will inform the development of informational approaches to support family communication and access to FDRs.

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POS1484-HPR THE ASSOCIATION OF STIGMA WITH DISEASE VARIABLES IN PATIENTS WITH FIBROMYALGIA (FM)

M. Offenbächer¹, L. Toussaint², M. Weigl³, J. Dezutter⁴, N. Kohls⁵, M. Vallejo⁶, J. Rivera⁷, F. Sirois⁸, J. Hirsch⁹. ¹Gasteiner Heilstollen, Medical Department, Bad Gastein, Austria; ²Luther College, Psychology, Decorah, United States of America; ³University Hospital, Department of Orthopaedics, Physical Medicine and Rehabilitation, München, Germany; ⁴University of Leuven, School Psychology and Development in Context, Leuven, Belgium; ⁵Coburg University of Applied Sciences, Health Promotion, Coburg, Germany; ⁶UNED, Psychology, Madrid, Spain; ⁷Gregorio Marañón Hospital, Rheumatology, Madrid, Spain; ⁸The University of Sheffield, Psychology, Sheffield, United Kingdom; ⁹East Tennessee State University, Psychology, Johnson City, United States of America

Background: Stigma, defined as social devaluation of an individual, can be an important stressor for chronic pain patients [1]. Not every condition is stigmatized. A relevant factor for illness stigmatization seems to be whether the cause is mental-behavioural or physical. Chronic pain is often regarded as an imaginary illness or caused by psychological problems [2]. Sources of stigma for chronic pain patients are perceived negative attitudes from family members, the general public, and physicians [1].

Objectives: To assess perceived stigma and the associations with disease variables in a cohort of patients with FM.

Methods: We invited 18 FM self-help groups in Germany to participate anonymously in our survey, and we sent the survey battery to 192 potential participants via postal mail. To measure perceived stigma, we used the Chronic Pain Stigma Scale (CPSS) developed by Reed [3], which has 30 items and 3 subscales (public, physicians, family). We also assessed sociodemographic characteristics, disease related variables (e.g., pain, stress, depression, anxiety), and other health-related factors, including health related quality of life [Healthy Days Core Module (CDC HDQOL-4)], disease specific impact (FIQ), fear avoidance belief questionnaire (physical activity subscale) (FABQ-PA), pain catastrophizing scale (PCS) and pain self-efficacy questionnaire (PSEQ).

Results: In total 162 FM patients participated (=84% response rate). Their mean age was 58 years (SD=10), 84% (N=135) were female. Highest level of education was: Elementary School 29%, Junior High School 35%, High School 15%, College 12%, and other 10%. Duration of chronic pain was 18.2 years (SD=12.0). There was no significant gender difference in the stigma subscales, nor was there an association with duration of chronic pain. Table 1 presents the significant Pearson correlations.

Table 1. Correlations of CPSS stigma subscales with health variables.
* $p < .05$; ** $p < .01$; ns=not significant.

	CPSS-public	CPSS-physician	CPSS-family
Regional pain scale	ns	.19*	.20*
VAS pain today	ns	ns	Ns
FIQ	.20*	.16*	.22**
HADS-anxiety	.37*	.20*	.24*
HADS-depression	.41**	.16*	.25**
CDC-HDQOL-4			
General health	.19*	.18*	.22**
Physical health	.19*	ns	ns
Mental health	.20*	ns	.21*
Impairment	.24*	ns	ns
Perceived stress scale	.44**	.24**	.37**
FABQ-PA	ns	-.17*	ns
PCS	.21*	ns	ns
PSEQ	.19*	ns	.18*

Conclusion: Perceived stigma in our FM patient cohort has an important impact on a variety of different disease variables including mental and general health, physical functioning, and on pain coping. Stigmatizing attitudes perceived from the general public exhibited the greatest association with most variables in our chronic pain patients. Perceived stigma from physicians and the family were also related to negative disease consequences in our FM patients. To conclude, we assert that

assessing and addressing multi-source perceived stigmatization in routine clinical care may improve the management and wellbeing of patients with FM.

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POS1485-HPR PATIENTS' PERSPECTIVE ON CONTINUATION VERSUS TEMPORARY INTERRUPTION OF IMMUNOMODULATORY AGENTS DURING INFECTIONS IN PATIENTS WITH IMMUNE-MEDIATED INFLAMMATORY DISEASES: AN INTERVIEW STUDY

M. Opdam¹, L. M. Verhoef¹, J. Vriezeolk¹, B. Van den Bemt^{2,3}, A. Den Broeder¹. ¹Sint Maartenskliniek, Rheumatology, Ubbergen, Netherlands; ²Sint Maartenskliniek, Pharmacy, Ubbergen, Netherlands; ³Radboud University Medical Center, Pharmacy, Nijmegen, Netherlands

Background: Immune mediated inflammatory diseases (IMIDs) like rheumatoid arthritis (RA) are often treated with immunomodulatory agents (IA). Infection risks appear to be slightly increased in IMID patients using IA¹. However, it remains uncertain whether it is best to continue or temporary interrupt IA in case of an infection. For this decision, it is essential to know patient's perceptions about both strategies. Unfortunately, little is known about the patients' perceptions on this topic.

Objectives: To explore the patients' perspectives on continuation and temporary interruption of IA in case of an infection and assess possible barriers and facilitators.

Methods: Semi-structured interviews were conducted in IMID patients using IA. Patients were recruited from the rheumatology, dermatology and gastroenterology departments of two hospitals in the Netherlands. Purposive sampling was used to select a diverse patient population. Semi-structured interviews were performed until data saturation was reached and analyzed using inductive thematic analysis.

Results: 19 patients with 6 different IMIDs and 17 different IA were interviewed. The majority was female, mean age 51 years and mean disease duration 17 years. Four had experienced a severe infection (requiring hospitalization). 15 patients indicated that they would prefer to continue their IA in case of an infection, however, for most patients this would depend on the infection severity. Several facilitators and barriers were identified (Table 1). Patients mentioned disease flare as a barrier for temporary interruption. Beliefs about susceptibility to infections form barriers and facilitators for both temporary interruption and continuation. Patients also mentioned that they would follow their physician's advice on continuation/temporary interruption.

Table 1. Identified barriers and facilitators

Temporary interruption	
Barriers	Disease flare and its impact Loss of IA effects or increased side effects after restarting Long duration of interruption Belief: IA has no/a positive effect on infection (risk) Belief: not more susceptible for infections Practical barriers Not aware of possibility of interruption Not following physician's advice
Facilitators	More severe and/or longer lasting infection Interactions with medication needed for infection Positive effect of interruption on immune system Short duration of interruption Belief: more susceptible for infections Belief: IA has a negative effect on infection (risk) Concerned about infections Current stable disease Physician's advice Long duration of IA effects Wish to taper/stop IA in general Negative impact of infection on daily activities
Continuation	
Barriers	Belief: more susceptible for infections Belief: IA has a negative effect on infection (risk) Negative previous experiences during infection Loss of IA effects after long use Interactions with medication needed for infection
Facilitators	Belief: not more susceptible for infections Belief: IA has no/a positive effect on infection (risk) Not concerned about infections IA needed to control IMID Mild infection Positive previous experiences with continuation Physician's advice