yet, limited evidence exists regarding acceptance, usage and barriers among rheumatologists.

Objectives: This study aimed to evaluate the current level of acceptance, usage, and barriers among German rheumatologists regarding the utilization of ePROs. The importance of different ePRO features for rheumatologists was investigated. Additionally, the most frequently used PROs for patients with rheumatoid arthritis (RA) were identified

Methods: Data was collected via an online survey consisting of 18 questions. The survey was completed by members of the Working Group Young Rheumatologists of the German Society for Rheumatology (Deutsche Gesellschaft für Rheumatologie (DGRh)) at the annual 2019 DGRh conference. Only members currently working in clinical rheumatology were eligible to complete the survey.

Results: A total of 119 rheumatologists completed the survey. 90% reported collecting PROs in routine practice and 25.5% already used ePROs. 44.3% were planning to switch to ePROs in the near future.The main reason for collecting PROs was for clinical decision making (66.4%), followed by research (39.5%), reimbursement (23.5%), internal quality management (21.9%) and patient satisfaction (16.8%). The most commonly cited reason for not switching to ePROs was the unawareness of suitable software solutions (figure 1).Respondents were asked to rate the features for ePROs on a scale of 0-100 (0 = unimportant, 100 = important). The most important features were automatic score calculation and display (score: 77.5), as well as the simple data transfer to medical reports (76.9) (table 1). When asked about PROs in RA, the respondents listed pain, morning stiffness and physician global assessment (PGA) as the most frequently used PROs (figure 2).

Table 1. Ratings for features of ePRO on a scale of 0-100 (0 = unimportant, 100 = important))

Question	mean	SD
How important would the graphic display be to you for ePROs?	63.5	31.19
How important would the automatic score calculation and display of ePROs be to you?	77.5	27.64
How important would the simple transfer of the ePROs in medical report be to you?	76.9	30.07
How important would an automatic alarm of yourself be for you if a critical threshold is exceeded by an ePRO?	51.65	33.5
How important would an automatic alarm of the patient be for you if a critical threshold is exceeded by an ePRO?	34.55	30.61

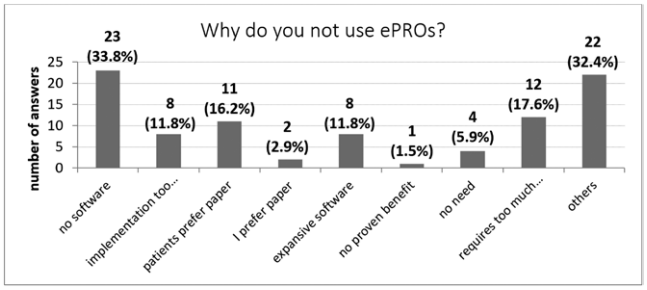

Figure 1. Reasons why ePROs are currently not used (multiple answers were possible for question)

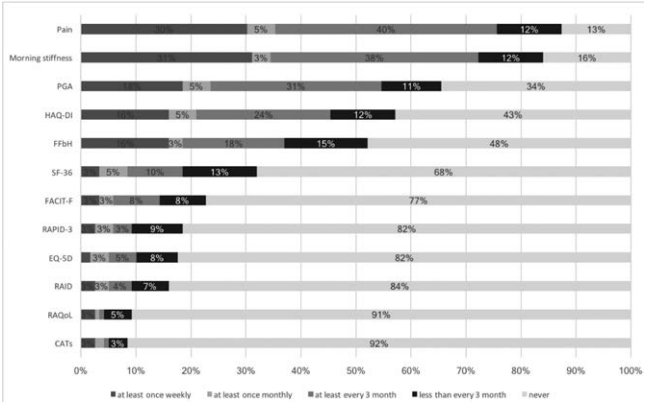

Figure 2. PROs being used in clinical practice and their respective frequency

Conclusion: The potential of ePROs is widely seen, and there is a great interest in ePROs. Despite this, a minority of physicians only uses ePROs, and the main reason for not implementing was cited as the unawareness of suitable software solutions.

Developers, patients and rheumatologists should work closely together to help realize the full potential of ePROs and ensure a seamless integration into clinical practice.

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THU0626-HPR IMPORTANCE OF A SYSTEMATIC COGNITIVE ASSESSMENT: IMPLEMENTATION OF A COGNITIVE EVALUATION AND REHABILITATION CLINIC IN RHEUMATIC PATIENTS

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Background: Cognition is the ability to learn, process and remember information to be used later.(1) Cognitive impairment reflects a decrease in one or more cognitive domains: memory, language, reasoning, among others. (2) It has been reported in rheumatic diseases such as systemic lupus erythematosus, rheumatoid arthritis, fibromyalgia, and it is frequently found in young patients during the first years of their illness correlating the disease progression.(3) This condition can lead to anxiety and depression, compromising the quality of life. Given the lack of consensus regarding the best test to diagnose cognitive impairment, multiple tools have been used to address this problem.

Objectives: To describe the systematical assessment in a Cognitive Evaluation and Rehabilitation Clinic in rheumatic patients from a University Hospital in Mexico.

Methods: Observational and descriptive study. A multidisciplinary team met for 6 months to establish the structure a Cognitive Evaluation and Rehabilitation Clinic in a University Hospital in Mexico (Figure 1). As a pilot group we included outpatients from a Rheumatology clinic, referred

Table 1. Demographic characteristics

	N=21
Age, mean (SD)	43.62 (14.68)
Female, n (%)	14 (66.66)
Years of education, mean (SD)	15.24 (2.70)
Psychiatric disorder	
Depression, n (%)	4 (19.04)
Rheumatic diagnosis	
Systemic lupus erythematosus, n (%)	13 (61.90)
Rheumatoid arthritis, n (%)	3 (14.30)
Others, n (%)	5 (23.80)

by their physician (Table 1). The following psychological tests were used: Montreal Cognitive Assessment (MoCA) and Neurobehavioral Cognitive Status Examination (NCSE). After results (Table 2), the team decided to extend the evaluation with Automated Neuropsychological Assessment Metrics (ANAM), Wechsler Adult Intelligence Scale (WAIS-IV) and International Neuropsychiatric Interview (MINI) (Figure 2). Statistical analysis was performed with SPSS v.24, descriptive statistic were used with measures of central frequency trend.

Table 2. Comparison of MoCA and NCSE results.

	MoCA N=21	NCSE N=21
Total score, mean (SD)	24.24 (3.49)	*38.52 (1.69)*
Level of cognitive impairment		
Normal, n (%)	7 (33.3)	17 (81)
Mild, n (%)	**13 (61.9)**	**1 (4.8)**
Moderate, n (%)	**1(4.8)**	**3 (14.2)**
Severe, n (%)	0 (0)	0 (0)

MoCA, Montreal Cognitive Assessment; NCSE, Neurobehavioral Cognitive Status Examination.

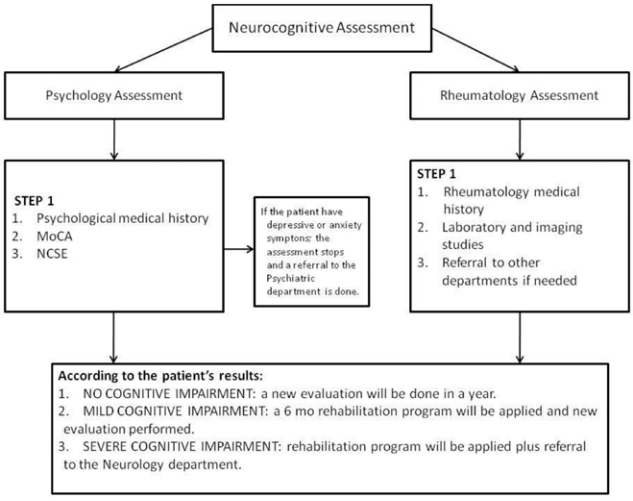

Figure 1. Pilot program of the Neurocognitive Assessment

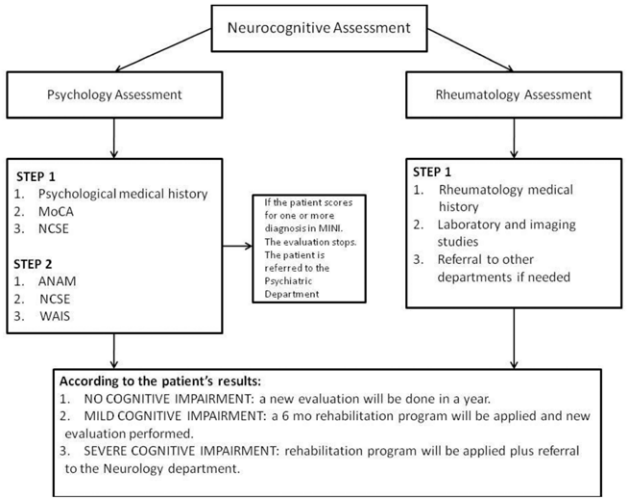

Figure 2. Final Program of the Neurocognitive Assessment

Results: We evaluated 21 patients (66% females) with an average age of 43.62 years (SD 14.6) (Table 1). The total number of patients with cognitive impairment was 15 (71%), 14 (66%) diagnosed with MoCA, 6 (28%) with NCSE and a coincidence of both tests in 4 (19%) patients (Table 2).

Conclusion: A high percentage of patients with cognitive impairment was found, also a discrepancy between the MoCA and NCSE results. We realized those tests were not enough to get a detail cognitive functioning, for this reason it was decided to make a more extensive evaluation adding ANAM, WAIS-IV and MINI. Neuropsychological evaluation should be performed as part of a multidisciplinary management for the patient and the rheumatologist should be aware of this manifestation and the importance of cognitive testing.

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THU0627-HPR JOINT INVOLVEMENT SIGNIFICANTLY INFLUENCES QUALITY OF LIFE OF PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: Joint involvement is one of the most common features observed in Systemic Lupus Erythematosus (SLE), potentially involving up to 90% of patients [1]. Several patients' reported outcomes (PROs) have been employed to measure Quality of life (QoL) in SLE patients, but frequently not specifically developed for SLE patients. More recently, the LupusQoL has been validated, a disease specific questionnaire[2,3].

Objectives: We focused at assessing the relationship between musculoskeletal manifestations and QoL in a large SLE cohort, by using the LupusQoL.

Methods: SLE patients with a clinical history of joint involvement (arthralgia/arthritis – group A) were enrolled in the present study. SLE diagnosis was performed according to the revised 1997 ACR criteria. As a control group, we enrolled SLE patients without history of joint involvement (group B).Disease activity was assessed by the SLE Disease Activity Index-2000 (SLEDAI-2k). The activity of joint involvement was assessed by using the disease activity score on 28 joints ($DAS28_{ESR}$). The LupusQoL was administered to the enrolled patients (Group A and Group B). It consists of 34 items referring to eight domains: physical health (PH), pain (P), planning (PL), intimate relationships (IR), burden to others (BO), emotional health (EH), body image (BI) and fatigue (F).

Results: Group A included 110 patients [M/F 8/102; median age 49 years (IQR 13), median disease duration 156 months (IQR 216)], while group B included 58 patients [M/F 11/47; median age 40 years (IQR 15), median disease duration 84 months (IQR 108)]. Group A showed a significantly lower disease duration and mean age in comparison with group B (P< 0.001 for both comparisons). As represented in figure 1, group A showed significantly lower values in all LupusQoL domains except for "burden to others" domain. Moreover, we observed an inverse correlation between $DAS28_{ESR}$ and all the LupusQoL domains in group A patients [PH (r=-0.5, P>0.0001), P (r=-0.5, P<0.0001), PL (r=-0.5, P<0.0001), IR (r=-0.2, P=0.006), BO (r=-0.4, P=0.0004), EH (r=-0.3, P=0.0009), BI (r=-0.4, P=0.001), F (r=-0.4, P<0.0001)]. Conversely, SLEDAI-2k values inversely correlated only with PL (r=-0.3, P=0.006), IR (r=-0.25, P=0.02), EH (r=-0.3, P=0.02).