

a three month period in response to daily, weekly and monthly question sets (table 1). An optional diary component was included, but not integrated into the EPR. The ePROS had been determined during earlier interviews with rheumatology patients, practitioners and researchers.

Qualitative interviews were conducted with patients at the end of the three month period. Interviews explored patients' views on the components of the app, and perceived implications for self-management and clinical care. Interviews were transcribed and analysed thematically.

Results: Qualitative analysis of the data identified a number of themes including: the benefits and limitations of using scales to reflect changes in symptoms experienced, the value of the diary for providing contextual information and an "outlet" for feelings, and the impact the data made to their clinical consultation and self-management.

Overall, the collection of longitudinal data was seen as useful by patients. Successful integration with the EPR allowed data to be displayed graphically during clinical consultations. Reviewing remote monitoring data detected changes which may otherwise have been missed such as flares in disease, or gradual improvements in response to new treatments. Data therefore facilitated "a shared conversation" and decision making around treatment plans.

Additionally, being able to self-reflect on data recorded enabled patients to identify triggers and alleviators in relation to their disease activity and take steps to self-manage their RA; for example, by recognising when they needed to rest as opposed to "just carrying on" when their symptoms were more severe.

Table 1. ePROS

Daily	Pain, difficulty with physical activities, fatigue, sleep difficulties, physical wellbeing, emotional wellbeing, coping
Weekly	Morning stiffness Number of tender & swollen joints Global assessment of wellbeing Employment status Impact on number of hours worked Experienced a flare Description of flare
Monthly	Health Assessment Questionnaire (HAQ) impact of disease on daily activities.

Conclusions: The app was well received by patients and feedback suggests that the ePROS recorded can capture changes in disease activity in a manner that is meaningful to patients and facilitates both clinical consultations and self-management.

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[1] <http://oml.eular.org/Toolbox of Patient Reported Outcomes>.

Acknowledgements:

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.6552

AB1098 TEMPORARY WORK DISABILITY CAUSED BY MUSCULOSKELETAL DISEASES AT THE HOSPITAL CLÍNICO UNIVERSITARIO DE VALLADOLID: 6 MONTHS EXPERIENCE

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Background: Musculoskeletal diseases are the leading cause of disability in the world and have a high impact on direct (health) and indirect (labor) costs. Labor casualties in Spain, when temporary, are known as temporary work disability (TWD). Since 2013, follow-up of patients with TWD (when the origin of the disease is a musculoskeletal condition) is being carried out in a monographic consultation within the external consultations of the Rheumatology Service of the Hospital Clínico Universitario de Valladolid.

Objectives: To describe the experience of the last 6 months in the consultation of temporary musculoskeletal incapacities (TWDMSDs) of the Hospital Clínico Universitario de Valladolid.

Methods: The TWDMSDs consultation is operational 2 days a week. The referral system is direct from Medical Inspection via email (1st part confirmatory work leave). The patients come from 7 Health Centers (population 82,000 people). The agenda is configured daily according to the emails sent, contacting the patients by telephone, excluding those with trauma, surgeries, pregnancies, non-localized, rejection or discharge. The assessment of the patients in consultation, according to usual clinical practice. A medical report is issued (medical history, physical examination, completed or requested tests, recommendations and treatment). The data are collected in SPSS, proceeding to its subsequent analysis.

Results: During the last six months of follow-up, 354 emails have been received. A total of 106 patients were evaluated, with the following characteristics: 54.3% women and 45.7% men, mean age 43.4 years, 95% performed physical work. Axial pathology was observed in 67.8% of cases and peripheral in 32.2%. The patients evaluated with some rheumatic pathology reached 96%. The average delay from the start of the work leave to the email was 12.2 days, and from the start of the work leave to the first consultation of 6.7 days (including weekends). 65.4% of the patients were discharged from the TWDMSDs agenda in the 1st consultation, without requiring interconsultations or requests for diagnostic tests, with an infiltration of 8% of the patients, arthrocentesis at 2%, ultrasound at 28%

and Exercise guidelines were given to 76% of patients. The mean number of consultations up to discharge was 1.3. The mean time from onset of discharge to discharge was 21.1 days and from the first consultation until discharge by Rheumatology was 6.6 days.

Conclusions: The TWDMSDs consultation makes possible the early detection of rheumatologic musculoskeletal pathology, allowing an early action that minimizes the number of requested tests and interconsults generated and achieves an early diagnosis and treatment of patients, with the consequent benefits that this entails. The patients evaluated in consultation are mainly of average age, with physical work, mechanical pathology, resolution of the problem that causes the TWD and reincorporation to the working life of early form. In the discharge report, recommendations are included to minimize future casualties (work refocus, orthotics, exercises, treatment regimens in the event of a recurrence of symptoms) and explain the importance of being actively involved in their pathology to prevent progression.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.2886

AB1099 COUNSELLING ON FAMILY PLANNING AND CONTRACEPTION, AND PREGNANCY OUTCOME IN WOMEN WITH RHEUMATIC DISEASES: A NATIONAL SURVEY OF 398 PATIENT-REPORTED QUESTIONNAIRES FROM 24 RHEUMATOLOGY CENTERS

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Background: Rheumatic diseases (RD) predominantly affect young women during reproductive age. Pregnancy, contraception and family planning (FP) are crucial for the quality of life of these patients.

Objectives: We aimed to investigate 'women's health' through a self-reported questionnaire. Answers from patients with connective tissue diseases (CTD) vs chronic arthritis (CA) were compared.

Methods: 24 centres distributed the questionnaire (65 multiple-choice and 12 open-answer questions) to women with RD (18–45years) regularly attending their outpatient clinics.

Results: Answers were collected from 249 CTD vs 149 CA patients. Their desire to have children was influenced by RD in 40% of cases: half of them reduced the number of children they wanted (Table 1). 39% CA vs 29% CTD were afraid of being mother because of disability.

24% CTD vs. 18% CA had at least one miscarriage; 21% CTD vs. 2% CA had more than one.

31% CTD and 34% CA were never asked about their desire to have children. 61% CTD vs 70% CA received counselling about contraception, given by a gynaecologist (G) (58% vs 64%), rheumatologist (R) (22% vs 14%) or both (7% vs 9%). 60% in both groups received a counselling before pregnancy: 34% vs 39% from R and G, 14% vs 22% by R. This positively changed family planning in 64% vs 59%. We created a Knowledge Index (based on the average of the normalized performed scores on 6 key questions for different sections): 55% CTD patients vs 44% CA had a medium-high score. A higher score directly correlated with the desire to become pregnant and with a multidisciplinary counselling.

The disease has reduced your desire to have children?		
	CTD	CA
NO	36/91 (40%)	22/54 (41%)
YES	52/91 (57%)	28/54 (52%)
No Answer	3/91 (3%)	4/54 (7%)
If yes, I reduced the number of children that I wanted, because I was afraid...		
...of not being able to take care of them because of the disease	26/91 (29%)	21/54 (39%)
...that the child could have the same disease	15/91 (17%)	8/54 (15%)
...that drugs or disease could harm the baby	26/91 (29%)	20/54 (37%)

Table 1. Reasons for reduced family size in patients who declared that their RD had influenced their desire of having children

Conclusions: This survey suggested that CTD have a major impact on FP and family size, possibly mediated by the increased rate of miscarriages as compared to CA. Concerns about reproductive issues could be positively overcome by adequate counselling.

Rheumatologists should implement the discussion about FP and the compatibility of drugs with pregnancy in the management of young women with RD, especially those with CTD for whom contraception and pregnancy have particular implications.

Acknowledgements: Statistical analysis supported by an unrestricted grant by UCB Pharma

Thanks to Patients' Associations and Participants

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.2268

AB1100 PATIENT SELF-MANAGEMENT APPS AS ONE MODULE OF AN INTEGRATED TIGHT-CONTROL CONCEPT BASED ON THE EXAMPLES OF THE DIGITAL APPLICATIONS RHEUMALIVE UND AXSPALIVE

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Background: Medical Applications have the potential to support physicians and patients to document the course of the disease and optimize therapies. We describe the linkage and integration of patient reported outcomes (PROs) into existing medical office software and rheumatologic documentation systems by means of the digital applications RheumaLive and AxSpALive. RheumaLive is certified as medical product class I, and certification for AxSpALive is in preparation.

Methods: RheumaLive and AxSpALive are applications that can be downloaded free of charge from the common app-stores (Android, Apple) and installed on mobile devices (smartphones, tablets). A freeware version for PCs is also available (Windows- und Mac OS X-Version). A diary functionality allows to document the medication uptake (partially filed, memory-functionality for medication uptake available), validated scores like VAS, SJC, morning stiffness, FFBh (comparable to HAQ), BASDAI, RADA, etc. and days of sick leave (+/- related to the rheumatic disease). All App-versions are password-protected, which is provided by the treating rheumatologist (relationship patient-physician).

The patient reported outcomes are stored locally on the respective device. For the subsequent visit, they can be printed or sent encrypted to the treating physician via internet in a prespecified interval. A specific software allows to integrate the data into the existing medical office software.

In daily practise, data entered by patients into RheumaLive can be screened and compared with collected clinical data and laboratory measures, because of its certification as medical product. In case of an increasing disease activity the patient can be rapidly contacted and medication can be modified, if necessary. Regular F2F-appointments remain integral part of the medical care, even in case of good controlled disease activity. But in case of F2F-appointments, PROs can be delivered by patients, saving time and resources.

The PROs can be made available to rheumatologic documentation systems like RheumaDok via predefined interfaces.

Results: In a first pilot phase 54 patients in 4 rheumatologic specialised practices were documented. In the next phase the number of patients and participating practices/centres shall be increased.

Further studies are necessary to show if the integration of PROs which are collected via electronical application can lead to an improvement of rheumatologic diseases.

Conclusions: The integration of PROs collected with RheumaLive and AxSpALive into existing rheumatologic documentation systems allows a close monitoring of disease courses and therapies according to the "tight control" principle.

Acknowledgements: RheumaLive and AxSpALive were developed by Starhealth GmbH on behalf of UCB Pharma GmbH.

Disclosure of Interest: M. Feuchtenberger Speakers bureau: UCB, S. Kleinert Speakers bureau: UCB, F. Schuch Speakers bureau: UCB, S. Spähtling-Mestekemper Speakers bureau: UCB, C. Kuhn: None declared, M. Welcker Speakers bureau: UCB

DOI: 10.1136/annrheumdis-2017-eular.5782

AB1101 QUALITY OF LIFE AND WORK IN PATIENTS WITH ANKYLOSING SPONDYLITIS OF WORKING AGE

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Background: The assessment of the quality of life is a current research issue in patients with ankylosis spondylitis^{1,2}. The tools for assessing the life quality,

come to complete the other methods of investigation, which assess in a subjective manner the negative impact of the disease on daily activities.

Objectives: The purpose of this study is to define the functional ability, the disease activity, to investigate the correlation between work and quality of life, and the impact of the quality of life in patients with AS.

Methods: The study is an observational prospective study, which includes a total of 91 patients defined with AS in according to the modified New York criteria, from the Rheumatology Clinic of Targu-Mures. Data were obtained by questionnaires including several generic and disease related Quality of life tools. It includes specific tools: BASDAI (Bath Ankylosing Spondylitis Disease Activity Index); BASFI (Bath Ankylosing Spondylitis Functional Index); ASQOL (Ankylosing Spondylitis Quality of Life); and generic tools: SF-36 (Short-Form 36), EQ-5D (European-Quality of life 5 Dimensions), HAQ (Health Assessment Questionnaire and VAS (Visual Analogue Scale).

Results: Out of 91 patients, 82% were males, 18% were females; mean age (years) 50,27±11,05SD; age at disease onset (years) 36,20±13,51SD; duration of disease (years) 14,22±9,69SD; retiring mean age (years) 44,54±7,65SD. The mean values for BASDAI=4,23±2,21SD; BASFI=4,88±2,61SD; EQ-5D=5,71±0,20SD; EQ-VAS=64,26±18,938D; HAQ=0,747±0,51SD; SF-physical summary=33,53±8,33SD; SF-emotional summary=47,57±10,03SD; ASQOL=6,94±2,68SD. We found a positive correlation between the disease onset and retiring age p<0,0001, r=0,731 and a negative significant correlation between BASFI and SFphysical summary (p<0,0001, r=-0,798), ASQOL and SF-emotional summary, p<0,0001, r=-0,595).

Conclusions: The results showed the invalidant potential of the AS, with major impact upon the quality of life.

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2017-eular.6559

AB1102 LOW BONE MINERAL DENSITY IS A MAJOR CONTRIBUTOR IN THE EUROPEAN HEALTH BURDEN DUE TO ROAD TRAFFIC ACCIDENTS IN PEOPLE AGED 50 YEARS AND ABOVE

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Background: Road traffic accidents (RTAs) are the second leading injury health burden and cause of death in Europe, after falls (1). A significant but as yet unreported proportion of such burden is potentially due to low bone mineral density (BMD), especially among older people, through its relationship with fractures.

Objectives: To measure the percentage of deaths, disability-adjusted life years (DALYs) and years lived with disability (YLDs) due to RTA in people aged 50 years and above attributable to low BMD in the European population for the year 2015.

Methods: The estimates followed the Counterfactual Risk Assessment methodology used in the GBD study (1). Systematic review was performed seeking population-based studies with femoral neck BMD (FNBM) measured by Dual-X-Ray-Absorptiometry in people 50 years and over. Age- and sex- specific levels of mean +/-SD FNBM (g/cm²) were extracted from eligible studies, and this was used as the exposure variable. The age and sex-specific 99th percentile from non-Hispanic whites in National Health and Nutrition Examination Survey (NHANES) 2009–2010 was used as theoretical minimum risk factor exposure distribution, to estimate the potential impact fraction (PIF) of FNBM for fractures. Relative risks of FNBM for fractures were obtained from a previous meta-analysis (2). Attributable deaths due to RTA-related fractures were obtained through coded hospital data. Disability levels were established by applying disability weights to each type of fracture. Then, PIFs were applied to obtain attributable deaths and disability due to low BMD.

Results: In the European population aged 50–69 and 70 years and above, 10.8% (95% CI: 8.9–12.4%) and 30.9% (29.1–32.4%) of RTA-related deaths, respectively, were attributable to low BMD. In the age group 50–69 this was the second most important risk factor following alcohol use and in those 70 years and above became the most important risk factor, with double the weight of alcohol use. This represents 2,537 and 5,460 absolute deaths in those aged 50–69 and 70 years and above, respectively. The percentage of health burden and disability caused by RTAs attributable to low BMD grew steadily from the ages of 50 and onwards.

Conclusions: This data shows the non-previously reported important role of low BMD as a preventable risk factor for European RTAs' health burden in population 50 years and over, which requires urgent attention.