by VAS scales, zero indicating no support and 100 indicating full support. The associations of disease activity, activity limitation and DMARD use with sickness absence and how these associations were moderated by support from significant others, were analyzed using zero-inflated negative binomial regression.

Results: Higher activity limitation (HAQ) was associated with lower risk of sickness absence (p<.001) but more days with sickness absence (p=.001). Higher disease activity (DAS28) was associated with lower risk of sickness absence (p=.003). However, when including family support, this association was not significant (p=.117) and associated with higher risk of sickness absence, but the association was weaker with family support (p=.029). Disease activity was also associated with more days of sickness absence (p=.013). The use of DMARDs had no significant relation to sickness absence (p=.150) or number of days with sickness absence (p=.852). Although, when including support from friends, DMARD use was associated with higher risk of sickness absence (p=.041). However, this association decreased significantly with support from friends (p=.022).

Conclusion: Support from significant others has an impact on previously known relationships between disease activity, use of DMARDs and sickness absence. Hence, support from significant others has the possibility to help decrease sickness absence among persons with RA one year after diagnosis.

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AB1395-HPR BURDEN IN CAREGIVERS OF PATIENTS WITH RHEUMATIC CONDITIONS

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Background: Rheumatoid arthritis (RA) is a chronic, disease that affects more than 1% of global population, it is a long term condition that causes pain and disability. Evidence had shown that most of the patients are moderately disabled, which brings the necessity of a caregiver to become the patients companion due to its chronic disease. The caregiving role can have an impact in the psychological and physical spheres of the caregivers life.

Objectives: The aim of this study was to explore demographical characteristics and caregiver burden through the Zarit Scale.

Methods: We conducted a cross sectional study in a meeting where caregivers in a rheumatoid arthritis specialized setting. We collected sociodemographic information, and applied the Zarit caregiver burden interview (ZBI) adapted to Spanish. The ZBI includes 22 questions which has 5 responses from 0 (never) to 4 (nearly always), where scores lower than 47 indicated little to no burden, 47 to 55 low burden and >55 intense burden. We calculated means, and standard deviations for continuous variables and categorical variables were presented as rates.

Results: We applied a survey to 132 caregivers. Mean age was 52 years SD 19 and 72% were women, 78% of them were taking care of a patient with rheumatoid arthritis, 12% osteoarthrosis 2% lupus, 2% osteoporosis the remaining 6% were caregivers of patients with ankylosing spondylitis, fibromyalgia, Sjogren syndrome. Regarding the time as caregiver 48% of them had been carrying the task for less than a year, 16% between two and three years, 18% for more than three years, and 13% for more than four years 5% of them were temporarily caregivers. In our study 85% of caregivers were a family member while15% was a nurse or a non-related person. Zarit mean score was 38.2913, additionally 35% had a score higher than 41 points. See table 1.

Variable	n	%
Zarit Score		
0-21 (little or no burden)	9	6.34
22 - 40 mild to moderate burden	82	57.75
41 - 60 moderate to severe burden	43	30.28
61-88 severe burden	8	5.63

Abstract AB1395HPR Table 1. Zarit scale classification

Conclusion: In our study 93% of our patients reported to have moderate to severe burden; thus, it is important to develop strategies and explore the factors related to burden in caregivers in patient with rheumatoid arthritis.

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AB1396-HPR SEXUAL SATISFACTION AND SEXUAL DYSFUNCTION IN PARTNER OF PATIENTS WITH ANKYLOSING SPONDYLITIS

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Background: Sexual satisfaction is defined as a special experience with biological rules, value judgments and taboos and also is an important indicator of sexual satisfaction, social harmony and physical-mental well being. Sexual dysfunction or reluctance may be psychological, physiological or combination of both. Current studies showed that most of Ankylosing Spondylitis (AS) patients had sexual problems. They have not also severe joint deformities but also have painful intercourse. Therefore decrease in the range of motion of the hip joint due to AS complicates pelvic pain and sexual dysfunction.

Objectives: The aim of study was investigation of sexual satisfaction and sexual dysfunction in partner of patients with AS.

Methods: 50 individuals: 21 female partner of patients with AS with an average age of 40.38 5.31, 29 male patner of patients with AS with an average age of 52.37 5.84 were included in this study. The male partners were evaluated with the International Index of Erectile Function (IIEF) and the female partners were evaluated with the Female Sexual Function Index (FSFI).

Results: Total score of FSFI was 52.37 5.84 (Sexual desire:5.472.01, arousal:11.664.97, orgasm: 8.524.74, lubrication:12.005.06, satisfaction: 8.474.49, pain:8.044.17) in female partner. Erectile score of IIEF was 24.35 6.65, orgasm score was 8.85 3.28, sexual desire score was 7.271.70, sexual satisfaction score was 10.373.86 and general satisfaction score was 8.142.83 in male partner.

Conclusion: According to the results of the study, female partner had moderate sexual dysfunction, male partner had mild erectil function. This study showed that the sexual functions of female and male partners of patients with AS were affected negatively. Further studies need to assess their pelvic floor symptoms as well.

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AB1397-HPR CLINICAL FEATURES IN COHORT OF PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS IN KAZAKHSTAN

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Background: Systemic lupus erythematosus (SLE) refers to socially significant diseases and the improvement of diagnosis, treatment of the disease belongs to the target indicators of the State Program in Kazakhstan.
Objectives: The aim of this study was to assess the demographic, clinical features, the degree of activity, damage to internal organs and therapy in patients with SLE.
Methods: The study involved 89 patients with a documented diagnosis of SLE (ACR, 1997) hospitalized for inpatient treatment in rheumatology centers. The register included an assessment of gender, age, Disease Activity Index (SLEDAI 2K), organ Damage Index (DI, SLICC, 2012), and therapy. For qualitative signs, absolute and relative values (n,%) are presented.
Results: In the studied cohort of patients with SLE prevailed women (98.8%), the mean age of patients was 33.610.47 years, 47% of them under 30 years old. The debut of the disease in the overwhelming majority (52%) patients is associated with stress, pregnancy and childbirth. By ethnicity: Kazakhs - 67 (75.2%), Russian - 7 (7.8%), Uighurs - 6 (6.7%), Korean - 5 (5.6%), other 5 (5.6%). 56% of patients had higher and secondary-special education. Only in a third of patients SLE was diagnosed in the first months of the disease, the rest had erroneous diagnoses, such as rheumatoid arthritis, reactive arthritis, and other systemic diseases. The disease activity (SLEDAI 2K) was very high in 9 (10.1%), high in 24 (26.9%), medium in 39 (43.9%), low in 15 (16.8%) patients and without activity were 2 (2.2%) patients.
Among SLE patients, 92% with mucocutaneous manifestations, 64% had photosensitivity, 56.2% had enanthema, 77.5% had arthritis and arthralgia, 28.1% with serositis, 55% had renal involvement, 25.8% had neurological and 58.4% had hematological disorders. Irreversible organ damages (SLICC) were detected in 67.4% of patients: low DI (1 point) - 26 (29.2%), moderate (2-4 points) - 33 (37.1%) and high (> 4 points) - in 3 (3.4%) patients. Medium and high DI were observed in patients with renal and neurological involvement.
Patients were predominantly in therapy: methylprednisolone (98%), cytostatics and mycophenolate mofetil (42.3%), hydroxychloroquine (39%). Biological therapy (rituximab, belimumab) was performed in patients with a high degree of activity, nephritis, and neurolupus and in 6 (6.7%) patients with good effect and the possibility of reducing glucocorticoids to minimal doses.
Conclusion: Creating a register and forming a cohort allows for a more complete assessment of activity, organ damage and therapy in patients with SLE.
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AB1398-HPR RHEUMATOID ARTHRITIS– BIOLOGICAL DMARDS EXPERIENCE IN TAWAM HOSPITAL, UAE. A 2-YEAR RETROSPECTIVE STUDY

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Background: Arthritis is the leading cause of disability in America, affecting 50 million adults. Although there is currently no cure for rheumatoid arthritis (RA), improved understanding of RA disease pathogenesis in recent years has led to the development of new treatments. Disease Modifying Anti-Rheumatic drugs (DMARDs) are added at early stages in the treatment of RA to suppress inflammation; they may be used as monotherapy or more commonly in combination. The treatment of RA, psoriatic arthritis (PSA) and ankylosing spondylitis (AS) is aimed at achieving the lowest disease activity and remission. Patient compliance is considered necessary for the success of treatment in chronic diseases.
Objectives: The objective of this study was to assess the patient adherence to their medications and clinic visits in addition to assessing the prescribing, screening and monitoring parameters of biological disease DMARDs according to the care pathway at Tawam Hospital and EULAR recommendations.
Methods: A retrospective observational review using data from the computer based system at Tawam hospital. All adult patients with RA, PSA and AS starting a biological DMARD during our study period; December 2016 to December 2018 were eligible.
Results: A total of 54 patients were included. Eighty percent were females. Sixty three percent RA patients, 24% PSA patients and 13% AS patients. Indication, dosing and blood monitoring criteria were met for 100% of the patients. Vaccination criteria was met in only 20%. Screening criteria was met by 57%. Ninety two percent of the RA and PSA patients were started on methotrexate for 3 months before biologics initiation as per guidelines. Forty three percent of AS patients used 2 non-steroidal anti-inflammatory drug before starting biological therapy.
Medication adherence was measure by; the duration of therapy, consistent clinic visits and regular medication refills. Eighty four percent of the total number of patients had a duration of therapy for 6 months or more. Twenty six percent were consistent with their monthly clinic visits. Sixty one percent were compliant with their monthly medication refills.
RA patients were further analysed as they made the majority of our patients. Ninety seven percent of the RA patients had a baseline DAS documented. Eighteen percent had a baseline of DAS28<2.6. Fifty percent had a baseline DAS28>3.2. Twenty nine percent had a baseline DAS28>5.1.Three percent of the patients started on a biologic with no baselines DAS. One hundred percent of the patients were started a biological DMARD including the 18% that had DAS28≤2.6; however the reasons were clearly stated (example of reasons, contemplating pregnancy, adverse reaction to previous treatment).
The DAS 28 was documented again at the end of the study period. Fifty nine percent of the patients had DAS28<2.6. Twenty six percent had DAS between 2.6-3.2, twelve percent had DAS28>3.2 and three percent of the patients had a DAS28>5.1. All the patients with DAS28>3.2 (15%) changed their treatment regimen.
Conclusion: This audit concluded 100% compliance with the care pathway at Tawam Hospital and EULAR recommendations in the treatment of RA, PSA and AS with regards to starting a biologic treatment, switching treatment, dosing and monitoring. Overall the patients adherence to their clinic visits and medication refills was satisfactory; however improving adherence to therapy could therefore dramatically improve the efficacy of drug therapy. However there was a gap in the vaccination and screening parameter which indicates a need to add a tool in computer system to aid the physicians in fulfilling this gap.

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