ULT was administered to pts with RA and HU 4 times less frequently than to pts with GA. The effectiveness of ULT in RA and HU is two times lower than in GA.

**Conclusion:** 1) HU negatively affects the decrease of RA activity. 2) HU in RA is associated with increased comorbidity 3) ULT is assigned to pts with RA and HU 4 times less frequently than to pts with GA and is ineffective in 76.71% of cases.

Additional research is needed to evaluate the influence of UAs’ serum lev-

**RESULTS:**

88.5% of RA patients had low muscle strength, 61.1% of people had low physical performance. No correlation was found between physical performance and age, RA activity, body composition and BMD. In persons with reduced physical performance, HAQ, EQ-SD index, VAS and RAID were worse than in women with normal physical function (p<0.0001; p<0.0001; p<0.004; p=0.010, respectively). Also, these patients had more pronounced signs of anxiety and depression, assessed using HADS-A (p=0.004) and HADS-D (p=0.001). HAQ positively correlated with the number of comorbidities (r=0.35, p<0.001) and negatively correlated with the SPPB and gait speed (r=0.35, r=-0.39 and r=-0.37, respectively, p<0.001). EQ-SD index positively correlated with SPPB and gate speed (r=0.44 and r=0.39, respectively, p<0.001). HADS-A and HADS-D positively correlated with the number of comorbidities (r=0.35 and r=0.34, respectively, p<0.001). HADS-A negatively correlated with the biological therapy duration (r=0.36, p=0.032) and with BMI (r=0.34, p<0.001). HADS-D negatively correlated with the SPPB (r=-0.38, p<0.001). RAID negatively correlated with the biological therapy duration (r=-0.35, p=0.032) and with SPPB (r=-0.35, p<0.001).

**Conclusion:** 88.5% of RA patients had low muscle strength and 61.1% - low physical performance. Quality of life negatively correlated with physical performance.

**Disclosure of Interests:** None declared

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**AB0317**

**QUALITY OF LIFE AND LOCOMOTORIC FUNCTIONS IN PATIENTS WITH RHEUMATOID ARTHRITIS**

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**Objectives:** To evaluate quality of life and its relationship with muscle strength and physical performance in patients with rheumatoid arthritis (RA).

**Methods:** 159 women (mean age 58.7±8.8) with confirmed RA according to ACR/EULAR criteria (2010) were enrolled. Hand grip strength was measured using mechanical dynamometry. Dual-energy X-ray absorptiometry (DXA) was performed to assess the body composition and bone mineral density (BMD) of the lumbar spine, femoral neck and total hip. SP was defined as muscle strength < 16 kg and appendicular lean mass index (ALMI)<5.5kg/m² or appendicular lean mass (ALM) <15kg. RA activity was assessed by C-reactive protein (CRP) and disease activity score using 28 joint counts and erythrocyte sedimentation rate (DAS28-ESR). The relation between low ALM with disease parameters was analyzed using Spearman’s R. Factors associated with SP were evaluated using regression analysis.

**Results:** SP was diagnosed in 33 (20.6%) women with RA. Patients with SP did not differ in age from those without it (59.0±8.9 and 58.7±8.8 years, respectively, p>0.05). 75.8% patients with SP and only 27.8% women without SP had normal physical performance. No correlation was found between physical performance and age, RA activity, body composition and BMD. In persons with reduced physical performance, HAQ, EQ-SD index, VAS and RAID were worse than in women with normal physical function (p<0.0001; p<0.0001; p<0.004; p=0.010, respectively). Also, these patients had more pronounced signs of anxiety and depression, assessed using HADS-A (p=0.004) and HADS-D (p=0.001). HAQ positively correlated with the number of comorbidities (r=0.35, p<0.001) and negatively correlated with the SPPB and gait speed (r=0.35, r=-0.39 and r=-0.37, respectively, p<0.001). EQ-SD index positively correlated with SPPB and gate speed (r=0.44 and r=0.39, respectively, p<0.001). HADS-A and HADS-D positively correlated with the number of comorbidities (r=0.35 and r=0.34, respectively, p<0.001). HADS-A negatively correlated with the biological therapy duration (r=0.36, p=0.032) and with BMI (r=0.34, p<0.001). HADS-D negatively correlated with the SPPB (r=-0.38, p<0.001). RAID negatively correlated with the biological therapy duration (r=-0.35, p=0.032) and with SPPB (r=-0.35, p<0.001).

**Conclusion:** 88.5% of RA patients had low muscle strength and 61.1% - low physical performance. Quality of life negatively correlated with physical performance.

**Disclosure of Interests:** None declared

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**AB0318**

**PREVALENCE OF SECONDARY SJÖGRÉN’S SYNDROME IN PATIENTS WITH RHEUMATOID ARTHRITIS: A SINGLE CENTER STUDY FROM NORTHERN INDIA**

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**Background:** Sjogren’s syndrome (SS) is a systemic autoimmune disease characterized by lymphocytic infiltration of salivary and lacrimal glands leading to dry eyes and dry mouth. Sjogren’s syndrome either present alone (primary Sjogren’s syndrome) or sometimes can occur with other autoimmune diseases like rheumatoid arthritis, systemic lupus erythematosus, and scleroderma. In such instances, the condition is termed secondary Sjogren’s syndrome. SS may be a marker of more aggressive joint disease in patients with RA, and hence it is essential to characterize the symptoms in the RA cohort, which may help in the management and treatment of the disease.

**Objectives:** Primary Objective

The primary objective of the current study is to estimate the prevalence of secondary Sjogren’s syndrome in a cohort of patients with rheumatoid arthritis.

**Secondary Objective**

To compare the clinical characteristics in rheumatoid arthritis patients with Sjogren’s syndrome and in rheumatoid arthritis patients without Sjogren’s syndrome.

**Methods:** The study was conducted from 2016-2018 in a tertiary care hospital in the Department of Rheumatology, New Delhi, India. Patients with a rheumatologist-diagnosed RA were enrolled. There were 726 patients with rheumatoid arthritis. Patients were enquired about their symptoms. Out of 726, 193 had secondary Sjogren’s syndrome (26.58%). In patients without Sjogren’s syndrome, complete clinical data were available only for 377 patients hence the analysis on the comparison of clinical characteristics was limited to 377 patients. The other patients were excluded due to lack of the data required for the study.

**Results:** It was identified that out of 726 patients, 193 had symptoms of secondary Sjogren’s like dry eyes dry mouth, or both. It was found that in patients with secondary Sjogren’s syndrome (n=193), the mean age was significantly higher than those patients without secondary Sjogren’s syndrome (n=377) [52.58 ± 12.36 Vs. 48.42 ± 13.98, p=0.005]. Similarly, the mean disease duration was significantly longer among RA patients with secondary SS than those without secondary SS [10.76 ± 8.34 Vs. 6.81 ± 7.29, p<0.001]. Similarly, comorbidities like hyper tension, diabetes mellitus, and hypothyroidism were more seen in patients with rheumatoid arthritis with Sjogren’s syndrome.

In a meta-analysis involving 18 studies, it was identified that the prevalence of SS in RA was 19.5%. The differences in the prevalence of secondary SS in RA patients could be attributable to inter-ethnic variation, disease duration, and clinical scores employed in the studies. Further to our study, Santhosh et al. reported that patients with secondary SS had a longer disease duration than those without secondary SS.

**Conclusion:** The prevalence of Sjogren’s syndrome among patients with rheumatoid arthritis in the North Indian cohort of patients with RA was 26.58%.

**REFERENCES:**