rate 76.9%; males 74.2%; mean age 46.0 yrs (SD 12.6), range 18–75 yrs; mean symptom duration 19.8 yrs) and 6 months. Self-reported AS and general health transition at 6 months were the criteria used to assess validity and responsiveness. The relationship between changes in instrument scores and responses to transition items was assessed for a linear trend.

Results Significant correlations between mean change in instrument scores and both forms of transition question supports the longitudinal validity of all instruments ($p < 0.001$): the largest levels of change were found for the PGI-AS and the Bath AS Disease Activity Index (BASDAI), both demonstrating a stronger relationship with general transition. The modified standardised response mean (MSRM) was used to assess responsiveness (Table 1). The Body Chart, a measure of AS specific pain, had a moderate relationship with AS transition only (better -0.44 , worse 0.51), which may support the importance of specific pain evaluation.

Conclusion Although certain domains may not be expected to change over 6-months, this period reflects normal practice in AS evaluation in many rheumatology centres. The responsiveness of the PGI-AS and BASDAI may make them suitable for routine monitoring where management may result in small but important changes in health related quality of life.

Abstract HP0034 Table 1

	AS transition – MSRM Better (n = 56)	AS transition – MSRM Worse (n = 73)	General transition – MSRM Better (n = 51)	General transition – MSRM Worse (n = 62)
AS Quality of Life (ASQoL)	–0.29	0.35	–0.55	0.26
BASDAI	–0.60	0.22	–0.67	0.43
Revised Leeds	–0.32	0.28	–0.37	0.34
Disability (RLDQ)				
PGI-AS (informed/ open)	0.42 (n = 20)	–0.48 (n = 21)	0.74 (n = 25)	–0.75 (n = 18)

HP0035 ASSOCIATION BETWEEN TESS FUNCTIONAL QUESTIONNAIRE AND TIMED TESTS OF FUNCTION

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Background It is important to evaluate the functional result of any orthopaedic intervention. This is commonly achieved by completing tests which evaluate function in a controlled environment under a specific set of conditions, allowing objective measures to be gathered. Alternatively patient-reported assessments may be used, which reveal the limitations that the patients experience when carrying out everyday activities in their own environment. This study investigated the association between these two methods.

Method 40 adult patients undergoing lower limb reconstruction surgery completed the Toronto Extremity Salvage Score (TESS) pre-operatively and at 6, 12 and 24 months post surgery. TESS evaluates a single domain, physical disability, based on patients' reports of their function. It is applicable to a heterogeneous

population being sensitive to change across a range of levels of disability.¹ They also performed 3 timed tests of stair climbing, sit-to-stand and walking.

Results Within subjects changes were analysed using the Wilcoxon matched-pairs test and associations between variables by a Spearman's Rank Correlation Coefficient.

Subjects, on average, improved on all of the functional measures, with significant improvements from the baseline score at 12 and 24 months ($P < 0.001$). Changes at 6 months were not significant. There was a poor correlation between TESS and the timed function tests. To explore this further the association between specific questions in TESS and the objective performance tests were tested. This showed significant correlations between walking speed and the question about walking indoors (0.53 , $P < 0.003$), between stair climbing and the question about going upstairs (0.64 , $P < 0.001$) and downstairs (0.42 , $P < 0.025$) and sit-to-stand and the question about getting out of a chair (0.41 , $P < 0.03$).

Conclusions The association between the self-reported and observed outcome measures was not as strong as may have been expected when both purport to measure the same dimension of physical function. One explanation for this may be that the observed outcomes were all timed activities and patients' satisfaction with their functional abilities may not be related to time. Whilst timed tests may be reliable tests of function, they may not be as valid or useful a measure as patient-reported measures.

REFERENCE

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SP0169

NEW APPROACH TO THE CARE OF RHEUMATIC PATIENTS WITHIN THE PROJECT "PATIENT PARTNERS"

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New approaches to the care of rheumatic patients within the Project "Patients Partner". An important component of the care of patients with a chronic rheumatic disease is a complex care and an individual approach. Rheumatism is generally thought of as a disease of elderly persons, although certain types of rheumatism attack also younger age groups. There are various topics that I feel deserve to be given attention to:

- Communication and information – the patient should learn communication skills and should receive a maximum of information about his disease and its treatment.
- Complex care and the importance of teamwork. Of importance is a good collaboration among the various specialists. The role of the nurse in providing complex care is indispensable.
- Establishment of national and international organisations of rheumatic patients – a good opportunity for meeting other patients, exchanging experience, giving advice about how to cope with pain. A good example is the Revma League in Prague and its branch at Bruntal.
- Social problems – equal rights for healthy and disabled persons (Public transport, abolishment of legal discrimination etc.).

Development of future practice – multidisciplinary

HP0036 MULTIDISCIPLINARY CARE IN OUTPATIENT CLINICS: THE CLINICAL NURSE SPECIALIST'S INPUT

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Rationale In The Netherlands multidisciplinary care for inpatients with rheumatic diseases is quite common. It is generally recognised that this kind of care is necessary to fulfil the treatment goals. Within the University Medical Centre Nijmegen the multidisciplinary meetings are not only scheduled for inpatients, but also for outpatients. This way the continuity of treatment and care will be positively influenced.

Objective In order to propagate and let more patients benefit from this kind of care, we will describe the role and input of the nurse practitioner in the multidisciplinary team.

Patients and methods At our outpatient clinic the multidisciplinary meetings are scheduled once a month. The team consists of rheumatologists, social workers, occupational therapists, and the clinical nurse specialists. All team members have the possibility to add their case (s) to the agenda for discussion. Generally these are patients with more complex problems, necessitating optimal co-ordination of treatment and care.

The discussion and decision making process take place on the 'base of equality'. In our team, each member's knowledge and experience are respected and applied. This equality of disciplines is required to guarantee optimal quality of the multidisciplinary care.

The role of the clinical nurse specialist consists of:

- representing the patients by clearly explaining their questions and problems
- input of her expert opinion to the multidisciplinary treatment approach
- advising the colleagues in the clinic as well as the primary health care
- making a working schedule and point out priorities, based on the planned treatment approach.

Conclusion The clinical nurse specialist is more and more an expert with a crucial role in patient care. Within the multidisciplinary team, an open relationship between physicians and health professionals is an important condition for good quality of the decision making process.

Plan Training of the rheumatology nurse specialist (RNS) in intra-articular and soft tissue injection using corticosteroids took place prior to notifying general practitioners of the rapid access clinic. Local general practices were informed of the service and guidelines for referral were developed outlining the appropriate patients to refer.

Action Twelve months consecutive referrals were seen at a specialist joint injection clinic. 8 patients were appointed for each clinic, allowing adequate time for assessment, education and, if required, injection. Patients were sent the Arthritis and Rheumatism Council information leaflet on intra-articular injection with their appointment and are encouraged to ask questions regarding their treatment.

269 consecutive patients were seen, assessed and treated. All were sent a questionnaire 3 months after their appointment.

Referring general practitioners were also questioned to assess their impressions of the service.

Results Of the 269 questionnaires sent to patients, 189 (71%) were returned. 253 (94%) patients felt that they received sufficient information prior to their appointment. Response duration (as determined by patient) was as follows;

- three months: 61 patients (32.2%)
- 172 (91%) patients stated that they would be willing to receive a further injection if required and 185 (98%) patients rated the service overall as good or very good.

The survey of general practitioners, carried out six months after the clinic had commenced, returned 65 of 80 questionnaires (81%). 59 (90.8%) stated that they were aware of the clinic, 35 (53.8%) stated that they referred patients directly to the joint injection clinic, 21 (32.3%) had not required to refer patients and 9 (13.8%) continued to refer to the General Rheumatology clinic. 62 (95.4%) thought it was a valuable resource and were satisfied with the service provided.

Conclusions It can be concluded from the results of the patient questionnaire that overall the joint injection clinic is a well-accepted effective method of organising joint injections, both for patients and referring doctors. This has been achieved through no need for additional funds. Importantly, it reduces pressures on the standard rheumatology clinic and provides an additional educational role, which has proved a valuable resource to health care professionals. Maximum waiting time is two weeks from referral.

We are planning to introduce an electronic appointment system, whereby general practitioners can book patients appointments directly via the GPASS desktop system, with emailing of the referral letter to the clinic.

SP0145 DEVELOPMENT AND PRESENT STATE OF THE CZECH LEAGUE AGAINST RHEMATISM

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The Czech League against Rheumatism (CLAR) was founded in 1991 and accepted as a member of EULAR in 1999. Since 2000 CLAR participates in activities within the framework of Bone and Joint Decade 2000–2010 and of European Manifesto for People with Arthritis/Rheumatism for the third Millennium as well. The central CLAR branch is located in Prague and the second one was instituted recently in Moravia.

Patient centred health care

HP0037 ESTABLISHING A ONE-STOP DIRECT-ACCESS JOINT INJECTION CLINIC

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Background All intra-articular and soft tissue injections were previously carried out at the general rheumatology clinic however due to the increasing patient referrals we developed a direct access, one-stop intra-articular and soft tissue injection clinic.