophizing was associated with pain VAS scores in RA patients with 1 or less on 28joints-SJC/TJC and CRP, emphasising that residual pain in the patients should be treated in a biopsychosocial framework focussing on pain catastrophizing.

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POS1483-HPR

A QUANTITATIVE ASSESSMENT OF THE LIKELIHOOD THAT PATIENTS WITH RHEUMATOID ARTHRITIS WILL COMMUNICATE INFORMATION ABOUT RHEUMATOID ARTHRITIS RISK TO RELATIVES

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Background: First-degree relatives (FDRs) of patients with rheumatoid arthritis (RA) are at increased risk of RA and are being recruited to studies of predictive and preventive approaches. Access to FDRs is usually via the proband with RA. Qualitative investigations have shown that communication of RA risk to FDRs is a complex and selective process. However, quantitative data are needed to develop a robust understanding of this process and its determinants to develop effective communication strategies and support for RA patients and their relatives.

Objectives: To identify predictors of the RA patients' reported likelihood of communicating RA risk information to their FDRs.

Methods: Patients with RA were invited to anonymously complete a survey assessing patient characteristics including age, gender, duration of RA, information seeking and decision making preferences (Autonomy Preference Index¹), interest in FDRs taking a predictive test for RA, dispositional openness, and the general functioning subscale of the McMaster Family Assessment Device². Reported likelihood of communicating RA risk to each of the patients' FDRs was assessed using a Likert scale ranging from extremely unlikely (0) to extremely likely (4). The median score across all FDRs was calculated for each patient. The association between patient characteristics and the median score was examined using univariate approaches.

Results: Surveys were completed by 482 patients (median age 65 years, 72% female). Most patients reported being likely to communicate RA risk to their FDRs (median score=3). Those who reported their likelihood of communicating RA risk to both children and siblings were more likely to communicate risk to children than siblings ($p<0.001$). No significant difference was found for FDRs' gender, or patients' gender, on reported likelihood to communicate about RA risk ($p=0.32$ and $p=0.87$, respectively). Patients who were older and who had had RA for longer were less likely to communicate about RA risk with their relatives. Patients who had higher interest in their FDRs taking a predictive test for RA, information seeking preferences, openness to communicate, and family functioning were more likely to communicate about risk (Table 1).

Table 1. Descriptive statistics and Spearman's rank-order correlations for the association between patients' characteristics and their median reported likelihood of communicating to their FDRs about RA risk

Patient characteristics	Descriptive statistics	Association with median likelihood to communicate risk to relatives	
		Test statistic	P value
Age; median (IQR)	65 (55-72)	-0.19	<0.001*
RA duration; median (IQR)	10 (4-20)	-0.18	0.001*
Autonomy preferences			
Information seeking; median (IQR)	84 (75-97)	0.26	<0.001*
Decision making; median (IQR)	54 (42-67)	0.09	0.048
Interest in children taking a test; median (IQR)	3 (2-3)	0.44	<0.001*
Interest in siblings taking a test; median (IQR)	2 (2-3)	0.44	<0.001*
Openness; median (IQR)	2 (1-3)	0.13	0.004*
Family functioning; median (IQR)	2 (2-3)	0.23	<0.001*

* p values significant at the Bonferroni adjusted value of 0.006.

Conclusion: Respondents were willing to communicate RA risk to their FDRs, and were more likely to communicate about risk to their children than their siblings. Factors including information seeking preferences, dispositional openness, interest in FDRs taking a predictive test, and family functioning were associated with increased likelihood of communicating RA risk information to FDRs. Patients' age and RA duration were associated with decreased likelihood. These findings increase understanding of communication about RA risk in families, and