Following an initial pilot study, recipients were invited to complete a short online questionnaire and provide feedback to allow refinement of the provision.

Results: Respondents were asked a series of questions, each on a scale of 1-5. Every respondent gave a score of 5 in response to "What do you think of the idea of *A Little Box Of Hope*?"

Every parent of children under ten years old gave a score of 5 for every item when asked "How useful is each item in your *Little Box Of Hope*?"

Respondents also gave free-text comments:

* "It was very well thought out and I felt supported"

* "I know so much more about JIA now than I did before. I cannot thank you enough."

* "It was extremely useful and made me feel supported during a very stressful time and this enabled me to support my son more effectively."

* "It made my daughter feel less alone."

Some parents of older children felt that some information specifically for teens would be useful, and a Teen pack is being developed.

Conclusion: Recipients of *A Little Box Of Hope* have found the information useful and feel supported. Following the pilot study, we have developed *My JIA*, a booklet reviewed by a multi-disciplinary clinical team, with comprehensive information for families affected by JIA. A Teen pack, for children aged around 10 years or older, is being developed to provide targeted support to this group.

The COVID-19 pandemic has adversely affected access to healthcare services, increasing the need for remote parent- and charity-provided support through *A Little Box Of Hope*.

As such, we intend to expedite the roll-out of the project across the country building on the success of the pilot project.

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OP0279-PARE CHRONIC RHEUMATIC DISEASE (CRD) AND SPORT

P. Lemesle¹, L. Poulain², X. Grapton³, N. Bouhedja² on behalf of CREER.

¹Hospital of Courbevoie, *Clinic Rives de Seine, Courbevoie, France*; ²La Garenne-Colombes, *Private practice, La Garenne-Colombes, France*; ³Neuilly-sur-Seine, *Private practice, Neuilly-sur-Seine, France*

Background: In order to study the state of mind of patients with chronic inflammatory rheumatic disease (CRD) regarding physical/sports activity, excluding household activities despite their quantifiable energy value (MET), the CREER group produces this study.

Objectives: Analyze a population in the Ile-de-France region with CRD practicing a physical activity (their motivations, expectations, nature and rhythm). Determine the place of physical activity in the management of an CRD by the rheumatologist (Rh).

Methods: 207 patients, 53 yo average, 56% between 50 and 70 years, 60% are women; 97% of the CRD, Rheumatoid arthritis (RA): 57%) or Ankylosing Spondylitis (AS): 40%, low or moderate activity (66%).

10 years evolution (RA) and 11.5 years (AS), corticosteroids RA/AS as follows (34/5 %), NSAIDs (15/52 %), conventional DMARDs (84/30%) or biotherapies (21/43%).

Co-morbidities are found for RA/AS in 55% vs 44%, includes high blood pressure 20%, overweight 21%, tobacco 13.5%, other 19%.

Results: 7/10 patients are encouraged to engage in physical activity, regardless of gender, age, RA or AS. The most common activity proposed is walking (53%), followed by swimming and/or aquagym (40%) and gym (19%). The practice is regular in 60% more by women, RA=AS, more before 40 yo and after 60 years old (70%). The activity actually practiced is: 1- walking 46.4%, 2- aquatic activities 37%, 3- cycling 29%, 4- home sports 19%.

Once/week minimum is good for cycling and swimming, insufficient for walking, very good for sport at home.

50% have been practicing for 3 years. 60% adapt the rhythm to rheumatism. Their motivations are: to maintain one's health, to de-stress.

A discordance exists between Rh/General physician that advise sport 8 times/10 vs 4.5/10. Nevertheless 50% ignore whether he or she is getting worse or better, hence the need for information.

Rh needs to communicate more about the interest of physical activity and the absence of deleterious effect on CRD which one patient over two ignores.

If 60% of patients modify their activity with CRD, many do not participate in sports because no time, no need, no desire RA=AS.

If the activity is supervised, adapted, prescribed is well-known, its application is confidential due to lack of coaches, and of qualified centers.

Conclusion: If the main activity practiced by patients and advocated by Rh is walking, the patients go beyond this framework by mobilizing for cycling, walking, swimming and gym. But the reluctance persists and we must, through therapeutic education convince of the benefits of the activity on CRD and its co-morbidities, unknown to 50% of patients. To map lesions, judge the ability and desires are necessary to set goals for duration and frequency of activity. Using connected tools improves compliance. Finally, walking which does not require neither schedule nor equipment (otherwise a cane) should become a first-line prescription.

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OP0280-PARE A MINDFULNESS PROGRAM DOSING STUDY TO EVALUATE IMPROVEMENT IN EMOTIONAL DISTRESS AMONG PEOPLE WITH RHEUMATIC DISEASE

J. Thompson¹, N. Parikh¹, K. Gavigan¹, S. Venkatachalam¹, W. B. Nowell¹.

¹Global Healthy Living Foundation, Patient Centered Research, Upper Nyack, United States of America

Background: Mindfulness-based interventions for chronic pain and emotional distress have increased in popularity as complementary therapies among people living with rheumatic and musculoskeletal disease (RMD).^{1,2} Despite growing evidence that mindfulness meditation reduces pain and anxiety associated with RMD, more research is needed to specify the optimal duration of mindfulness training necessary to be effective for short- and long-term benefit.

Objectives: To evaluate and compare the effectiveness of full-length versus brief mindfulness training programs for improving anxiety among people living with RMD.

Methods: Adult US participants (pts) within the ArthritisPower registry were invited to participate in the Healthy Mind Healthy You study comparing the effectiveness of two online mindfulness training programs of different lengths accessed via the MoodNetwork platform. The full-length mindfulness based cognitive therapy program lasted 8 weeks, while the brief evidence-based mindfulness program lasted 3 weeks. Pts were randomized to one of the two programs and completed assessments every two weeks during the program and then every four weeks during the 12-week follow-up period. Assessments included World Health Organization-Five Well-Being Index (WHO-5), Five Facet Mindfulness Questionnaire (FFMQ), Perceived Stress Scale (PSS), and two measures of emotional distress, PROMIS Short Forms for Anxiety and Depression. Analyses compared demographic characteristics and assessment scores by program length.

Results: 324 pts completed assessments at baseline and 70 pts completed them at week 8, an attrition rate of 78% in each of the program arms. The majority of pts were female, White, with 67% between the ages of 45-64 years. No statistically significant differences were observed at baseline between participants randomized to each of the two programs, and in their assessment scores at week 8 (Table 1); PROMIS Anxiety and Depression scores improved from baseline to week 8 for pts in both programs (Figure 1). Overall, mean (SD) PROMIS Depression scores improved from 58.4 (7.7) at baseline to 55.4 (7.2) at week 8 (p=0.018), a meaningfully important difference, among the 70 pts reporting scores at both time points.

Table 1. Assessment Scores at Baseline and Week 8, Mean (SD)

	Baseline				Week 8			
	All (n=324)	8-week course (n=163)	3-week course (n=161)	p-value	All (n=70)	8-week course (n=35)	3-week course (n=35)	p-value
WHO-5 ^b	10.6 (4.9)	10.4 (4.8)	10.9 (5.0)	0.378	12.0 (5.1)	12.5 (5.5)	11.6 (4.7)	0.488
FFMQ ^c	42.7 (6.1)	42.7 (6.1)	42.7 (6.1)	0.932	39.2 (5.7)	38.9 (6.1)	39.4 (5.3)	0.741
PSS ^d	18.7 (7.5)	19.2 (6.8)	18.3 (8.2)	0.304	16.6 (7.3)	15.7 (7.8)	17.6 (6.8)	0.291
PROMIS Depression ^e	58.5 (8.3)	57.3 (8.0)	55.7 (8.6)	0.097	55.1 (8.5)	54.8 (9.3)	55.5 (7.8)	0.735
PROMIS Anxiety ^f	58.7 (8.2)	59.0 (8.2)	58.4 (8.1)	0.470	55.4 (7.2)	54.6 (7.4)	56.1 (7.1)	0.404

^a denotes use of Fisher's Exact Test ^b Range 0 (worse) to 25 (better), ^c Range 3 (worse) to 15 (better), ^d Range 0 (better) to 40 (worse), ^e Range 24.7 (better) to 63.5 (worse), ^f Range 25.7 (better) to 62.0 (worse)

Conclusion: People living with RMD who are part of a real-world US registry are willing to participate in an online mindfulness training program study, but may require additional support to remain engaged and adherent throughout the program and to participate to study conclusion. Participation in a mindfulness training program, whether full-length or brief, appears to improve symptoms of emotional distress among people with RMD.

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New Developments in COVID-Research

OP0281

EXCESS GIANT CELL ARTERITIS CASES ARE ASSOCIATED WITH PEAKS IN COVID-19 PREVALENCE

B. Mulhearn^{1,2}, J. Ellis¹, S. Skeoch¹, J. Pauling^{1,2}, S. Tansley^{1,2}. ¹Royal United Hospital, Royal National Hospital For Rheumatic Diseases, Bath, United Kingdom; ²University of Bath, Pharmacy and Pharmacology, Bath, United Kingdom

Background: Immediately following the first wave of the COVID-19 pandemic, the number of giant cell arteritis (GCA) diagnoses noticeably increased at the Royal National Hospital for Rheumatic Diseases in Bath, UK. Furthermore, there was an increase in the proportion of patients with visual complications [1]. The finding supports the viral hypothesis of GCA aetiopathogenesis as previously described [2]. This not only has ramifications for understanding the underlying disease mechanisms in GCA but also has implications for the provision of local GCA services which may have already been affected by the pandemic.

Objectives: The objective of the study was to estimate the incidence of giant cell arteritis during the COVID-19 pandemic years of 2020 – 2021 and compare it to 2019 data. Given that there have now been two distinct peaks of COVID-19 as reflected by hospital admissions of COVID-19-positive patients this has allowed us to investigate if there is a temporal relationship between the prevalence of COVID-19 and the incidence of GCA.

Methods: The incidence of GCA was calculated by assessing emailed referrals to the GCA service and the hospital electronic medical records to identify positive cases from 2019 to the current date. Local COVID-19 prevalence was estimated by measuring the number of hospital beds taken up by COVID-19 positive patients, available publicly in a UK Government COVID-19 dataset [3].

Results: There were 61 (95% Poisson distribution confidence interval [CI] 47 – 78) probable or definite GCA diagnoses made in 2020 compared to 28 (CI 19 – 40) in 2019 (Figure 1). This is an excess of 33 cases in 2020, or an increase in 118%. Given that 41% of the hospital's catchment population is over 50, this

equates to an annual incidence rate of 13.7 per 100,000 in 2019 and 29.8 per 100,000 in 2020. This compares to a previously estimated regional incidence rate of 21.6 per 100,000 for the South West of the UK [4].

Figure 1. Prevalence of hospital COVID-19 and incidence of GCA (2019 – 2021). Graph showing the number of hospital beds occupied by COVID-19-positive patients in 2020 – 2021 (blue circles), number of daily GCA diagnoses in 2020 – 2021 (red circles), and previous GCA diagnoses in 2019 (green circles). The broken lines represent moving averages with a period of 7 days for COVID-19 cases and 28 days for GCA diagnoses.

A peak in COVID-19-positive inpatients was seen on 10th April 2020 with a corresponding peak of GCA diagnoses on 29th May 2020, giving a lag period of approximately 6 weeks between these peaks (Figure 1).

Conclusion: The incidence of GCA in Bath was significantly increased in 2020 compared to 2019. This may be the result of the widespread infection of the local population with the COVID-19 virus as a precipitating factor. Possible mechanisms include, but are not limited to, endothelial disruption by the virus, immune system priming towards T helper cell type 1 (Th1) cellular immunity and/or activation of the monocyte-macrophage system. More work is currently underway to assess the causal relationship between the two diseases.

There was a lag period of 6 weeks between the peak during the first wave of the pandemic and the rise in GCA cases. We shall be closely monitoring the number of referrals that follow the current wave of the pandemic.

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OP0282

RITUXIMAB ASSOCIATED WITH SEVERE COVID-19 AMONG PATIENTS WITH INFLAMMATORY ARTHRITIDES: A 1-YEAR MULTICENTER STUDY IN 1116 SUCCESSIVE PATIENTS RECEIVING BIOLOGIC AGENTS

R. Felten¹, P. M. Duret², E. Bauer³, M. Ardizzone⁴, H. J. Djossou⁵, J. H. Salmon⁶, C. Fabre⁷, J. Walther⁷, I. Chary Valckenaere³, M. Geoffroy⁶, L. Messer², F. Berenbaum⁵, M. Soubrier⁸, J. Sellam⁵, J. E. Gottenberg¹ on behalf of BIOCOV Study Group. ¹Hôpitaux Universitaires de Strasbourg, Service de Rhumatologie, Centre National de Référence des Maladies Auto-immunes Systémiques Rares Est Sud-Ouest (RESO), Strasbourg, France; ²Hospices Civils de Colmar, Hôpital Pasteur, Service Rhumatologie, Colmar, France; ³Hôpitaux Universitaires de Nancy, Service de Rhumatologie, Nancy, France; ⁴Hôpital Emile MULLER de Mulhouse, Service de Rhumatologie, Mulhouse,