problems at various moments along their patient journey; this population can benefit from more continuous information about their medication and healthcare provider support to manage drug-related problems. To most effectively employ telephone healthcare services, 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 patient preferences. Furthermore, it is important to offer a variety of telehealth applications as preferences differ among patients and circumstances.

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POS1528-HPR HEALTH PROMOTION IN INDIVIDUALS WITH KNEE PAIN – DIFFERENT WAYS TO ENABLE AND MAINTAIN A BALANCE IN EVERYDAY LIFE BASED ON THE ABILITIES

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Background: Most individuals with knee pain develop radiographic knee osteoarthritis (KOA) [1,2] and develop chronic widespread pain (CWP) [3]. 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 the health-promoting activities among individuals with knee pain.

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

Methods: The study was a part of the Halland Osteoarthritis cohort (ClinicalTrials.gov NCT04928170), including 306 individuals with knee pain without earlier diagnosed KOA, cruciate ligament injury or other rheumatological disorder. The 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’ responses and, in order 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, using external resources, and 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 | Category | Sub-categories |
|-------|----------|----------------|
| Enabling and maintaining a balance in everyday life based on abilities | Using facilitators to take care of the body | Being physically active, Having a healthy diet |
| | | Using external resources, Promoting vitality |
| | Managing stressors of everyday life | 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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POS1528-HPR FACTORS ASSOCIATED WITH FRAILTY STATUS IN PATIENTS WITH AXIAL SpondyloArthritis

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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. Frailty was defined as Kihon Checklist score ≥3. Pre-frail was defined as Kihon Checklist score ≥2 but ≤3. Nutritional status, disease activity, functional level and quality of life were assessed using Mini Nutritional Assessment (MNA), Bath Anklyosing Spondylitis Disease Activity Index (BASDAI), Bath Ankliozan Spondylitis Functional Index (BASFI), Anklyosing 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 51.7±8.77, the mean disease duration was 7.8±4.1 years, the mean body mass index was 29.9±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 ASQoL (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).
The mean score of the DAS-28 disease activity index was 5.0±3.9. The study group presented a mean level of disease acceptance (AIS = 29.8 ± 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, WHOOQL-BREF<59 points, disease activity ≥35 points and VAS≥35. 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=1.103; 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 sexual 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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**POSI530-HPR**

**RHEUMATIC MUSCULOSKELETAL DISEASES (RMDs) DURING THE FIRST WAVE OF THE COVID19 PANDEMIC: PATIENTS’ POINT OF VIEW ON THE ROLE OF TELERHUMATODERMOLOGY**

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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 outpatient clinic over 6 months in 2021. Standardized questionnaires were used in the study: The Sexological Questionnaire to assess self-assessment of the incidence of sexual disorders, WHOOQL-BREF to assess QoL, 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 = 29.8 ± 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, WHOOQL-BREF<59 points, disease activity ≥35 points and VAS≥35. 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=1.103; 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 sexual 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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**POSI525-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 outpatient clinic over 6 months in 2021. Standardized questionnaires were used in the study: The Sexological Questionnaire to assess self-assessment of the incidence of sexual disorders, WHOOQL-BREF to assess QoL, 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 = 29.8 ± 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, WHOOQL-BREF<59 points, disease activity ≥35 points and VAS≥35. 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=1.103; 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.

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