



Figure 1. Percentages of patients according to their frailty status.

Table 1. Comparison of patients according to their frailty status

	Robust (n= 13)	Pre-frail (n=16)	Frail (n=21)	P ₁	P ₂	P ₃
Age (years)	53.84±7.27	49.75±6.22	52.04±6.74	.24	.73	.56
Sex, women/men (n)	2/11	10/6	14/7	-	-	-
BMI (kg/m ²)	27.86±5.61	28.31±3.15	30.19±5.07	.96	.35	.46
BASDAI	2.39±1.81	4.83±1.60	5.93±1.83	.00	.00	.15
BASFI	1.96±2.01	2.87±2.10	5.41±2.19	.48	.00	.00
ASQoL	4.23±3.94	7.75±4.76	12.61±4.22	.08	.00	.00
Mini Nutritional Assessment	25.61±1.47	24.59±2.13	23.59±2.16	.36	.01	.29

BMI; body mass index, BASDAI; Bath Ankylosing Spondylitis Disease Activity Index, BASFI; Bath Ankylosing Spondylitis Functional Index, ASQoL; Ankylosing Spondylitis Quality of Life Questionnaire. P₁; P value between robust and pre-frail individuals, P₂; P value between robust and frail individuals, P₃; P value between robust and frail individuals.

Conclusion: Frailty or pre-frailty is common in patients with axSpA and the main factors associated with frailty status were poor nutritional status and level of quality of life. Since it is a reversible condition, identifying the frailty status and its associated factors may help to prevent further decline in functional level and to design appropriate treatment interventions. Further studies are needed to determine frailty prevalence and its predictors in patients with axSpA.

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POS1529-HPR SEXUAL DYSFUNCTION AND QUALITY OF LIFE IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Sexual health is a major component of human well-being. The World Health Organization (WHO) defines sexual health as "a state of physical, mental, emotional, and social well-being in relation to sexuality." Sexuality is a very important, inherent part of human functioning. As repeatedly shown in research, satisfaction with sex life and sexual fulfillment correlate positively with quality of life (QoL) in most of its aspects. It is thus true that a reduced quality of one's sex life and lack of sexual fulfillment can contribute to poorer QoL overall. As poor sex life quality and sexual dissatisfaction result from sexual dysfunction, effective treatment of such a dysfunction can be assumed to contribute significantly to a better QoL.

Objectives: To describe an assessment of sexual problem among RA patients as a part of patient-reported outcome measures assessment.

Methods: 171 consecutive RA patients (mean age 48.3±14.6) attending the rheumatology outpatients clinic over 6 months in 2021. Standardized questionnaires were used in the study: The Sexualogical Questionnaire to assess self-assessment of the incidence of sexual disorders, WHOQOL-BREF to assess QoL level, Disease Acceptance Scale and VAS scale to assess pain intensity.

Results: The mean duration of the disease in the study group was 13±9 years. The mean score of subjective assessment of mobility was 6.2 ± 1.6, and the mean score of the DAS-28 disease activity index was 4.0±1.9. The study group presented a mean level of disease acceptance (AIS 29.6 ± 11.6). The comparative analysis showed significant differences in reaching orgasm and declared sexual dysfunctions. These problems occurred more often in women than in men (34.2%

vs. 18% and 43% vs. 40% respectively p=0.002). In univariate analysis, factors correlating positively with the frequency of declaring sexual dysfunction were: subjective motor score less than 6 points, AIS<36 points, WHOQOL-BREF<59 points, disease activity ≥3.5 points and VAS>3. In multivariate logistic regression analysis independent factors positively correlating with frequency of sexual dysfunction declaration were: general QoL (β=1.255; p=0.035) and pain limiting social life (β=1.564; p=0.030). The absence of comorbidities correlated negatively and reduced the prevalence of sexual dysfunction (β=-1.030, p=0.043). Patients with reduced QoL had 3.5 times and patients with pain limiting social life had 4.8 times higher risk of sexual dysfunction than other patients. In contrast, those without comorbidities were 2.8 times more likely to be free of sexual dysfunction than those diagnosed with other chronic diseases besides RA.

Conclusion: Sexual dysfunction is a problem found both in women and in men with RA. The most common problems include lack of orgasm, vaginal dryness in women, and erectile dysfunction in men. Psychological factors that contribute to sexual dysfunction include low or no illness acceptance and poor QoL. The absence of comorbidities is an independent determinant of lower sexual dysfunction incidence, whereas low QoL and pain limiting the patient's social life are independent determinants of increased incidence of sexual dysfunction in both sexes.

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POS1530-HPR RHEUMATIC MUSCULOSKELETAL DISEASES (RMDs) DURING THE FIRST WAVE OF THE COVID19 PANDEMIC: PATIENTS' POINT OF VIEW ON THE ROLE OF TELEMEDICINE

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Background: The COVID19 pandemic has caused health problems in people's daily lives with a significant psychological impact. In fact, patients with RMDs have experienced diseases' flare and also psychological problems. The lockdown and the "social quality changes" have impacted the life and the well-being of RMDs patients, influencing directly the implementation of telemedicine during daily practice.

Objectives: A descriptive observational study was designed to analyse the short-term effect of the first wave on RMDs patients on social quality changes and the usefulness of telemedicine.

Methods: The survey was carried out by administering a questionnaire consisting of 30 questions, developed *ad hoc* using Likert scales. Items such as family and work environment, access to healthcare facilities, healthcare provided to the patient, disease activity and the mental health status of individuals (anxiety / depressive symptoms) were investigated. Preliminary data on the first wave were collected between September and November 2021 through patient associations and social networks.

Results: 40 RMDs patients (Rheumatoid Arthritis 57.5%, Psoriatic Arthritis 35%, Fibromyalgia and others 7.5%) prevalently women (97.5%) were included in the survey. During the pandemic, 72% of respondents reported cancellation or delays in scheduled appointments and 50% did not have alternative contacts (telephone consultations, e-mail prescriptions, telematics training) with the hospital. 40.5% of patients reported difficulty in finding DMARDs and material for the treatment of ulcers, 28.2% reported difficulties in accessing the health facilities. In particular, 34.2% reported the total closure of the hospital facilities. Moreover, our data show a worsening of health status due to an increased anxiety concerning the management of their RMDs, an increased stress within the

family, a reduced access to care facilities due to their closure or travel restrictions. In 57% of patients, a worsening of health status was reported, while in 90% stress and a feeling of abandonment was developed since the beginning of the pandemic. In this context, telemedicine was considered useful by 97.5% of patients, although patients felt that an improvement was necessary with an integration with the regular follow up.

Conclusion: Patients with RMDs reported that the significant delays or cancellation of the outpatient visits provoked an increase of stress, worry and anxiety for their health. The majority was very concerned about the overall management of their RMDs. The worsening of symptoms in more than half of the patients was the most worrisome observation. Almost all patients agreed that Telemedicine might help the clinical evaluation of their RMDs, also providing a significant support to their psychological condition because of the direct contact with the caring physician and health professionals.

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POS1531-HPR

PATIENT-REPORTED ADVERSE DRUG REACTIONS ATTRIBUTED TO THE USE OF ETANERCEPT: DISTINCTION BASED ON NATURE, FREQUENCY AND BURDEN

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Background: Research regarding adverse drug reactions (ADRs) associated with the use of etanercept in patients with inflammatory rheumatic diseases (IRDs) usually focuses on the nature and frequency of ADRs without considering the burden of the ADRs. However, not every ADR causes the same burden for patients. Information is lacking about the degree of experienced burden per ADR by patients with IRDs.

Objectives: First, to describe ADRs of etanercept based on nature, frequency and burden, and second, to propose a new model for identification of relevant ADRs for health care professionals.

Methods: Data of the Dutch Biologic Monitor (DBM) was used to categorize patient-reported ADRs into high and low burden. In this prospective cohort event monitoring system patients were asked to fill out bimonthly questionnaires on experienced ADRs that they attributed to the use of a biological DMARD. The questionnaire included a quantification of the burden of the reported ADRs using a five-point Likert scale ranging from 1 (no burden) to 5 (very high burden). The nature of the reported ADRs were grouped into preferred terms (PTs) according to the Medical Dictionary for Regulatory Activities (MedDRA). Inclusion criteria for this study were patients with IRDs using etanercept and who reported an ADR with at least one burden score. For every patient, the mean burden scores per ADR (MedDRA PT) were analyzed. The burden was classified in two categories: 'high' when the mean burden score was equal to or more than 2.5, and 'low' when it was less than 2.5. Text analytics of the reported ADRs (MedDRA PTs) and a comparison word cloud were used to visualize ADRs that were more often reported with high burden or more often reported with low burden. For this, the relative ADR frequencies of the low burden classes were subtracted from the relative frequencies of the high burden class, resulting in a percentual difference between the high and low burden class for every ADR. Therefore, the highest

percentual difference corresponds to the ADRs that are experienced as most burdensome.

Results: A total of 187 patients (70% female) met the inclusion criteria and reported 905 ADRs, of which 373 (41%) were reported with high burden (see Table 1). The word cloud (Figure 1) visualizes which ADRs were more often reported with high or low burden. These ADRs correspond to the greatest difference in relative class frequency. Patients experienced the burden of headache, pneumonia and pruritus mainly as high, and the burden of injection site pruritus and injection site erythema as low.

Table 1. Characteristics of patients and reported adverse drug reactions (ADRs)

Characteristics	Total		
Patients (n = 187)			
Gender (female, %)	130 (70)		
Age (years) (mean ± SD)	58.1 ± 14.1		
Indication ^a			
Rheumatoid arthritis (%)	132 (71)		
Ankylosing spondylitis/axial spondyloarthritis (%)	19 (10)		
Psoriatic arthritis (%)	46 (25)		
Adverse drug reactions	Total	High burden	Low burden
Adverse drug reactions (ADRs) (%)	905 (100)	373 (40)	532 (60)
Drug-induced ADR burden (mean ± SD)	2.5 ± 0.9	3.3 ± 0.7	1.9 ± 0.5
High burden ADRs:			
Headache	30	22	8
Pruritus	23	17	6
Pneumonia	20	15	5
Feeling cold	11	11	0
Skin atrophy	11	11	0

