Conclusion: Different ways of coping may be used simultaneously during an acute flare of seropositive RA. In pts with high disease activity dysfunctional coping is the only coping strategy predicting a worse disease outcome after 12 months and dysfunctional coping correlates with depression and anxiety.

REFERENCES:

Disclosure of Interests: Juliana Rachel Hoepner: None declared, Ioana Ilaidis: None declared, Marianne Richter: None declared, Sara Eileen Meyer: None declared, Kai Kahl: None declared, Torsten Witte: None declared, Kirsten Hoeper: None declared, Marianne Richter: None declared, Sara Eileen Meyer: None declared, Juliana Rachel Hoeper: None declared, Ioana Iliadis: None disclosed.

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POST1484-HPR LUMBOPELVIC STABILITY, TRUNK POSITION SENSE, AND SPINE POSTURE IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS

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Background: Axial Spondyloarthritis (axSpA) are chronic systemic inflammatory rheumatological diseases characterized by axial skeletal involvement and enthesitis. The trunk is the central key point of the body, playing an essential role for postural control, the coordination of the extremities, and functional activities. The systemic, inflammatory nature of axSpA, chronic pain, inflammatory cytokines, changes in the bone and ligaments of the spine may affect lumbopelvic stability, trunk position sense, and spine posture.

Objectives: We aimed to investigate lumbopelvic stability, trunk position sense, and spine posture in patients with axSpA.

Methods: Twenty axSpA patients (mean age; 33.65± 5.72, 75% female) and 20 age- and gender-matched healthy controls were included in the study. In axSpA patients, mean time since symptom onset was 9.75±4.82 years and mean time since diagnosis was 6±3.97 years. Lumbopelvic stabilization was evaluated by a pressure biofeedback unit (Stabilizer Pressure Biofeedback Unit, Chattanooga Group Inc., Hixson, TN, USA). Trunk position sense, as indicated by trunk reposition errors (TRE), was assessed with a digital inclinometer. Thoracic and lumbar curvature tests were performed with a digital inclinometer.

Results: Comparisons of lumbopelvic stability, trunk position sense and posture were shown in Table 1. Lumbopelvic stabilization values were significantly lower in the axSpA group when compared to the control group (p<0.001). TRE, in which higher scores indicate poorer trunk position sense, was higher in the axSpA group compared to the control group (p<0.001). The degree of thoracic curvature was higher (p = 0.001) in the axSpA group compared to controls whereas the degree of lumbar lordosis was not significantly different between the groups (p = 0.444).

Table 1. Comparison of lumbopelvic stability trunk position sense, and posture of the groups

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>AxSpA group (n=20)</th>
<th>Control group (n = 20)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumbopelvic stabilization (mmHg, median; min–max)</td>
<td>43.65 (41.3;51.3)</td>
<td>48.6 (46.2;62.6)</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>Trunk position sense (TRE), in (median; min–max)</td>
<td>3.6 (0.66; 8.6)</td>
<td>1.3 (0.66; 2)</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>Spine posture</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Thoracic curvature (°, median; min–max)</td>
<td>39.95 (29.5;53.3)</td>
<td>34.3 (29.6;3)</td>
<td>p = 0.001</td>
</tr>
<tr>
<td>Lumbar curvature (°, mean ± SD)</td>
<td>37.9 ± 7.6</td>
<td>37.9 ± 7.2</td>
<td>p = 0.444</td>
</tr>
</tbody>
</table>

TRE trunk reposition error, AxSpA Axial Spondyloarthritids, SD standard deviation; p< 0.05, a Independent samples t-test; b Mann-Whitney U test.

Disclosure of Interests: None declared.

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POST1485-HPR DIGITALLY ENHANCED TREAT-TO-TARGET AND SHARED DECISION-MAKING APPROACH WITH A DIGITAL HEALTH APPLICATION: INTERIM RESULTS FROM A RANDOMIZED CONTROLLED TRIAL

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Background: Digital health applications (DHA) became indispensable patient companions accelerated by the current COVID pandemic [1]. In 2020, for the first time worldwide, a regulatory framework to reimburse DHA was established in Germany. To get listed as a DHA, preliminary evidence needs to be generated – next to fulfilling highest standards in quality and safety. The DHA ABATON RA consists of two parts; 1) digital shared-decision-making (SDM) including choosing an appropriate electronic patient reported outcome (ePRO) instrument and the respective ePRO target for the next visit, 2) remote patient monitoring and ePRO tracking by the patient. Hereby, ABATON RA supports a digitally guided Treat-to-Target (T2T) approach.

Objectives: The objective of this study is to evaluate a potentially beneficial effect for the patient by using ABATON RA.

Methods: Three-armed, partially blinded multicenter trial (RCT) including RA patients who regularly use a smartphone. Patients attend 3 visits, 3 months apart (T0, T3, T6), with one follow-up visit (T9). Intervention group (IG): Patients use ABATON RA. Via SDM patients and rheumatologists choose a specific ePRO and respective treatment target for the next visit in three months, e.g. RAID ≤4. Control group (CG): Standard of care treatment (no DHA). Placebo group (PG): Usage of a placebo version of ABATON RA providing only Regensburger Insomnie Skala (RIS) and Epworth Sleepiness Scale (ESS) as ePROs. No SDM is conducted and ePRO results are not presented to HCP.

Results: This interim analysis evaluated the first 38 patients that completed T3. IG: 13 patients (Av. age 55.9, 61.5% females); PG: 12 (Av. age 50.7, 66.7% females); CG: 13 (Av. age 56.1, 76.9% females). We observe a significant improvement in the mean over time in a pairwise comparison within the intervention group for the following: Pt-GA mean difference of 2.98 (p = 0.025, partial η2