

circulating auto-reactive B cells in patients with PR3-AAV, and suggests that PR3-specific B cells are associated with disease activity and may represent a promising biomarker to predict relapse risk in patients in clinical remission. The progressive enrichment in PR3-specific B cells during the B-cell maturation steps in patients suggest that auto-reactive B cells are actively selected and escape peripheral tolerance checkpoints.

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HPR mind over matter - patients perspectives

OP0138-HPR DO PATIENTS' TREATMENT BELIEFS AFFECT TREATMENT CHOICES IN KNEE AND HIP OSTEOARTHRITIS?

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Background: Patients' beliefs about treatment modalities for knee/hip osteoarthritis (OA) might influence their treatment choices. The Theory of Planned Behavior predicts that patients' beliefs, the norms and values of one's social environment (subjective norm) and one's perceived self-efficacy influence behaviour¹. Moreover, symptom severity may influence treatment choices². However, these relationships have not been studied yet in the context of treatment decision-making.

Objectives: To test whether treatment beliefs, subjective norm, perceived self-efficacy and symptom severity were associated with intended treatment choices in OA.

Methods: Patients with knee/hip OA who visited the Sint Maartenskliniek in 2015 and 2016 (N=700) were invited to fill out a booklet. The Treatment beliefs in OsteoArthritis questionnaire was used to assess positive and negative treatment beliefs regarding five treatment modalities: physical activities, pain medication, physiotherapy, injections and arthroplasty. Other measures were demographic and clinical variables, self-efficacy (ASES), and symptom severity (WOMAC). Associations between variables were assessed in three models (Figure 1): 1) whether treatment beliefs are associated with intended treatment choice (model 1); 2) whether treatment beliefs, subjective norm and perceived self-efficacy are associated with intended treatment choice (model 2); 3) whether treatment beliefs, subjective norm, perceived self-efficacy and symptom severity are associated with intended treatment choice (model 3). Path analyses were conducted to examine the hypothesized associations.

Results: 289 patients filled out the booklet. Model 2 had the highest explained variance for each of the treatment modalities (range 32–45%). Positive treatment beliefs and subjective norm were consistently associated with intended treatment choice across all treatment modalities. Negative treatment beliefs were associated with intended treatment choices for pain medication and arthroplasty. Perceived



Figure 1a: Model 1

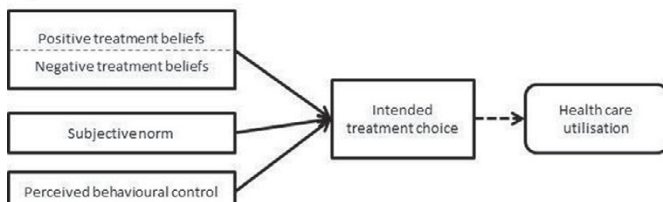


Figure 1b: Model 2

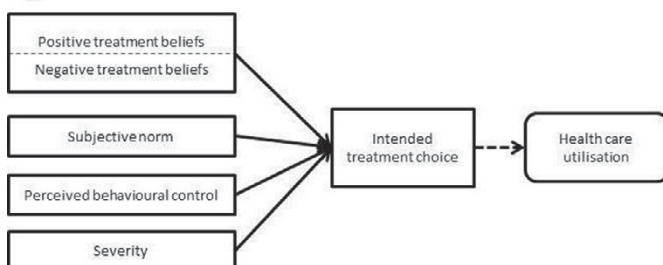


Figure 1c: Model 3

symptom severity was not related to intended treatment choices. No other associations were found.

Conclusions: This is the first study that found empirical support for the relationship between treatment beliefs and treatment choices. The findings suggest that positive beliefs about treatment modalities and the norms and values of one's social environment are related to a specific treatment choice for knee/hip OA and should be addressed in the clinician's consulting room.

References:

[1] Ajzen, I. (1991). The Theory of Planned Behavior. *Organ Behav Hum Dec* 50. 179–211.

[2] Rosemann (2007). Health service utilization patterns of primary care patients with osteoarthritis. *BMC Health Serv Res* 7: 167.

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OP0139-HPR REDUCING ARTHRITIS FATIGUE - CLINICAL TEAMS (RAFT) USING COGNITIVE-BEHAVIOURAL APPROACHES: AN RCT

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Background: RA fatigue is common. Group Cognitive Behavioural Therapy by CBT therapists is effective¹ but few rheumatology teams have psychologists, thus we trained rheumatology teams to deliver RAFT, a cognitive behavioural approach (CBA).

Objectives: To test if usual care plus a group CBA course for RA fatigue delivered by rheumatology teams reduces fatigue impact more than usual care alone, in a randomised controlled trial.

Methods: A pair of rheumatology nurses/OTs in each of 7 UK hospitals were trained in RAFT. RAFT is 6, weekly 2hr group sessions and a consolidation session (wk 14). Links between thoughts, feelings and behaviours (pacing, communication, sleep, stress) are addressed, with daily diaries of energy expenditure and weekly goal-setting. Usual care was a 5min discussion of the Arthritis Research UK fatigue booklet. Entry criteria were RA, Bristol RA Fatigue (BRAFF-NRS) severity $\geq 6/10$ and no recent major medication change. Primary outcome was fatigue impact (BRAFF-NRS impact, 0–10) at 26 wks; plus wider aspects of fatigue (BRAFF-Multi-Dimensional Questionnaire), pain, disability, sleep, quality of life, mood, self-efficacy, patient global opinion, valued life activities & disease activity. Intention-to-treat regression analysis involved adjustment for baseline scores and centre.

Results: 308/333 randomized patients completed 26 wks. The 25 who withdrew had similar (10yr) disease duration but were older (69 vs 62.4 yrs). Baseline fatigue impact was similar for RAFT (n=156, BRAFF-NRS 7.10, SD 1.7) and controls (n=152, 7.23, SD 1.6), as were all clinical variables. At 26 wks the RAFT arm had significantly less fatigue impact than controls (BRAFF-NRS 5.74, SD 2.4 vs 6.36, SD 2.4). Mean BRAFF-NRS impact was reduced by -1.36 (p<0.001) in RAFT vs -0.88 in controls (p<0.004). Regression analysis showed the difference between changes in fatigue impact NRS was -0.59 in favour of RAFT (CI -1.11, -0.06). Regression analysis also showed significant differences in secondary outcomes in favour of RAFT: BRAFF-MDQ total fatigue -3.42 (CI -6.44, -0.39); Living with Fatigue -1.19 (CI -2.17, -0.21); Emotional Fatigue -0.91 (CI -1.58, -0.23); and RA self-efficacy (RASE, +3.05, CI 0.43, 5.66). There were no differences between arms for changes in fatigue severity or other clinical variables.

99% of RAFT patients would definitely recommend the course to others compared to 50% controls (p<0.001). 90% of RAFT patients rated satisfaction $\geq 8/10$ (including 62% rating 10/10); in comparison 50% controls rated satisfaction $\geq 8/10$ (including 26% rating 10/10, (p<0.0001). Over 26 weeks 20 control patients sought extra appointments for fatigue help compared to 8 RAFT patients (14.2% vs 5.3%, p<0.01).

Conclusions: Rheumatology teams delivering a manualized CBA group intervention addressing fatigue impact, not only improve RA fatigue impact, but also emotional & overall fatigue, living with fatigue and self-efficacy, with very high patient satisfaction. Providing rheumatology teams with CBA skills is a potential new therapeutic approach to change practice and improve patient outcome.

References:

[1] Hewlett et al, *ARD* 2011;70:1060–7.

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OP0140-HPR ACCEPTANCE AND COMMITMENT THERAPY: A RETROSPECTIVE STUDY OF OUTCOMES FROM A HOSPITAL-BASED, GROUP, PAIN REHABILITATION PROGRAMME IN RHEUMATOLOGY SERVICES IN THE SOUTH EAST OF IRELAND

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Background: Acceptance and Commitment Therapy (ACT) is a form of cognitive