HPR Epidemiology and public health (including prevention)

POS0794-HPR SNAPS JIA - SURVEY OF ADOLESCENTS' NEEDS AND PARENTS' VIEWS ON SEXUAL HEALTH IN JUVENILE IDIOPATHIC ARTHRITIS

Acknowledgements: NIL.
Disclosure of Interests: None Declared.
DOI: 10.1136/annrheumdis-2023-eular.4701

POS0795-HPR STAGE 1 HYPERTENSION CARRIES EXCESSIVE CARDIOVASCULAR RISK IN AXIAL Spondyloarthritis PATIENTS: A 12-YEAR LONGITUDINAL COHORT STUDY

Keywords: Self-management, Cardiovascular disease, Spondyloarthritis

Disclosure of Interests: None Declared.
DOI: 10.1136/annrheumdis-2023-eular.182

Figure 1. Timeline of immunosuppressive treatments and/or biologics administered in patients with non-infectious uveitis who required at least two treatments, according to diagnosis. Shaded: treatment that resolved the uveitis. RAUU: recurrent acute anterior uveitis AS: axial spondyloarthritis MTX: Methotrexate ADA: adalimumab MFM: mycophenolate methotrexate IFX: infliximab TCZ: tocilizumab SAR: sarilumab CYA: Cyclosporine SSZ: sulfasalazine

Acknowledgements: NIL.
Disclosure of Interests: None Declared.
DOI: 10.1136/annrheumdis-2023-eular.4701

Conclusion: The use of systemic corticosteroids and immunosuppressive/biologics was necessary in a high number of patients with non-infectious uveitis. In our series tocilizumab proved to be significantly more effective in the resolution of macular edema.

REFERENCE:

Background: According to the world health organization, sexual health (SH) is “a state of physical, emotional, mental and social well-being in relation to sexuality”. Studies on the impact of juvenile idiopathic arthritis (JIA) on SH are scarce especially during the critical phase of adolescence. We can ask ourselves: are health professionals (HP) “good” interlocutors for JIA patients?

Objectives: We aimed to determine the expectations of JIA adolescents (10-19 years) and the perceptions of their parents regarding exchanges with HP in the field of SH.

Methods: A multicenter survey was performed in nine French rheumatology centers and three patient associations from September 2021 to April 2022, among JIA patients, aged 18-45 years and their parents. On the advice of two child psychologists and a psychiatrist, we interviewed an adult population to obtain convincing data about their adolescence with the necessary hindsight on the subject. Self-administered questionnaires and interviews were designed for JIA patients and parents, after an extensive literature review and experts’ consensus and distributed to participants.

Results: 76 patients and 43 parents completed the anonymous questionnaires. Most patients were women (75%), with a mean age of 26 (72) years and an education level higher than high school (89%). Parents were mainly mothers (88%), with a mean age of 54 (5.6) years and an education level higher than high school (56%). Half the patients considered that JIA impacted their life. The main causes were body complexity (46%) and low self-esteem (40%). The impact on their sexuality was not clear-cut. Love life was discussed with parents for 52% and sexual life for 20% of patients. 59% of patients reported they were comfortable to discuss SH with an HP (yet, only 26% had done). Their main sources of information were referees (at school (46%), family (43%) or social networks (34%)). If patients reported that SH has been discussed, it was mainly when the HP was proactive (56%), with the hospital rheumatologist (50%), from a biomedical perspective. Focusing the needs for optimal care, patients and parents agreed to address SH during an individual patient education session in hospital (51% vs 35%), a regular consultation (47% vs 53%) or a dedicated consultation by request of the adolescent without parents being informed (38% vs 21%). Most patients and parents agreed that the HP should be proactive (78% vs 70%). At hospital, for patients, the most competent or the most affordable HP were the gynecologist (68%; 47%, respectively), the rheumatologist (55%; 41%), and the psychologist (53%; 39%). Patients and parents both considered that a peer expert would make patients feel more comfortable (38% vs 37%); however, contrary to patients, fewer parents point out their skills (46% vs 25%, p=0.0276). The opportunily of a suitable moment (64% of patients vs 53% of parents), an HP comfortable with the subject (59% vs 53%), and availability of brochures (45% vs 49%) seemed to be helpful for both. The only statistically significant difference concerned HP gender, less cited by parents (7% vs 43%, p<0.0001). The use of digital resources was significantly more cited by patients than parents (video information (29% vs 9%, p=0.0127); smartphone application (25% vs 9%, p=0.0372). 79% of patients were looking for general information (impact of JIA and treatments on sexuality), discussion (68%), reassurance (65%), and listening (51%). General information (58%, p=0.0158) and discussion (39%, p=0.0024) were significantly less cited by parents.

Conclusion: To our knowledge, this is the first study to address the SH needs of adolescents with JIA. HPs should take up this real need about SH, especially in hospital in order to meet with adolescents' expectations.

Acknowledgements: This project has obtained the financial support of the French Society of Rheumatology.

Disclosure of Interests: None Declared.
DOI: 10.1136/annrheumdis-2023-eular.182

Figure 1. Timeline of immunosuppressive treatments and/or biologics administered in patients with non-infectious uveitis who required at least two treatments, according to diagnosis. Shaded: treatment that resolved the uveitis. RAUU: recurrent acute anterior uveitis AS: axial spondyloarthritis MTX: Methotrexate ADA: adalimumab MFM: mycophenolate methotrexate IFX: infliximab TCZ: tocilizumab SAR: sarilumab CYA: Cyclosporine SSZ: sulfasalazine

Acknowledgements: NIL.
Disclosure of Interests: None Declared.
DOI: 10.1136/annrheumdis-2023-eular.4701

Conclusion: The use of systemic corticosteroids and immunosuppressive/biologics was necessary in a high number of patients with non-infectious uveitis. In our series tocilizumab proved to be significantly more effective in the resolution of macular edema.
Background: Hypertension (HT) is one of the modifiable risk factors for the development of CV event (CVE) [1,2]. The American College of Cardiology/American Heart Association (ACC/AHA) recommended a new definition for arterial HT in adults since 2017 [3]. Whether this new definition of HT is associated with increased CV risk in patients with axSpA remains unknown.

Objectives: To ascertain whether stage 1 hypertension at baseline is a predictor of future cardiovascular event (CVE) in patients with axial spondyloarthritis (axSpA).

Methods: We conducted a retrospective cohort study in axSpA patients who were recruited from 2001-2017. Patients with at least 2 years of follow-up and without prior CVE were divided into three groups according to the calculated mean BP over the first 2-year period (adjusted mean BP ≥140/90 mm Hg, 130-139/80-89 mm Hg, and <130/80 mm Hg). They were followed from baseline until the end of 2020 or occurrence of a first CVE. Multivariate Cox regression analyses adjusting for baseline and time-varying variables were used to assess the relationship between mean BP and with CVE.

Results: Out of the 458 patients fulfilling the inclusion criteria, 56 (12.2%) and 261 (57.0%) were hypertensive. They were divided into three groups according to the calculated mean BP over the first 2-year period (adjusted mean BP ≥140/90 mm Hg, 130-139/80-89 mm Hg, respectively, and 261 (57.0%) were normotensives. After a median follow-up of 12 [7-18] years, 56 (12.2%) CVE were documented. The incidence rates were 21.4, 14.2 and 5.9 per 1000 patient-years for the three groups respectively. A adjusted mean BP of 130-139/80-89 mm Hg was independently associated with the occurrence of CVE after adjusting for the baseline covariates (Figure 1) as well as time-varying inflammatory burden (Table 1). This association was not significant after adjustment for time-varying traditional CV risk factors.

Conclusion: Stage I hypertension at baseline is associated with increased risk of developing CVE in axSpA patients. This association may be mediated by other traditional CV risk factors.

REFERENCES:

Table 1. Multivariable Cox regression analysis of the 3 BP groups stratified by age group after excluding patients who are older than 60 years.

<table>
<thead>
<tr>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>p-value</td>
<td>p-value</td>
<td>p-value</td>
</tr>
<tr>
<td>Time-dependent HR (95%CI)</td>
<td>Time-dependent HR (95%CI)</td>
<td>Time-dependent HR (95%CI)</td>
</tr>
<tr>
<td>Age group</td>
<td>Age group</td>
<td>Age group</td>
</tr>
<tr>
<td>&lt;130/80</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td>130-139/80</td>
<td>0.98</td>
<td>0.98</td>
</tr>
<tr>
<td>≥140/90</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Age group</td>
<td>Age group</td>
<td>Age group</td>
</tr>
<tr>
<td>30-39</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>40-49</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>50-59</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>60-69</td>
<td>&lt;0.001</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>DM ever</td>
<td>0.005</td>
<td>0.005</td>
</tr>
</tbody>
</table>

Figure 1. Kaplan-Meier analysis for CVE-free cumulative survival among the three patient groups (green line: ≥140/90mm Hg, red line: 130-139/80-89 mm Hg, blue line: <130/80mm Hg).

Acknowledgements: I would acknowledge all the supports from our teammates.

Disclosure of Interests: None Declared.

DOI: 10.1136/annrheumdis-2023-eular.330