in these events. However, in 2022 we offered physical events as well. We are trying to reach out as broadly as we can in order to meet the different needs from people with RMD.

Conclusion: The use of live events and videos is a way to unfold the professional

Counselling service in order to give help and advice to a broader audience. It has been a huge success with many viewers who interact with us. These digital offers are contributing to make the Danish Rheumatism Association appear as a modern and progressive association. An important notice when wanting to become more digitalized as a patient organization is, that even on a low budget you can reach many people with RMD as long as the content is relevant. We will for sure develop even more digital offers in the future regarding patient information and education in order to improve the quality of life for more people with RMD.

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POS007-HPR

CAREGIVER BURDEN AMONG IDIOPATHIC INFLAMMATORY MYOPATHY (IIM) CAREGIVERS

Keywords: Myositis, Patient-led research, Quality of life

M. Lubin1*, Y. P. Hu1, L. Wilson2, J. Williams1, A. Bhattachary1, S. Bhal1.
1Myositis Support and Understanding, Patient-Centered Research, Lincoln, DE, United States of America; 2Massachusetts General Hospital - Surgery, Boston, United States of America; 3U of Texas Southwestern Medical Center, Neurology, Dallas, United States of America

Background: Idiopathic inflammatory myopathies (IIMs) often lead to severe impairments in quality-of-life related to physical and emotional burdens. While the healthcare delivery burden in patients with specific types of IIMs has been explored[1, little is known about caregivers’ burden, especially in rare diseases.[2]

Objectives: Myositis Support and Understanding (MSU), a non-profit patient-led advocacy organization for IIMs, distributed a survey to its members to better understand caregiver burden. The aim of this study was to evaluate the association between caregiver burden by IIM subtype and factors that impact caregiver wellbeing.

Methods: Data Source: An anonymous survey was distributed via RedCAP to MSU members worldwide. A total of 120 caregivers (age range: 30-89) responded to the survey over the course of 4 weeks. Survey: Demographic, diagnostic information, and disease duration data was collected from participants and their caregivers. The Zarit Burden Inventory (ZBI), a validated instrument for a diverse range of patients and caregivers, was used to determine caregiver burden, testing domains including health, mental well-being, personal relationships, physical overload, social support, and home environment[3].

Statistical analysis: Pearson chi-square test was performed to assess the association between duration of caregiving, myositis type, and caregiver age on the social well-being of caregivers. Regression analysis was also conducted to identify risk factors for increased caregiver burden. Significance was set at p<0.05.

Results: Most of the caregivers in this study were responsible for the care of patients with inclusion body myositis (IBM, 64%) followed by dermatomyositis (DM, 22%). Caregivers reported that 74% of IBM patients under their care had moderate to severe difficulties with mobility and required help some or most of the time. A total of 102 caregivers completed the ZBI: reported burden was mild to moderate in 44%, moderate to severe in 25%, and severe in 4% of caregivers. There was a high degree of at least moderate severity burden in IBM (33%), DM (25%), and polymyositis (25%).

Conclusion: Caregivers face a high degree of burden, most evident in IBM. Burden positively correlated with disease duration with an inflection time of 6 years, thereafter caregivers reported increased burden. The domains that were most impacted include personal strain, social and family life, role strain, and loss of control over one’s life. Insights from this study can help create specific emotional coping strategies for myositis patients and their caregivers.

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HPR Poster Tour: Diverse interventions and patient perspectives

Keywords: Physical therapy/Physiotherapy, Psoriatic arthritis, Systematic review

M. Kaerts1, J. Eelen2, N. Planck3, F. Van Loock2, A. Lievens2, K. De Vlam1, R. Lories1, W. Dankers2, T. W. Swinnen1, B. Neenknick1, KU Leuven, Skeletal Biology and Engineering Research Center, Leuven, Belgium; KU Leuven, Research Group for Musculoskeletal Rehabilitation, Leuven, Belgium; University Hospitals Leuven, Division of Rheumatology, Leuven, Belgium

Background: Patients with psoriatic arthritis (PsA) have a remarkable increased risk for cardiometabolic comorbidities impacting their disease management and functioning. Studies in the general population have demonstrated that higher levels of physical activity, better cardiorespiratory fitness and muscle strength interventions were studied.[1-4] Physical therapy is highly recommended as part of the non-pharmacological management of PsA patients. [2-4] Physical activity recommendations were composed but specific guidance on the type, duration or intensity was not provided.[5] Therefore, a summary of the available evidence on physical therapy, physical activity and physical fitness in PsA patients is needed to strengthen the non-pharmacological management.

Objectives: This study aimed to systematically review and appraise the quality of research on physical therapy, physical activity and physical fitness in PsA patients.

Methods: The protocol was prospectively registered at the PROSPERO database (ID 555501). A systematic literature search was performed in May 2022, using four different databases (Medline, Embase, Web of Science and Cochrane library). We included papers examining physical therapy, physical activity and physical fitness (cardiorespiratory and muscular fitness) in PsA patients, with a minimum age of 18 years and diagnosed by a physician, classification criteria or self-reported. A mixed population of patients with rheumatic and musculoskeletal diseases was allowed if the proportion of PsA patients was at least 10%. All eligible interventional or observational (quantitative or qualitative) studies with a full-text paper written in English or Dutch were included without restrictions regarding the publication year. The quality was assessed through the Newcastle-Ottawa Scale and the Revised Cochrane risk-of-bias tool for randomized trials. A meta-analysis was not possible due to the wide variety of interventions and outcomes. Therefore, a narrative synthesis was used.

Results: After deduplication, a total of 6026 abstracts were retrieved, of which 380 abstracts were selected for full-text analysis. Ultimately, 85 papers published between 1994 and 2022 were included, of which 6 papers were added from screening references. Most studies were cross-sectional (n=31) or randomized controlled trials (RCT; n=18). Forty-seven % of the studies consisted of PsA patients only. Low risk of bias was scored in 2 RCTs, 1 cohort study (n=9), 4 case-control (n=9) and 7 cross-sectional studies. The risk of bias was mainly increased due to inclusion bias, the use of non-validated and/or patient-reported outcomes and the lack of blinding possibilities in case of physical therapy intervention. In 23 papers physical activity was measured, of which 8 studies used a validated questionnaire and only 1 study used an objective method. Cardiorespiratory and muscular fitness were assessed in 5 and 9 studies respectively. A variety of physical therapy interventions were studied: resistance training (n=1), cardiorespiratory training (n=1), physical therapy high-intensity training (n=2), mind-body exercises (n=3), behavioural change programs (n=2), therapeutic modalities (n=4) and mixed rehabilitation programs (n=5). One RCT with low risk of bias evaluated an increase in cardiorespiratory fitness and a reduction in truncal fat percentage in PsA patients after 11 weeks of high intensity interval training. Qualitative research (n=11) emphasized the need of patients for education.

Conclusion: Scientific evidence on physical therapy, physical activity and physical fitness in PsA is limited. Further research is needed on non-pharmacological interventions and aspects in general, especially on physical fitness.