Enthesis thickness was significantly increased in PsO, in every examined site. Enthesophyte length was significantly increased in PsO group at quadriceps tendon, patellar distal insertion and Achilles tendon.

Conclusion: No differences in clinical manifestation and rheumatological history between IBD and PsO patients were observed. Subclinical (US) abnormalities were significantly increased in IBD patients with associated PsO, as compared to patients affected by IBD.

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Acknowledgements: Abbvie provided funding for medical writing

Disclosure of Interests: Giorgia Citriniti: None declared, Alessandra Soriano: None declared, Elena Bertolini: None declared, Gilda Sandri: None declared, Angela Bertani: None declared, Ilaria Tinazzi: None declared, Federica Martinis: None declared, Nicolò Girolimetto: None declared, Carlo Salvarani: None declared, Marina Beltrami Grant/research support from: Abbvie provided funding for medical writing, Pierluigi Macchioni: None declared

DOI: 10.1136/annrheumdis-2021-eular.4162

HPR - Understanding and measuring: expanding the toolbox

POS0266-HPR PATIENT-PERCEIVED ASPECTS OF RA FLARE EVOLVE OVER TIME, AS REFLECTED BY THE FLARE-RA QUESTIONNAIRE: POST-HOC ANALYSIS OF TAPERA

M. Doumen^{1,2}, S. Pazmino¹, D. Bertrand¹, D. De Cock¹, J. Joly², R. Westhovens^{1,2}, P. Verschueren^{1,2} on behalf of the TapERA study group. ¹KU Leuven, Skeletal Biology and Engineering Research Center, Leuven, Belgium; ²University Hospital Leuven, Rheumatology, Leuven, Belgium

Background: Flares are common in rheumatoid arthritis (RA). While flares negatively impact clinical and patient-reported outcomes, different aspects of disease activity may constitute a flare to patients. Flare Assessment in RA (FLARE-RA) is a patient-reported questionnaire aiming to detect active or recent RA flares (1). During its validation, arthritis and general health subscales were identified and the instrument was adapted from 13 questions (1-6 Likert scale) to 11 questions (0-10).

Objectives: To investigate which patient-perceived aspects of flare are assessed by FLARE-RA in the context of a TNFi-tapering trial, using exploratory factor analysis (EFA).

Methods: Patients with RA in DAS28CRP/ESR-remission (≥ 6 months) and treated with etanercept 50mg weekly (≥ 1 year) were included in the 12-month TapERA (Tapering Etanercept in Rheumatoid Arthritis) trial between 2012 and 2014. Participants completed 3-monthly FLARE-RA questionnaires.

The first and final follow-up visits (M3 & M12) were analyzed. Missing data were imputed with multiple imputation ($n = 10$). Sampling adequacy was assessed by Kaiser-Meyer-Olkin (KMO) and correlations between variables were evaluated with Bartlett's sphericity test. Spearman correlation matrices were constructed in each of the 10 imputed datasets. The pooled matrix was then analyzed by EFA with principal component extraction and promax-rotation. EFA aims to identify clusters of questions that elicit similar responses because of association with the same underlying latent (not observable) constructs/factors.

Results: Sixty-six patients (68% female) with a mean age of 55 years (SD 13) and a mean disease duration of 14.8 years (SD 9) completed a total of 330 FLARE-RA questionnaires. Sampling adequacy was acceptable (KMO = 0.94) and correlation between items was sufficient for factor analysis ($p < 0.001$).

Table 1 shows the results of EFA in TapERA compared to the validation study (1). Factor loadings indicate how strongly each item correlates with its underlying factor. EFA of the full 13-item FLARE-RA at M3 revealed 3 factors: Arthritis,

General health and a Medication factor relating to management of flare. The Arthritis factor explained the largest proportion of variance (31%). EFA at M12 showed the same underlying factors, but a less robust factor structure (cross-loadings > 0.3) and a larger proportion of variance explained by the General health factor (33%).

Conclusion: FLARE-RA assessed similar patient-perceived aspects of RA flare within the context of a TNFi-tapering trial when compared to the validation study, including a Medication factor reflecting use of both glucocorticoids and analgesics. This underlines the usefulness of FLARE-RA in providing a multi-faceted view of patients' conceptions of RA flare. However, these aspects and their relative importance do seem to evolve over time. Further research is needed to assess if this is due to the influence of time or specific to the studied population/tapering setting.

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Table 1. Factor loadings (> 0.3) from exploratory factor analysis of the 13-question FLARE-RA collected in TapERA, compared to results from the FLARE-RA validation study (1). Factors presented in descending order of % variance explained. Q5 & Q7 were removed in the final FLARE-RA.

ITEM	FLARE-RA Validation		TapERA M3			TapERA M12		
	GF	AF	AF	GF	MF	GF	AF	MF
Q1: stiffness	0.33	0.75	0.93					0.73
Q2: pain	0.47	0.65	0.91					1.00
Q3: swelling	0.35	0.80	0.92					0.93
Q4: nocturnal pain	0.39	0.82	0.67					0.76
Q5: overall	0.39	0.84	0.86					0.86
Q6: analgesics	0.36	0.81			0.68	0.47		0.51
Q7: glucocorticoids					0.91			0.96
Q8: fatigue	0.68	0.51		0.70		0.87		
Q9: limitation	0.73	0.48	0.30	0.75		0.74		
Q10: irritability	0.85	0.39		0.77		0.69		
Q11: mood	0.83	0.44		0.97		0.79		
Q12: withdrawal	0.90			0.89		1.06		
Q13: needing help	0.81	0.38		0.72		0.60	0.30	
Variance explained (%)	66	10	31	31	12	33	31	10

AF = arthritis factor, GF = general health factor, MF = medication factor

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.2003

POS0267-HPR IDENTIFYING MEANINGFUL AND DETECTABLE CHANGE FROM THE PATIENT PERSPECTIVE ACROSS COMMON FATIGUE MEASURES IN RHEUMATOID ARTHRITIS

S. J. Bartlett^{1,2}, U. Haque³, V. Bykerk⁴, J. R. Curtis⁵, M. Jones³, C. Bingham³.
¹McGill University, Clinical Epidemiology & Rheumatology, Montreal, Canada;
²Johns Hopkins Medicine, Rheumatology, Baltimore, United States of America;
³Johns Hopkins Medicine, Rheumatology, Baltimore, United States of America;
⁴Hospital for Special Surgery, Rheumatology, New York, United States of America;
⁵University of Alabama at Birmingham, Rheumatology, Birmingham, United States of America

Background: Different tools are commonly used to assess fatigue in RA including single items (visual analogue (VAS), numeric rating (NRS), and Likert scales), SF-36 Vitality, and PROMIS. Evidence is needed to identify scores that reflect meaningful change to patients to interpret fatigue results in trials and for clinical care.

Objectives: To use symptom-specific and RA change anchors to estimate meaningful and detectable change scores from the patient perspective across several fatigue measures.

Methods: Stable RA patients (ACR/EULAR 2010 criteria) were recruited from 3 academic clinical practices across the Southern, Mid-Atlantic, and Northeastern United States. Scales were administered at 2 consecutive visits to capture PROs including fatigue. We also asked a fatigue-specific change question (*How would*