personal goals can help physicians providing targeted and personalised medicine.

Figure 1. themes of treatment goals at baseline and follow-up

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AB0885-HPR SLEEP IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Many patients with rheumatoid arthritis (RA) live with the consequences of arthritis in everyday life. Sleep disturbances, including insomnia, are highly prevalent and a complex issue that increases existing RA-related symptoms, such as pain, fatigue, and depressed mood. To our knowledge, only two studies have qualitatively investigated the patient perspective and experiences of sleep in people with RA (1-2).

Objectives: To investigate how people with RA and concomitant sleep disturbances describe their sleep and experience everyday life with poor sleep.

Methods: This study is a qualitative phenomenological study. In total, 14 people with RA and sleep disturbance were recruited from an RCT study (3) from the Center for Rheumatology and Spine Diseases at Rigshospitalet in 2012. Semi-structured interviews were performed after the last follow-up in the RCT. The analysis was based on Giorgis' descriptive phenomenological psychological analysis.

Results: For the characteristics of participants, see Table 1. We identified six essences; 1) "When sleep is put into words" covered that the participants described their poor sleep experiences simultaneously to their wishes for good sleep still existed. 2) "The struggle to sleep" included participants' descriptions of difficulties sleeping and how thoughts and worries could interfere with sleep at night. 3) "Pain is a companion day and night" included how pain affected sleep and how participants had problems with pain management. 4) "To take sleep in their own hands" described how the participants tried to create their framework for sleeping and how they also strove to reach out for help from, e.g. of professionals. 5) "Everyday life in the shadow of sleep" included the overwhelming fatigue, a need to rest during the day, and how social relationships were affected negatively. 6) "Adapt to the circumstances," which meant that the participants tried to seek shelter behind a facade, and at the same time tried to learn to live with the consequences of poor sleep in everyday life.

People with RA and sleep disturbances describe several challenges that affect their sleep, e.g., pain, thoughts at night, and many reasons for awakenings. Participants in this qualitative study were not aware of the difference between fatigue and poor sleep, both regarding reasons for occurring and management of the two highly prevalent consequences of RA. At the same time, they believed that health professionals lacked knowledge on sleep disturbances and management hereof in people with RA.

Conclusion: When people with RA and concomitant sleep disturbance describe their sleep, a struggle to sleep was most often described, characterized by pain, thoughts, difficulty falling asleep, and many and early awakenings. Everyday life experience with sleep disturbances was marked by fatigue and sleep

deprivation, negative impact on social skills and relationships, and failure when they reached out for help.

Table 1. Characteristics of participants

	(N=8)
Age, median (range)	50 (44-60)
Sex, Women, n %	7 (77,8%)
RA-related	
Duration of RA, median (range)	14,75 (6-32)
DAS28-CRP, median (range) ¹	1,9 (1,62-3,03)
Physical function, HAQ, median (range) ¹	0,5 (0,000 – 2,13)
Sleep	
PSQI, median (range) ²	9,5 (6-15)
Fatigue	
VAS fatigue, median (range)	33,4 (2-65)
BRAF-MDQ, median (range) ³	25,5 (4-36)
Pain	
VAS pain, median (range)	25 (0-60)
Quality of Life	
VAS global, median (range)	45,6 (8-40)

¹ Disease activity score-28 C-reactive protein²Health Assessment Questionnaire, score 0-3 (Higher score indicates worse physical functioning).² Pittsburgh Sleep Quality Index, score 0-21 (score of 5 or more indicates sleep disturbances)³ Visual Analog scale, score 0-100 (higher score is worse)⁴ Bristol Rheumatoid Arthritis Fatigue Multidimensional Questionnaire score 0-70 (higher score indicates more fatigue)

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AB0886-HPR ASSESSMENT OF SEASONAL VARIATIONS ON CHRONIC INFLAMMATORY RHEUMATISMS ACTIVITY

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Background: Although rheumatoid arthritis (RA) and spondyloarthritis (SA) activities have been described to vary under the influence of several factors, little is known about the influence of seasonality on the activity of chronic inflammatory rheumatisms.

Objectives: To assess the influence of seasonality on the activity of chronic inflammatory rheumatisms.

Methods: We conducted a cross-sectional study involving patients with RA (2010 ACR/EULAR criteria) and SA (2009 ASAS criteria). Chronic inflammatory rheumatisms activity was assessed during the summer (June-September) and winter (December-February) using clinical parameters including the Patient's Global Assessment of disease activity (PGA), 10-cm Visual Analog Scale (VAS) pain score, morning stiffness, nocturnal awakenings, and joint count for RA (tender joint count (TJC) and swollen joint count (SJC)); biological parameters including erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP); disease activity scores including the SDAI, CDAI and DAS₂₈ for RA, BASDAI and ASDAS_{CRP} for SA. An analysis of variance (ANOVA) was used to assess the statistical relationship between seasonality and rheumatism activities.

Results: We enrolled 175 patients (100 RA and 75 SA) with a sex ratio of 0.5 and a mean age of 57.75 ± 10.53 years [23-83]. The mean chronic inflammatory rheumatism duration was 12.38 ± 4.6 years. RA was erosive in 91% of cases. Rheumatoid factor and anti-citrullinated peptides antibodies were positive respectively in 84% and 85% of cases. Seventy-five percent of RA patients were on corticosteroids with a mean dose of 10.14 mg/day of prednisone equivalent and 79% of SA patients were on non-steroidal anti-inflammatory drugs. Eighty percent of our patients were treated with conventional synthetic DMARD and 44% with biological DMARD. Small joints were more affected than large joints regardless of the season in RA patients (p=0.05). The following parameters were higher in winter than in summer in RA patients: mean PGA 4.73 vs 4.64 (p=0.01); mean morning stiffness 1.6 vs 1.1 (p=0.01); mean SJC 8.7 vs 7.5 (p=0.01); mean DAS₂₈ ESR 4.56 vs 3.99 (p= 0.05); mean DAS28 CRP 4.6 vs 3.41 (p= 0.05), mean SDAI 21.8 vs 19.5 (p= 0.05); mean CDAI 20.5 vs 18.75 (p= 0.01) and mean ESR 45.6mm/h vs 38.2mm/h (p=0.01). As for SA, the following parameters were higher in winter than in summer: mean morning stiffness 2 vs 1.4 (p= 0.01); mean ASDASCRP 3.9 vs 3.1 (p= 0.01) and mean BASDAI 6.2 vs 4.9 (p= 0.05). However, we found no statistically significant