Objectives: We conducted a retrospective study of the incidence of falls in patients with RA, who are more prone to fractures and falls, using fall risk medications, especially hypnotics and anxiolytics, which aimed to determine the relationship between falls and fall risk medications in patients with RA.

Methods: This study is a retrospective cohort study conducted in Showa University Hospital between December 1, 2019 and March 31, 2020. We included of RA patients who visited the outpatient and fulfilled the American College of Rheumatology (ACR) /European League against Rheumatism (EULAR) classification 2010 criteria. The main exposure was the fall risk medication. The fall risk medication group was defined as RA patients who were prescribed fall risk medication (sedative/hypnotic, antidepressants, antipsychotics, and anxiolytic (benzodiazepines) drugs) for all the observational period. The comparison group was defined as RA patients who had never been prescribed any fall risk medications.

Outcome measure was the prevalence of fall incidents in the past one year, obtained by using questionnaires to patients. Logistic regression analysis was performed to investigated the relationship between the prevalence of fall events and the use of fall-risk medications. The co-variables we selected were as follows: age, sex, stroke, dementia, diabetes and osteoarthritis as covariates.

Results: We obtained data from 331 patients, of which 303 were included in the analysis. Among the 303 patients, the median age was 67 years (56-75), and 78.5% were women. Of the 303 patients, 45 patients used fall risk medication and 69 patients experienced at least one fall in a year. Of the 45 patients who used fall risk medication, 18 patients experienced at least one fall in a year. Of the 69 patients who experienced falls, 30 patients experienced twice or more falls in a year. Of the 18 patients who used fall risk medication and experienced falls, 9 patients experienced twice or more falls. 4 patients were admitted to the hospital as result of falls, 2 patients used fall risk medication. These results are shown as percentages in Figure 1. The group of fall risk medication was significantly higher than using non fall risk medication. (adjusted odds ratio (AOR) 2.31, 95% Confidence Interval (CI) 1.14-4.68, p=0.02).

Figure 1.

Conclusion: Use of fall risk medications may have increased falls with patients with RA.

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Disclosure of Interests: None declared


AB0243

ASSOCIATIONS BETWEEN JOINT DEFORMITY, DISEASE DURATION, DISEASE ACTIVITY, ACTIVITIES OF DAILY LIVING, QUALITY OF LIFE, PAIN, AND FATIGUE IN PATIENTS WITH RHEUMATOID ARTHRITIS

I. Yoshii1, N. Sawada2, T. Chijiva1. 1Yoshii Hospital, Rheumatology, Shimanto City, Japan; 2Dohgo Onsen Hospital, Rheumatology, Matsuyama, Japan; 3Kochi Memorial Hospital, Rheumatology, Kochi, Japan

Background: Patient with rheumatoid arthritis (RA) have disease-related problems such as joint deformity, disease duration, disease activity, activities in daily life (ADL), quality of life, pain, and fatigue. All these problems correlate interactively.

Objectives: Aim of this study is to clarify association among these problems statistically using retrospective cohort data.

Methods: Patients with RA who were followed up more than three years were recruited. Their EuroQol-5th dimension (EQSD) as an indicator of quality of life (QOL), simplified disease activity index (SDAI) as an indicator of disease activity, Health Assessment Questionnaire Disability Index (HAQ) as an indicator of ADL, pain score using visual analog scale (PS-VAS), and fatigue score using visual analog scale (FS-VAS), were monitored every three months. Sharp/van der Heijde score (SHS) as an indicator of joint deformity was calculated annually. Association among average values of these factors and patient’s sex, age, disease duration (DD), and anti-citrullinated polypeptide antibodies (ACPA) titer were evaluated using multivariate linear regression analysis. Statistical significance was set within 5%.

Results: A total of 447 patients, in whom 120 male and 327 female included, were analyzed. Mean age, disease duration, EQSD score, SDAI score, HAQ score, SHS, PS-VAS, and FS-VAS during follow-up were 71.8-year-old, 12.9 years, 0.831, 4.26, 0.413, 46.9, 22.5, and 23.2, respectively. EQSD score correlated significantly with age, HAQ score, SDAI score, SHS, PS-VAS, FS-VAS, and DD using univariate models. In these, age, HAQ score, and FS-VAS correlated significantly using multivariate model (correlation coefficients (CC): 0.927). HAQ score correlated significantly with age, EQSD score, SDAI score, SHS, PS-VAS, FS-VAS, and DD using univariate models. In these, EQSD score, SHS, and FS-VAS correlated significantly using multivariate model (CC: 0.910). SDAI score correlated significantly with female gender, EQSD score, HAQ score, SHS, PS-VAS, and FS-VAS using univariate models. In these, SHS score, SDAI score, and DD correlated significantly using multivariate model (CC: 0.685). PS-VAS correlated significantly with EQSD score, SDAI score, SHS, and FS-VAS using univariate models. In these, SDAI score and FS-VAS correlated significantly using multivariate model (CC: 0.732). FS-VAS correlated significantly with EQSD score, HAQ score, SDAI score, and DD using univariate models. In these, EQSD score, HAQ score, and PS-VAS correlated significantly using multivariate model (CC: 0.715). ACPA did not correlated with any factors significantly.

Conclusion: These results suggested that EQSD score, namely QOL is influenced by various disease-related factors and aging, especially correlated with ADL and fatigue closely. The HAQ score, namely ADL level is influenced by fatigue level and joint deformity directly. The SDAI score, namely disease activity level correlated with pain level and joint deformity level, and correlates with the other factors indirectly. A schematic figure that represents relationships among factors were shown in Figure 1. These information would beneficial for conducting treatment protocol of RA.

Figure 1.

Disclosure of Interests: None declared


AB0244

MEDICATION ADHERENCE AND BELIEFS ABOUT MEDICATION IN PATIENTS WITH RHEUMATOID ARTHRITIS

C. Jung1, C. Baenwald1, O. Seifert1. 1University Hospital Leipzig, Department of Internal Medicine, Rheumatology Unit, Leipzig, Germany

Background: Consistent immunosuppressive treatment of rheumatoid arthritis (RA) with disease-modifying anti-rheumatic drugs (DMARDs) is crucial for reduced progression and improved long-term outcome of the disease. Therefore, drug adherence is a prerequisite, which is often insufficient according to literature.

Objectives: Our aim was to investigate the relationship between adherence and beliefs about medication in patients with RA.
Methods: The study included 137 RA patients (102 female, 35 male; age range 28-86 years, 64.8 ± 12.6 years; SDAI ≥ 0.9 in 68.6; 41 % DMARD monotherapy, 31 % DMARD combination therapy, 8 % currently treated without DMARD). Medication adherence was measured with the Compliance-Questionnaire-Rheumatology (CQR). This is a self-report questionnaire with 19 items (4 response options each). The sum score is mapped to a scale from 0 to 100 % (CQR%). With 100% corresponds to optimal adherence. A CQR% ≥ 80 % was defined as satisfactory adherence. In addition, the specific part of the Beliefs about Medicines Questionnaire (BMQ) was used to assess patients' opinions about the necessity of their medication therapy and their concerns. Besides correlation analyses (Spearman-Rho) multiple linear regression was applied to determine factors influencing adherence (coefficient of determination: adjusted R²).

Results: Adherence was satisfactory in 93 RA patients (67.9 %) and insufficient in almost one-third (n = 44; 32.1 %). Analyses showed that adherence was significantly related to belief in necessity (r = 0.46; p < 0.01) and concerns about drugs (r = 0.39; p < 0.01). Furthermore, it appeared that adherence is closely linked to the age of the patient (r = 0.30; p < 0.01). Younger RA patients (≤ 60 yrs) had significantly lower CQR%-scores than older RA patients (≥ 60 yrs; p < 0.01). Belief in the necessity of therapy, medication concerns and age patient accounted for almost half of the patient-specific variability in adherence (each p < 0.01; R² = 42.9 %), suggesting a strong dependence of adherence on these three factors.

Conclusion: Adherence is insufficient in about one-third of RA patients. Additionally, adherence appears to be strongly dependent on the patient's belief in the necessity of therapy, medication concerns and age. Physicians should strive for all RA patients to have sufficient knowledge about their medication, strengthen the belief in the necessity of the therapy and be mindful of adherence when talking to patients.

Disclosure of Interests: None declared

RPM involvement in rheumatoid arthritis and secondary sjögren syndrome

A. R. Halidou1, K. Nassar1, S. Janani1. 1CHU Ibn Rochd, Rhumatologie, Casablanca, Morocco

Background: Rheumatoid arthritis (RA) is a severe inflammatory disease that affects the joints and other organs such as the lung. Gougerot-Sjögren's syndrome (rSJS) is an autoimmune disease. Secondary SGS can be primary or secondary and is defined by (1) the presence of another connective tissue disease, (2) the existence of dry eyes or dry mouth, and (3) objective evidence of ocular or salivary involvement. The presence of anti-SSA or anti-SSB antibodies is not necessary for the diagnosis of secondary SMS (4). The association of the two pathologies (RA-SGS) is frequent, and apart from osteoarticular involvement, various organs can be affected, in this case the lungs, by one or the other pathology. We are interested in respiratory illnesses.

Objectives: To determine the incidence of pulmonary involvement in a population of RA-SGS patients.

Methods: Retrospective study, conducted from January 2019 to October 2021, at the rheumatology department of the CHU Ibn Rochd of Casablanca. Inclusion criteria: patients followed for RA according to the diagnostic criteria (EULAR/ACR 2010) associated or not with secondary GSS. Exclusion criteria: patients followed for primary GSS alone or other inflammatory rheumatic diseases with pneumopathy.

Results: 139 patients were included in our study, with a female predominance of 96.40%. The mean age was 56.31 years, the mean duration of RA was 9.89 years (4 months - 34 years). GSS was associated in about 1/3 of the patients, 33.81%. In the study population 24.46% of patients had pulmonary involvement which was present in the majority of RA-SGS patients (63.83%). Clinically, exertional dyspnea was found in all these patients and chronic dry cough in 66.67%. On standard radiography, an interstitial syndrome was found in all of these patients and on the pulmonary CT scan, 2 patients were at the stage of pulmonary fibrosis, i.e. 6.67% (PR-SGS).

Discussion: Secondary GSS is found in 30% of patients with rheumatoid arthritis (3). Pulmonary infiltrative disease is similar in both conditions. In RA these diseases are in the foreground after pleural involvement. They have the same clinical, radiological and functional characteristics, associated to varying degrees with exertional dyspnea, dry cough, crepitus rales, and digital hippprasis (5,6). Pulmonary involvement is frequent in SSc, mainly represented by diffuse interstitial lung disease and bronchial and bronchiolar involvement (7). In SSc, the prognosis is rarely threatening (8). In RA, the overall prognosis of rheumatoid lung disease remains poor with significant morbidity and mortality. A particular evolutionary mode characterized by acute exacerbation of interstitial lung disease associated with connective tissue diseases has been reported, particularly in RA (9,10).

Conclusion: In our series, the frequency of association of secondary SGS with RA is similar to the data in the literature and lung involvement is particularly frequent in these patients. No study in the literature has looked specifically at the clinical and prognostic features of lung involvement in RA-SGS patients.