In low VAS group, 43% of the patients perceived low stress values vs 57% moderate-high. In VAS > 40 group 47% of the patients perceived low stress value vs 53% high-moderate. 80% of low- VAS < group did not take anxiolytics and antidepressant drugs and for this cluster of patients was not recorded a VAS increase regardless of PSS. 16.7% of patients (5/30) with VAS < 40, taking anxiolytics / antidepressant medications and with a moderate-high PSS displayed an average increase of VAS pain by 20mm. In the VAS > 40 group a VAS variation was not recorded, regardless of taking anxiolytics / antidepressant medications and PSS.

Conclusion: Lockdown impact on OA pain has been higher in the cluster of patients who were taking anxiolytics / antidepressant drugs with a moderate-high PSS. VAS pain increase in this cluster of patients exceeds minimal clinically relevant difference reported in literature¹. A relevant physical activity decrease which might negatively impact on OA course has also been recorded.

REFERENCES:

- [1] Hawker G. et al. Measures of adult pain: Visual Analog Scale for Pain (VAS Pain), Numeric Rating Scale for Pain (NRS Pain), McGill Pain Questionnaire (MPQ), Short-Form McGill Pain Questionnaire (SF-MPQ), Chronic Pain Grade Scale (CPGS), Short Form-36 Bodily Pain Scale (SF-36 BPS), and Measure of Intermittent and Constant Osteoarthritis Pain (ICOAP). *Arthritis Care Res (Hoboken)*, 2011.

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AB0684

LESS THAN 20% OF PATIENTS WITH A CHRONIC INFLAMMATORY RHEUMATIC DISEASE CHANGED THEIR IMMUNOSUPPRESSIVE MEDICATION BECAUSE OF THE COVID 19 PANDEMIC

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Background: The best treatment options of patients with chronic inflammatory rheumatic diseases (CIRD) in the pandemic have not been completely clear, especially in the beginning of the lockdown. Whether and to which degree pandemic-related therapy changes have occurred, has not been studied in detail.

Objectives: To study the behaviour of patients with CIRD initially facing the COVID 19 pandemic related to their disease status and medication.

Methods: Patients with CIRD were contacted by telephone to assess their health status and ask for changes in medication. Standardized assessment tools were used to assess disease activity, depression and anxiety. High disease activity was assumed if RADAI-5 ≥ 3.2 and BASDAI ≥ 4 . Anxiety (HADS-A) and depression (HADS-D) of patients were assessed using HADS. A score < 8 was taken as indication of no major problem in this regard.

Results: A total of 886 patients was interviewed between April 15 and June 15 of 2020. Here we report on 550 patients with complete information on standard assessments (62%). About 60% were female, mean age 54.4 $\pm$ 13.7, mean disease duration 12.2 $\pm$ 10.5 years. Most had spondyloarthritis (SpA, n=287) including axial SpA (axSpA, n=172) and psoriatic arthritis (PsA, n=116), in total 52.2%, while 40.2% had rheumatoid arthritis (RA, n=221), and 7.6% connective tissue diseases (CTD, n=42). Most RA patients were on methotrexate (48.8%), while 43.8% took glucocorticoids. In addition, 61.0% of patients were on bDMARDs, mostly on TNF inhibitors (59.6%). More SpA than RA patients were on bDMARDs: 71.0% vs 49.7% respectively. A recent change in medication was reported by 182 patients (33.1%): 89 with RA (40.2%), 88 with SpA (30.6%) and 5 with CTD (11.9%). Half of those who changed (n=92; 50.5%) admitted that the change was mainly made due to fear of the pandemic (16.7% of all patients). Altogether, significantly more patients changed bDMARDs (68.5%) than csDMARDs (57.3%). The data of patients who changed vs patients who didn't change is shown in the Table 1, including subgroup analyses. The median HADS scores were < 8.

Conclusion: Two thirds of patients did not change medication but one third changed. A relatively high number of patients did so due to fear of the pandemic, mostly those on biologics. There were no major differences between RA and SpA. Anxiety and depression do not seem to play an important role for the decision to change medication (Table 1 below).

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AB0685

IMPACT OF COVID-19 ON PATIENTS WITH RHEUMATIC DISEASES: EXPERIENCE OF THE DEPARTMENT OF RHEUMATOLOGY OF THE UNIVERSITY HOSPITAL OF IBN ROCHD OF CASABLANCA

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Background: The COVID-19 outbreak has been a source of major concern for the management of rheumatic patients, particularly those under immunosuppressants. It is generally admitted that patients followed for autoimmune diseases have an increased risk of infectious complications compared to the general population (1). However, to date, there is no established relationship between autoimmune diseases and an increased risk of infection with SARS-CoV-2 (2).

Objectives: The primary objective was to assess the severity of COVID-19 in patients followed in our department. The secondary objective was to assess the subgroup of patients on immunosuppressants.

Methods: We conducted a descriptive retrospective study of patients followed in the Department of Rheumatology of the University Hospital of Ibn Rochd, Casablanca. The patients who presented with COVID-19 between 08/2020 and 12/2020 were included. Epidemiological, clinical, therapeutic, and evolutionary data were collected and analyzed.

Results: Our series included 30 patients, with a sex ratio M/F of 0.3. The mean age of the patients was 46.4 years ($\pm$ 16.3), with a mean follow-up time of 8.1 years. 7 patients had a metabolic syndrome. Patients were followed for rheumatoid arthritis (n = 4), spondyloarthritis (n = 10), systemic lupus erythematosus (n = 5), scleroderma (n = 2), polymyalgia rheumatica (n = 1), adult onset Still's

Table 1. RA and SpA patients who changed and who did not change their medication

Group (N) / Reason	N	Active disease (%)	HADS-D ≥ 8 (%)	HADS-A ≥ 8 (%)	bDMARD therapy (%)
Rheumatoid arthritis	221	134 (60.6)	76 (35.0) [4]	94 (43.3) [4]	110 (50.9) [5]
Spondyloarthritis	287	130 (45.4)	83 (29.5) [6]	109 (38.8) [6]	204 (72.6) [6]
P ^a (RA vs SpA)		<0.001	0.228	0.354	<0.001
Patients did not change their medication					
Rheumatoid arthritis (%)	132 (59.7)	84 (63.6)	46 (35.9) [4]	58 (45.3) [4]	62 (48.4) [4]
Spondyloarthritis (%)	199 (69.3)	88 (44.2)	58 (30.1) [6]	69 (35.8) [6]	137 (71.0) [6]
P (RA vs SpA)	0.031	<0.001	0.358	0.101	<0.001
Patients changed their medication					
Rheumatoid arthritis	89 (40.3)	50 (56.2)	30 (33.7)	36 (40.4)	48 (54.5) [1]
P (vs no change)		0.331	0.846	0.567	0.457
Reason	[9]				
Pandemic	41 (51.3)	15 (36.6)	11 (26.8)	14 (34.1)	24 (60.0) [1]
Inactive disease	23 (28.8)	12 (52.2)	6 (26.1)	10 (43.5)	12 (52.2)
Active disease ^b	16 (20.0)	14 (87.5)	6 (37.5)	7 (43.8)	7 (43.8)
P (reasons)		0.003	0.687	0.687	0.526
Spondyloarthritis	88 (30.7)	42 (47.7)	25 (28.4)	40 (45.5)	67 (76.1)
P (vs no change)		0.673	0.889	0.157	0.451
Reason	[6]				
Pandemic	50 (61.0)	22 (44.0)	13 (26.0)	22 (44.0)	42 (84.0)
Inactive disease	15 (18.3)	7 (46.7)	4 (26.7)	7 (46.7)	10 (66.7)
Active disease ^b	17 (20.7)	11 (64.7)	6 (35.3)	6 (35.3)	11 (64.7)
P (reasons)		0.331	0.756	0.774	0.156
P (RA vs SpA)	0.031	0.294	0.950	0.603	0.004

Data are presented as numbers (percentage proportions; across rows except for column N) or medians (interquartile ranges). Missing values are in square brackets. ^a P values calculated using χ^2 test or Mann-Whitney rank sum test. ^b Self-reported claim of disease activity.