(88.3%), and cross-sectional (100%) in nature. In total there were 1281 patients, 47% ($n = 605$) were patients with primary SS and the remaining 53% ($n = 676$) were patients with secondary SS. Both patient groups were predominately comprised of females ($n = 600$; 99% and $n = 673$; 99.5%, respectively), with a combined mean age of 50.82 years (M ranges = 35 – 62.82 years). An amalgamation of results from 17 studies, found that women with SS who score higher on the ESSPRI scale (total score and the subdomains of pain, fatigue and dryness) were more likely to experience significantly greater levels of vaginal dryness, sexual dysfunction and sexual distress. Moreover, women with SS who present with clinical levels of anxiety or depression were also more likely to experience disruptions in their sexual functioning and appraise their sexual life more negatively. Furthermore, patients who report greater severity of oral or ocular dryness, or dyspareunia may experience vaginal dryness, which may have ramifications on sexual functioning. Women of all ages are at risk of experiencing sexual dysfunctions, however, younger women (≤ 50 years) may experience more burdensome disruptions than older women. Finally, women who do not use lubrication products during sexual activity may be impacted further.

Note. The solid line represents results that were significant across studies. The dotted line represents results where the significance was inconsistent across studies. Relationships that were unanimously non-significant are not shown.

Figure 1. Factors significantly associated with sexual dysfunction and sexual distress for patients with SS.

Conclusion: Younger women (≤ 50) with SS who present with more severe symptoms of fatigue, pain, and oral or ocular dryness, or with clinical levels of anxiety or depression, may be at increased risk of experiencing sexual dysfunction and sexual distress. Healthcare professionals should be aware of these potential risk factors and initiate conversations around sexuality as and when a potentially 'at risk' individual is identified.

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OP0259-HPR THE EFFECT OF OSTEOARTHRITIS ON HEALTHY WORKING LIFE EXPECTANCY AT AGE 50 IN ENGLAND

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Background: Retirement ages are rising in many countries due to population ageing and increasing life expectancy. However, poor health, comorbidity and workplace factors are major reasons for work absence and it is unclear if people in later working-age life (age ≥ 50) are able to work for longer. Osteoarthritis (OA), the most common joint condition in adults, is the fastest increasing major health condition globally and is a leading cause of disability (especially in adults age ≥ 50).

Objectives: We aimed to estimate healthy working life expectancy (HWLE; defined as the average number of years that adults from age 50 can expect to be healthy and in paid work) for adults with and without osteoarthritis and investigate the role of mental health problems as a comorbidity and the role of workplace factors through examining whether there is a sense of having any control over what happens at work.

Methods: Longitudinal survey data of adults aged ≥ 50 years were used from six waves (2002-2013) of the English Longitudinal Study of Ageing with linked

mortality data from the National Health Service Central Register. HWLE was defined using two self-report variables; health was defined as no long-standing illness or no activity limitation if long-standing illness was present, and work was defined being in employment or self-employment. OA status was identified by self-report of ever receiving a diagnosis from a doctor. Mental health and control of work were measured by self-report. Continuous-time multistate models with three states (healthy and working [state 1], other alive [2], dead [3]) were fitted in R (version 3.6.1) to investigate factors driving transitions out of the healthy and working state. Models included age and combinations of sex, OA, control at work, and mental health problems. Age-adjusted hazards of transitions between states were estimated using the 'msm' R package. HWLE for adults with different factors (OA, control of work, mental health) was estimated with the 'elect' R package using models fitted with 'msm'. Missing data was handled using multiple imputation by predictive mean matching.

Results: There were 11,540 adults with at least two observations (including survey and mortality data) for the study period (5251 males, 6289 females). Life expectancy at age 50 was 29.7 years for men and 33.4 years for women with HWLE being 9.9 years (men) and 8.3 years (women). HWLE at age 50 for adults with osteoarthritis was 7.3 years (men: 8.2, women: 6.8), and for adults without osteoarthritis was higher at 9.9 years (men: 10.6, women: 9.1). After adjusting for age, the instantaneous risk of ceasing to be both healthy and in work (not due to death) for people with OA was 1.5 times that of people without OA (hazard rate ratio 1.5 with 95% CI [1.3, 1.6]). For adults without OA, HWLE at age 50 was 13.2 years if they felt they had control at work and 4.1 years without control at work, whilst for adults with OA, HWLE was 10.4 years if they felt they had control at work and 3.1 years without. The effect of mental health problems as a comorbidity on HWLE was smaller; for adults without OA, HWLE at age 50 was 11.0 years for those without mental health problems and 8.3 years for those with, whilst for adults with OA, HWLE was 8.6 years for those without mental health problems and 6.2 years with.

Conclusion: While the average HWLE for men and women in England is lower than State Pension age, HWLE at age 50 is even lower (by approximately 25%) in adults with OA compared to adults without OA. Poor mental health further reduces HWLE. However, good quality work environments significantly lessen the impact of osteoarthritis (there is a 7.3 year difference in HWLE for those with OA who do and do not experience control at work). These results suggest that interventions and policies that create appropriate job opportunities and supportive workplaces for older workers with health conditions are key to the feasibility and success of extended working life policies.

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OP0260-HPR PREDICTORS OF WORK PARTICIPATION IN PATIENTS WITH ACTIVE RHEUMATOID ARTHRITIS AFTER 12 MONTHS OF T2T THERAPY INTERVENTION

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Background: Rheumatoid arthritis (RA) is associated with restrictions on work participation (WP) caused mainly by periods of sick leave (absenteeism), reduced productivity at work due to disease (presenteeism) and occupational disability, which account for a significant proportion of indirect costs.

Objectives: We investigate the predictors of WP after 12 months of Treat-to-Target (T2T) intervention.

Methods: Data were analyzed from the multi-center ERFASS study, which included patients with rheumatoid factor and/or ACPA positive RA after initiation or escalation of disease modifying anti rheumatic drug (DMARD) therapy following a T2T regimen prospectively over 12 months from 01/2018 to 12/2019. A total of 157 patients of working age (18 to 65 years) were included in this evaluation. Socio-demographic and occupational characteristics (WPAI, self-conducted work questionnaire), clinical parameters including disease activity (DAS28, RAI), impact of disease (RAID), functional capacity (FFbH), depression (PHQ-9) and fatigue (VAS) were analyzed and logistic regression analysis to detect baseline predictors for unimpaired WP after 12 months was performed.

Results: The mean age of the patients was 52.9 years (standard deviation (SD): 8.19) and 117 (74.5%) were female. 51 patients (32.5%) started first line DMARDs and in 106 patients (67.5%) treatment was escalated. T2T resulted in a significant decrease in mean DAS28 from 4.2 (SD 1.10) at baseline to 2.5 (SD 1.11; $p < 0.001$) after 12 months, 64.3% of the patients were in remission (DAS28 < 2.6) and 12.1% had low disease activity (DAS28 2.6-3.2). The proportion of patients with no impairment of WP increased significantly and presenteeism and absenteeism became significantly less prevalent, but the proportion

of patients with reduced WP at month 12 remained high (74.1%; graph 1). We observed a moderate positive significant correlation between presenteeism and absenteeism ($r_{\text{month 12}} = 0.446$; $p < 0.001$). Patients with no restrictions on WP showed a significantly greater decrease in mean DAS28 from 3.7 (SD 1.15) at baseline to 1.9 (SD 0.61) at month 12 as compared to patients with restrictions (mean DAS28: 4.4 (SD 1.04) at baseline to 2.7 (SD 1.15) at month 12; $p < 0.001$). Results from univariate and logistic regression analyses revealed high functional capacity and low depression score at baseline as major contributing factors for unimpaired WP (Table 1).

Table 1. Baseline predictors of work participation¹ at month 12

Predictors (independent variables)	Univariate analysis ² : p-values	Multivariate analysis ³ : Odds Ratios, p-values
gender	0.117*	OR: 0.412; $p = 0.113$
age	0.010**	OR: 0.951; $p = 0.071$
school graduation	0.150*	
professional degree	0.739	
duration of complaints	0.127*	
therapy group (starters vs. escalation/ change)	0.004**	
DAS-28(CRP)	0.001*	
CRP	0.906	
tender joints	0.004*	
swollen joints	0.021*	
disease activity (VAS)	0.003**	OR: 0.827; $p = 0.086$
subjective disease activity (RADAI)	<0.001*	
disease burden (RAID)	<0.001*	
functional capacity (FFbH)	<0.001**	OR: 1.477; $p = 0.031^*$
fatigue (VAS)	<0.001**	
depression (PHQ-9)	<0.001**	OR: 0.876; $p = 0.035^*$
working time model (full vs. part-time)	0.498	
physical work load	0.427	

¹ dependant variable: 0=reduced WP (not working/ absenteeism/ presenteeism (≥ 2)); 1=full WP (working without absenteeism/ presenteeism (≥ 2))² according to applicability chi-square test, t-test for independent variables, Mann-Whitney-U test³ binary logistic regression analysis, stepwise-backward procedure* included into logistic regression model* significance level: $p < 0.05$

Conclusion: Despite T2T and high DAS28 remission, we observed persistent limitations in WP. Impaired WP was associated with increased disease activity but logistic regression revealed a significant influence of depression and functional capacity. Our data underscore the multifactorial causes of impaired WP, which should be targeted by vocational rehabilitation.

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OP0261-HPR PERCEIVED CHALLENGES AT WORK AND NEED FOR SUPPORT AMONG PEOPLE WITH INFLAMMATORY ARTHRITIS

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Background: People with inflammatory arthritis (IA), i.e. rheumatoid arthritis, psoriatic arthritis and axial spondyloarthritis, often experience low work ability and up to 38% lose their job during the first years after being diagnosed with IA (1). As a result, people with IA have a higher risk of job loss and permanent exclusion from the labor market than people without IA (1, 2). Work-related rehabilitation is complex and encompass a variety of interventions which aim to reduce barriers to maintain work and improve work ability. Unfortunately, positive results from work-related rehabilitation is scarce (3), why a better understanding of the challenges people at risk for job loss experience is needed to develop relevant interventions.

Objectives: To explore perceived challenges and need for support to remain at work among people with IA who are at risk of job loss.

Methods: A qualitative explorative design based on a hermeneutic approach was applied. Outpatients with IA who considered themselves at risk for long-term job loss, were recruited at the Danish Hospital for Rheumatic Diseases. An interview guide was developed based on earlier results from a systematic review and qualitative studies in close cooperation with three patient research partners. Individual semi-structured interviews were performed from December 2019 to May 2020.

Results: Eleven women and four men with IA (aged 36-68 years) were interviewed. The participants were employed full time, part time or on sick leave. From the analysis, a main theme 'Balancing work as a part of everyday life' and four sub-themes emerged: 1) Working despite challenges, 2) Prioritizing energy for work, 3) Fatigue affects everything and 4) Need for support. To be able to work was very important to all participants. In general, they were stretching their limits, had concerns about maintaining their job and they used different strategies to deal with the challenges they met at work. Flexibility at work in every possible way and support from employers and co-workers were the main needs to be able to remain at work.

Conclusion: Overall, patients with IA prioritized to keep working, but experienced challenges with balancing their work and energy in everyday life. They need support and flexibility at work to be able to remain at work.

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OP0262-HPR THE NEURO-QOL UPPER EXTREMITY FUNCTION SCALE: NEW OPPORTUNITIES TO MORE RELIABLY AND PRECISELY MEASURE SELF-REPORTED HAND FUNCTION AND SELF-CARE ACTIVITIES IN PEOPLE WITH RA

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Background: RA is an inflammatory disease that results in pain and loss of function, especially in the hands and wrists. Brief self-assessment tools that can reliably and precisely quantify hand/wrist function are needed to assess inflammatory activity when a physical exam is not feasible and to capture day-to-day experience of living with RA. Neuro-QoL is part of the PROMIS family of self-report measures created using a patient-centred approach and IRT methodology. The Neuro-Qol Upper Extremity Function (UEF) scale measures ability across fine motor and ADLs involving digital, manual and reach-related function and self-care. Little is known about its performance in RA.