

1-day interval. ICC models were used to determine the test-retest reliability. Berg Balance Scale (BBS) was used as the reference standard to establish concurrent validity.

Results: All tests showed good to excellent reliability (ICC >0.94) except SLST which showed moderate to good reliability (ICC=0.74). Three of the tests (SLST, 10 MWT, 5x SST) found to have good to excellent validity ($r>0.75$) and three (2 MWT, TUG, FRT) found to have moderate to good reliability ($r>0.69$). Results are presented in details at Table 1 and Table 2.

Conclusions: TUG, 10MWT, SLST, FRT, 5x SST and 2 MWT are reliable and valid outcome measures, and could be used to assess balance and fall risk in patients with TKA. MDC scores presented in this study can be used to evaluate change in performance over time or effectiveness of interventions. 2 MWT and 5x SST were determined as the most reliable and valid methods among the investigated tests.

Disclosure of Interest: None declared

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FRI0737-HPR THE SOURCES OF PAIN IN ABDOMEN IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Systemic diseases of connective tissue associated with the early development of atherosclerosis [1,2]. It is well-known that the main cause of decrease the quality of life patients with rheumatoid arthritis (RA) is a chronic pain syndrome. The cause of pain can be joint inflammatory process, systemic manifestations of RA (vasculitis, pericarditis, pleurisy, polyneuropathy), complications of drug therapy, comorbid conditions. Pain in the stomach area may be associated with NSAID-gastropathy, problems with spinal discs, and perhaps with atherosclerotic lesions of the abdominal aorta.

Objectives: To estimate atherosclerotic changes of arteries in patients with RA and determine possible sources of pain in the abdomen by ultrasound-control palpation.

Methods: We included 75 patients with RA (age 38,7±7,4, males 93,3%) and 29 healthy subjects, matched for age and gender, without a history of cardiovascular diseases. An ultrasound investigation of the arterial vessel with measurement of the intima-media thickness (IMT) of carotids was performed. To determine the source of pain in the abdominal cavity ultrasound-control palpation of duodenal bulb, gallbladder, lumbar discs, and abdominal aorta was done. Severity of pain was assessed using the VAS.

Results: It has been determined, that in RA group IMT was 0.8 mm (0.7–0.9), compared with 0.6 mm (0.6–0.7) in control group. IMT positively correlate with the age, duration of disease, Ritchie index, C-reactive protein level. In 22 (29,3%) patients with RA we found atherosclerotic plaques lesion in carotids, aorta, and vessels of the lower extremities. Present of atherosclerotic plaques associated with disease durations (12 years (10–15) in group with plaques and 5 years (3–8) in group without plaques). The presence of atherosclerotic plaques is associated with rheumatoid factor ($c^2=1,02$, $p>0,05$), and systemic manifestations of RA ($c^2=15,89$, $p<0,001$).

In RA group 36 (48%) patients had indicated the presence of pain in the abdomen while performing ultrasound control palpation. In 15 (20%) cases was detected pain during palpation of the lumbar spine, VAS 48 (36–59). In 21 (28%) cases, patients indicated pain during palpation of the abdominal aorta, VAS 42 (31–65). In this group of patients we found signs of the atherosclerotic lesions of aorta: change in the contour of the vessel, the heterogeneous structure of the vascular wall. Atherosclerotic plaques in the abdominal aorta are founded in 21 (28%) cases.

Conclusions: Patients with RA had an increase thickness of IMT and atherosclerotic plaques, which appear in various vascular regions. During performing

ultrasound-control palpation in 36 (48%) patients was detected pain, associated with vertebral changes 15 (20%), and with atherosclerotic changes of abdominal aorta – 21 (28%).

References:

- [1] High incidence of cardiovascular events in a rheumatoid arthritis cohort not explained by traditional cardiac risk factors. I.D. del Rincon et al. *Arthritis Rheum.* 2001;44:2737–2745.
- [2] Cardiovascular disease and risk factors in patients with rheumatoid arthritis, psoriatic arthritis, and ankylosing spondylitis. C. Han et al. *J. Rheumatol.* 2006;33(11):2105–2107.

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FRI0738-HPR QUALITY IN REHABILITATION FOR RHEUMATIC AND MUSCULOSKELETAL DISEASES (RMDs): DEVELOPMENT AND TESTING OF A RMD REHABILITATION QUALITY INDICATOR SET

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Background: Rehabilitation in Norway is characterized by a lack of coordination across levels of care, and by large variations in content and quality. A means to monitor the quality of care is to use quality indicators (QI), which are related to structure (the settings in which care is given), process (what is actually being done) or outcome of health care.

Objectives: To develop and test a set of quality indicators for rehabilitation of people with RMDs.

Methods: The QI set was developed following the Rand/UCLA Method and pilot-tested for validity and feasibility in 29 specialist and primary care rehabilitation units. Pass rates were recorded in telephone interviews with managers of the rehabilitation units (structure QIs (yes/no)), or patients (process and outcome QIs (yes/no)). Time use and participants rating of face validity on a numeric rating scale (0–10, 10=high validity) were recorded. Separate QI pass rates and summary QI pass rates were calculated.

Results: A total of 164 patients (mean (SD) age 58.5 (16.5) years and 76% women) participated. Mean (range) validity score for managers/patients was 8.3 (8)/7.9 (9), and mean answering time was 6.0/5.5 minutes.

A 100% summary pass rate was reached by only two of the rehabilitation units and 4% of the patients.

Conclusions: To our knowledge this is the first QI set developed to measure QI pass rates for rehabilitation of RMDs. The results indicate that the QI set is acceptable to respondents, and it's validity and feasible format make it suitable for monitoring quality of rehabilitation. The large variety in pass rates suggests a high potential for quality improvement in rehabilitation.

Disclosure of Interest: None declared

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FRI0739-HPR A RHEUMATOLOGY PATIENTPANEL: THE PATIENT IS THE EXPERT, WE ARE THE SPECIALIST

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Background: Patient participation is known in the field of rheumatology research and is becoming more customary. The patient perspective can improve the care and line specific needs of the patient to the delivered care. Recently, our Rheumatology department within the Maasstad Hospital introduced the Value Based Health Care principle in order to optimize the current healthcare system.

Abstract FRI0738-HPR – Table 1. Structure, process and outcome Quality indicators (QI) with Pass rates (PR) in %

STRUCTURE QI (answered by unit managers)	PR	PROCESS QI (answered by patients)	PR
Has a defined patient target group	96		
Procedures for		Had an initial bio-psycho-social assessment	85
Developing an individual rehabilitation plan	76	Received a written rehabilitation plan	77
Regular team meetings with patients	72	Participated in minimum 2 team meetings	69
Meetings with possibility to participate for next of kin and external HPs*	65	It was possible for next of kin and external HPs to participate in the team meetings	19
Individual plans for follow-up after discharge	52	Received an individual plan for follow-up	65
		External HPs* were involved in follow-up	22
Procedures for involving patients in		Participated in	
Setting goals	93	Setting goals	91
Planning the intervention	93	Planning the intervention	71
Evaluating the intervention	89	Planning follow-up	74
Use of validated assessment instruments	69	OUTCOME QI (answered by patients)	PR
Assessment of		Satisfied or very satisfied with rehabilitation	88
Goal attainment at discharge	41	Reached important goals	89
Goal attainment 3–6 months after discharge	21		
Function at admission and discharge e	79	Had important improvement in physical, psychological or social function	86
Function 3–6 months after discharge	24		
HRQoL at admission and discharge	29	Had improvement in quality of life	77
HRQoL 3–6 months after discharge	17		
Registration of adverse events	96	Experienced negative events	12

*External HPs are health professionals from other health care settings, such as primary care.