positive inflammatory assessment with very high activity indices, with a mean of 4.6. 64.66% of the patients received NSAIDs, of which 11% responded well. 57% were treated with csDMARDs, and 17.86% were treated with biologics. At the time of our study, the mean visual analog score was 5.84 ± 17 out of 10 (2-9). The mean Epworth score was 8.38 ± 5.2 (0-21), 56.1% of patients had no sleep debt, 33.3% had a sleep deficit, and only 10.6% had signs of drowsiness. For the overall Pittsburgh score, the mean was 702 ± 3.6 (1-18). The mean of "subjective quality of sleep" was 1.12, "sleep latency" was 1.22, "duration of sleep" was 1.06, "usual sleep efficiency" was 0.74, "Sleep disturbance" of 1.28, "use of a sleep medication" of 0.54, and the average of the component concerning "poor shape during the day" was 0.03 out of 3. The LEQUESNE index went from an average of 6 to 8, which corresponds to an average handicap (P = 0.2) over a period of 3 years. 68% of the patients had an alteration in the quality of sleep, starting on average three years after the onset of symptoms. 11% reported having experienced anxiety and depressive symptoms, and reported having used antidepressants or anxiolytics in the past 5 years.

Conclusion: Our study showed the negative impact of SpA on the duration and overall quality of sleep. The degree of pain as well as functional impairment can cause and worsen sleep disturbances in SpA. We have shown that the Pittsburg score increases significantly with the increase of pain. The Lequesne score and the Epworth score increase with disease activity[1].

REFERENCES:

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Table 1 & Figure 1

Graph 1. Spread of Data points demonstrating a monotonic relationship with no outliers

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