

problems at various moments along their patient journey,³ this population can benefit from more continuous information about their medication and healthcare provider support to manage drug-related problems. To most effectively employ telehealth for this purpose, it is important that offered technologies match with patients' needs and preferences.

Objectives: Identify factors influencing the preference of patients with rheumatic diseases regarding telehealth applications.

Methods: A qualitative descriptive study was performed in the Netherlands between May and June 2021. Using a semi-structured interview guide, patients with a rheumatic disease were interviewed face-to-face. First, patients were presented four telehealth applications (frequently asked questions page, digital human, and chatting and video calling with healthcare providers). Second, patients were asked to use each application to answer one medication-related question predefined by the research team. During the process of finding an answer to the question, patients were asked to think aloud and were questioned on which factors influenced their experience and preference for each application. Third, patients were given additional hypothetical questions after which they were asked to explain their preferred application for answering the question, to elicit additional factors influencing preference. Interviews were audio recorded, transcribed verbatim and analysed thematically.

Results: Fifteen patients (aged 19 – 73 years, 53% female) participated. Three domains influenced patients' preference for telehealth applications. First, preference for telehealth applications was influenced by *factors related to individual patients* such as medication-related information needs, literacy, and skills with digital applications. Second, preference was influenced by *factors related to the specific applications* such as speed of answer, level of interaction, extent of privacy, the perceived usefulness of an application, and usability of the application. Third, preference was influenced by *factors related to the context* in which telehealth applications are offered, such as the support from healthcare providers in using telehealth applications, reliability of information source, and potential of telehealth to save time for healthcare providers.

Conclusion: Patients' preference for telehealth applications is influenced by patient-related, application-related and context-related factors. To effectively support patients with rheumatic diseases, telehealth applications should match with these patients' preferences. Furthermore, it is important to offer a variety of telehealth applications as preferences differ among patients and circumstances.

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2022-eular.1538

POS1527-HPR HEALTH PROMOTION IN INDIVIDUALS WITH KNEE PAIN – DIFFERENT WAYS TO ENABLE AND MAINTAIN A BALANCE IN EVERYDAY LIFE BASED ON THE ABILITIES

C. Sylwander^{1,2}, M. Andersson^{1,3}, E. Haglund^{1,3,4}, E. Sunesson¹, I. Larsson^{1,2,3}.
¹Spenshult Research and Development Centre, Halmstad, Sweden; ²Halmstad University, School of Health and Welfare, Halmstad, Sweden; ³Lund University, Department of Clinical Sciences, Section of Rheumatology, Lund, Sweden; ⁴Halmstad University, Department of Environmental and Biosciences School of Business, Innovation and Sustainability, Halmstad, Sweden

Background: Most individuals with knee pain develop radiographic knee osteoarthritis over time [1], and up to 30% develop chronic widespread pain (CWP) [2]. Many studies only focus on physical activity or weight loss when it comes to managing knee osteoarthritis (KOA) and chronic pain. There is a challenge to get more individuals to follow the existing recommendations for KOA, including physical activity and weight loss [3]. However, the interaction between the various physical, mental, and social factors regarding health promotion is complex. More research is needed to understand health-promoting activities applied amongst individuals with knee pain.

Objectives: To explore health-promoting activities in individuals with knee pain.

Methods: The study was a part of the Halmstad Osteoarthritis cohort (ClinicalTrials.gov NCT04928170), including 306 individuals with knee pain without earlier diagnosed KOA, cruciate ligament injury or other rheumatological disorder. A purposeful sample of 22 individuals (13 women, 9 men; median age 52 years) participated in the study. Ten had radiographic KOA, 12 had chronic regional pain, 9 reported CWP, 16 were overweight, and 13 met the WHO recommendations for physical activity with moderate intensity. Semi-structured interviews were conducted and followed a pilot-tested interview guide initiated with open-ended questions such as “What do you do to maintain your health?” and “What enables you to keep health?”

The interviewers followed the participants reasoning, and to obtain depth in the data, the participant received follow-up questions such as “Please, can you tell me more about...?”. The interviews were audio-recorded and transcribed verbatim. Data analysis was performed by latent qualitative content analysis and revealed an overall theme including two categories and six sub-categories.

Results: Health-promoting activities in individuals with knee pain were interpreted in the overall theme; *enabling and maintaining a balance in everyday life based on abilities*. Two categories explored the content in health-promoting activities as 1) *Using facilitators to take care of the body* with the sub-categories: being physically active, having a healthy diet, and using external resources. For example, the participants took care of the body by being physically active to decrease pain, reducing sugar intake and using external resources such as online workouts or help from health care. 2) *Managing stressors of everyday life* with the sub-categories: promoting vitality, allowing for recovery, and safeguarding healthy relationships. The participants managed stressors of life by, for example, being in nature, planning their work- and private life and spending time with friends and family. See Table 1.

Table 1. Overview of the results exploring health-promotion activities in individuals with knee pain.

Theme	Enabling and maintaining a balance in everyday life based on abilities					
Category	Using facilitators to take care of the body			Managing stressors of everyday life		
Sub-categories	Being physically active	Having a healthy diet	Using external resources	Promoting vitality	Allows for recovery	Safeguarding healthy relationship

Conclusion: Individuals with knee pain described various health-promoting activities, ranging from physical activity to social interactions, included in the theme of enabling and maintaining a balance in everyday life based on abilities. We suggest that a broader approach to everyday life can be helpful in treatment plans and health promotion to manage and prevent KOA and chronic pain while maintaining a healthy lifestyle.

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2022-eular.1584

POS1528-HPR FACTORS ASSOCIATED WITH FRAILTY STATUS IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS

Ö. Öztürk¹, Ö. Feyzioğlu¹. ¹Acibadem Mehmet Ali Aydınlar University, Physiotherapy and Rehabilitation, Istanbul, Turkey

Background: Frailty is characterized by increased fatigue and vulnerability which leads to adverse health outcomes. Recent studies have reported the increased prevalence of frailty in various rheumatological diseases regardless of age. However, information about the prevalence of frailty in patients with axial spondyloarthritis (axSpA) is limited.

Objectives: This study aims to determine prevalence of frailty and its associated factors in patients with axial spondyloarthritis (axSpA).

Methods: In this monocentric cross-sectional study 50 patients (26 women) with axSpA aged between 40 to 65 were included. Frailty status was determined using Kihon checklist. Patients were grouped as pre-frail, frail and robust according to the Kihon Checklist and <4 was accepted as robust, ≥4 pre-frail, ≥8 frail. Nutritional status, disease activity, functional level and quality of life were assessed using Mini Nutritional Assessment (MNA), Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Bath Ankylosing Spondylitis Functional Index (BASFI), Ankylosing Spondylitis Quality of Life Questionnaire (ASQoL) respectively. Analysis of variance and multivariate linear regression analyses were used to assess group differences and factors associated with frailty status.

Results: The mean age of the patients was 51.78±6.77, the mean disease duration was 7.8±8.41 years, the mean body mass index was 29.98 ±4.72 kg/m². Twenty-one patients were classified as frail, 16 was pre-frail and 13 was robust. Compared to robust patients, pre-frail and frail individuals had significantly higher BASFI, BASDAI and ASQoL scores. There was a significant high correlation between the Kihon checklist score and worse BASFI (r=0.62, p<0.001), BASDAI (0.69, p<0.001), ASQoL scores (0.73, p<0.001). Poor nutritional status was moderately correlated with frailty index score (r=-0.53, p<0.001). In multivariable linear regression analysis, nutrition status and level of quality of life were independently associated with frailty index score (p<0.001).

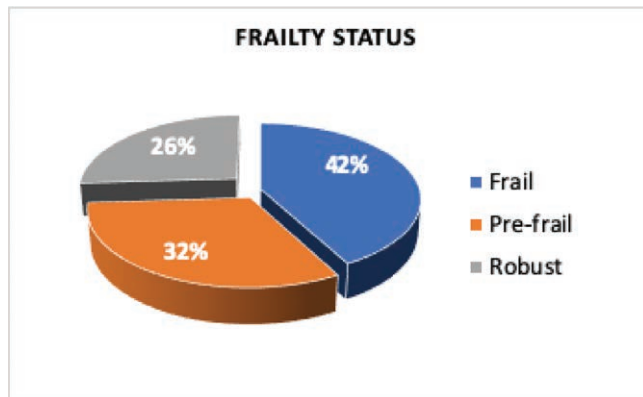


Figure 1. Percentages of patients according to their frailty status.

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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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2022-eular.2480

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

W. Tański¹, K. Dudek², N. Świątoniowska-Lonc³. ¹4th Military Teaching Hospital, Department of Internal Diseases, Wrocław, Poland; ²Wrocław University of Science and Technology, Department of Logistic and Transportation Systems, Wrocław, Poland; ³4th Military Teaching Hospital, Research and Innovation Center, Wrocław, Poland

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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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2022-eular.2617

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

K. El Aoufy^{1,2}, M. R. Melis^{1,2}, M. Balzani¹, S. Guiducci^{1,2}, S. Bellando Randone^{1,2}, S. Bambi³, L. Rasero³, M. Matucci-Cerinic^{1,4}. ¹University of Florence, Department of Clinical and Experimental Medicine, Florence, Italy; ²Careggi Hospital, Department of Geriatric Medicine, Division of Rheumatology, Florence, Italy; ³University of Florence, Department of Health Science, Florence, Italy; ⁴IRCCS San Raffaele Hospital, Unit of Immunology, Rheumatology, Allergy and Rare Diseases (UnIRAR), Milan, Italy

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