

responded by their parents/caregivers), between 12- and 17.9-years (adolescents), and 18-years or older (adults). A total of 387 mPwH responded to the questionnaires. Their median (Interquartile Range; IQR) age was 49.0-years (26.0–62.0), 340 (87.8%) were adults, 29 (7.5%) had past or current inhibitors, 197 (50.9%) had ever been treated with any clotting product, and 12 (3.1%) were currently on prophylaxis. Approximately 74% reported they perceived their disease was not serious or not serious at all, and the different activity groups responded similarly. Recent bleed at any site was reported by 24/47 (51.1%) non-adults, related to the previous quarter, and 96/340 (28.2%) adults, related to the previous year. Joint impairment was reported for 180 joints (22 perceived as severe) by 50/387 (12.9%) mPwH. Age at first hemarthrosis was 10.0 years [5.0–16.0] among 97 (25%) mPwH. Lifetime hospitalization due to joint surgery was reported by 31/358 (8.7%) mPwH. The analyses of PROMIS29 and RAND-26 (quality of life), and HAL (functional abilities) indicated good quality of life and functional abilities. mPwH who participated in the HiN-6 Study reported good social functioning and a non-impacting disease in their lives, although bleeds, joint impairment, and need for joint surgeries still occur.

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ERECTILE DYSFUNCTION IS RELATED TO QUALITY OF LIFE, BUT NOT TO RISK FACTORS FOR CARDIOVASCULAR DISEASES, AMONG ADULT MEN WITH HEMOPHILIA

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Erectile Dysfunction (ED) is a multifactorial disease related to psychosocial determinants and Cardiovascular Disease (CVD). Since Adults with Hemophilia (AwH) may have impaired psychosocial functioning due to the disease and have a high risk of developing CVD, we assumed ED might be prevalent among them. We evaluated perceived ED using a validated self-reported questionnaire in AwH participating in a cross-sectional study to describe CVD and CVD risk factors (HemoCardio Study). Male AwH aged ≥ 30 -years attending a Northeastern Brazilian Hemophilia Treatment Center were invited. Demographic and clinical/therapeutic hemophilia data were collected from medical files. Clinical/therapeutic data about CVD and CVD risk factors were obtained by interview, physical examination, and laboratory tests. Perceived ED was evaluated by the International Index of Erectile Function-Erectile Function Domain (IIEF-6) instrument. Quality of life (QoL) was evaluated by HemoLatin-QoL and EQ-5D. Well-

being was evaluated by the Hemophilia Well-Being Index (HWBI). For all questionnaires, higher scores meant better outcomes. A total of 84 AwH was included in the main study. Of the 52 AwH who responded to the IIEF-6, median age was 42.0-years (Interquartile Range [IQR] 36.0–51.8), 43 (83%) had hemophilia A, and 25 (48%) were severe. Median IIEF-6 was 29.0 (IQR 25.3–30.0) and 13 (25%) perceived ED. Perceived ED was associated with severe hemophilia ($p=0.025$), lower HemoLatin-QoL total score ($p=0.010$), and lower EQ-5D index ($p=0.038$), but fairly associated with the use of anti-hypertensive ($p=0.043$) and antidiabetic ($p=0.049$). HWBI did not differ between AwH who perceived or did not ED. IIEF-6 had a positive correlation with the emotional functioning domain of the HemoLatin-QoL ($n=47$, $r=0.313$, $p=0.032$), but not with HemoLatin-QoL total score, EQ-5D index, or HWBI. We could not find associations between CVD or CVD risk factors and perceived ED among AwH. However, perceived ED correlated with QoL.

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GENETIC AND NON-GENETIC DETERMINANTS OF SUCCESSFUL IMMUNE TOLERANCE INDUCTION IN PEOPLE WITH SEVERE HEMOPHILIA A

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