shown to predict improvement in pain, pressure tenderness, fatigue, stiffness, depression, disturbed sleep, disease specific health, physical aspects and quality of life in persons with FM/CWP. There is lack of research about long-term follow-up of work status in FM and CWP. To enable patients with FM or CWP to sustain in work or return to work it is crucial to gain knowledge about which factors that can affect their work status in the long-term.
Objectives: To investigate change in work status and possible predictors of work status after 12 years in a cohort of women with FM and CWP.
Methods: In 2004, 166 women with FM and CWP participated in a randomized controlled trial in Sweden investigating effects of patient education and pool exercise. The 166 women were invited to participate in a follow-up study in 2016 in which long-term effects on work status, aspects of health and physical function were investigated. 126 participated in the follow-up study of which 98 were <65 years of age (age of retirement in Sweden) and included in the present study of work status. Data was collected by a standardized interview, a battery of questionnaires and an examination including tests of physical function. Work status refers to percentage of full-time work divided into four categories; 0%/1–49%/50–79%/80–100%. Wilcoxon's signed-rank test was used for comparisons of work status over time within the group.
Multivariable forward stepwise logistic regression was used for analyses of predictors of work status after 12 years. The dependent variable was work status dichotomized into <50%/≥50% work. Independent variables were baseline values of age, work status, symptoms of stress, pain intensity, overall health status, leisure time physical activity, walking capacity, health related quality of life and depression.
Results: The 98 women showed a significant increase in work status ($p<0.001$) at the 12 years follow-up. Proportions of work status in category 1–4 at baseline were 56%/10%/22%/10% and at follow-up it was 36%/11%/23%/28%. The participants' age, overall health assessed with Fibromyalgia Impact Questionnaire (FIQ) and health related quality of life assessed with SF-36 Physical component summary (PCS) at baseline predicted work status 10–12 years later. Age (years): OR 0.90 (95% CI 0.84–0.97), p=0.004. FIQ total score (0–100): OR 0.94 (95% CI 0.91–0.97), $p<0.001$. SF-36 PCS (0–100): OR 1.1 (95% CI 1.0–1.2), p=0.019.
Conclusions: Women with FM or CWP appear to improve their work status on group-level over time. Lower age, better overall health and higher health related quality of life at baseline were found to predict higher probability of working 50–100% after 12 years.
Disclosure of Interest: None declared
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THU0755-HPR DIETARY PROTEIN INTAKE AND UPPER LEG MUSCLE STRENGTH IN PATIENTS WITH KNEE OSTEOARTHRITIS: DATA FROM THE OSTEOARTHRITIS INITIATIVE

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Background: In patients with knee osteoarthritis (OA) muscle weakness is common and is strongly related to more pain and activity limitations. Therefore, conservative treatment focuses on optimizing muscle strength in patients with knee OA. Determinants of muscle strength such as muscle quantity and quality, level of pain and physical activity are widely studied in knee OA. Only a limited number of studies have focused on the relation between nutrition and muscle strength in patients knee OA.
Protein is an essential building block for muscle tissue. Adequate dietary protein intake is needed to preserve muscle tissue. In a part of the general older population lower intakes than the recommended daily protein intake are observed [1,2]. Higher levels of dietary protein intake have been linked to greater muscle mass and strength in older adults[3,4]. Whether there is an independent association between lower dietary protein intake and lower muscle strength in knee OA patients in unknown.
Objectives: To determine whether lower dietary protein intake is associated with lower muscle strength in patients with knee OA.
Methods: In this cross-sectional study, baseline data of patients with symptomatic and radiographic knee OA from the progression subcohort of the Osteoarthritis Initiative (OAI) were used. Protein intake was measured by the Block Brief 2000 food frequency questionnaire and expressed as g per day/ kg bodyweight. Knee muscle strength was measured in the index knee by the Good Strength chair test, and expressed as the sum of both flexion and extension strength (N/kg bodyweight). Linear regression analysis was used to test the association, adjusting for relevant demographic, clinical and behavioral confounders.
Results: Data from 1128 patients (mean age 61.7±SD 9.1 y., 60.4% female) were used. A Kellgren and Lawrence grade of 2, 3 or 4 was scored in 25.7%, 44.7% and 30.0% of the patients, respectively.The mean daily protein intake was 0.68±SD 0.26 g/kg bodyweight, and the mean muscle strength was 5.33±SD 1.96 N/ kg bodyweight. In the unadjusted model, lower protein intake was associated with lower muscle strength (B = -0.804, 95% CI -0.336 to -1.272, p=0.001). After adjusting for age and gender, lower protein intake was still associated with lower muscle strength (B = -1.102, 95% CI -0.680 to -1.524, $p<0.001$) and was maintained after controlling for other relevant confounders.
Conclusions: Lower protein intake is independently associated with lower muscle strength in patients with knee OA. To confirm this relationship, future research is needed to test this association in longitudinal and interventional studies in patients with knee OA.
References:
[1] Fulgoni VL, 2008, Am J Clin Nutr 87:1554S–1557S.
[2] Kerstetter et al., 2003 J Nutr 133:855S–861S.
[3] Houston et al., 2008 Am J Clin Nutr. 2008 Jan; 87(1):150–5.
[4] Beasley et al., 2013 J Am Geriatr Soc. 2013;61(11):1863–71.
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HPR patients' perspectives, functioning and health (descriptive: qualitative or quantitative)

THU0756-HPR PREDICTORS OF FEAR OF MOVEMENT IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) is a systemic chronic autoimmune inflammatory disease characterized by synovial joint inflammation that results in functional limitations accompanied by social and psychological outcomes.
Objectives: The aim of this study was to investigate the association between fear of movement and age, upper and lower extremity functions and functional disability in patients with Rheumatoid Arthritis (RA).
Methods: A total of 88 patients with RA participated to the study. Disease activity was assessed using the Disease Activity Score in 28 joints (DAS28). Functional disability was assessed using the Health Assessment Questionnaire-Disability Index (HAQ-DI). The Disabilities of the Arm, Shoulder and Hand Score (QuickDASH) was used to assess the upper extremity function. The Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) was used to assess the lower extremity function. The Tampa Scale for Kinesiophobia (TSK) was used to assess pain-related fear of movement. The multiple stepwise linear regression model with R-square (R^2) was used to compare across the models and explain the total variance.
Results: Eight independent variables namely, age (r=0.215; p=0.044), QuickDASH (r=0.504; $p<0.001$), HAQ-DI (r=0.315; p=0.003), WOMAC Pain (r=0.512; $p<0.001$), WOMAC Stiffness (r=0.419; $p<0.001$), WOMAC Function (r=0.398; $p<0.001$), WOMAC Total (r=0.429; $p<0.001$), WOMAC range (r=0.419; $p<0.001$), demonstrated significant correlations with TSK. There were correlations between two independent variables (QuickDASH, p=0.013; WOMAC Pain, p=0.034) and TSK (R^2=0.293).
Conclusions: Health professionals should keep in mind that fear of movement were likely to cause poorer upper extremity functional disability and lower extremity pain levels in spite of varied drug therapies in patients with RA.
References:
[1] Wan, S. W., He, H.-G., Mak, A., Lahiri, M., Luo, N., Cheung, P. P., & Wang, W. (2016). Health-related quality of life and its predictors among patients with rheumatoid arthritis. Applied Nursing Research, 30, 176–183.
[2] Doury-Panchout, F., Metivier, J., & Fouquet, B. (2015). Kinesiophobia negatively influences recovery of joint function following total knee arthroplasty. European journal of physical and rehabilitation medicine, 51(2), 155–161.
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THU0757-HPR EUROPEAN QUALITATIVE RESEARCH PROJECT ON PATIENT-PREFERRED OUTCOMES IN EARLY RHEUMATOID ARTHRITIS (EQPERA): RATIONALE, DESIGN AND METHODS OF AN ONGOING MULTI-COUNTRY, MULTI-CENTER, MULTI-LANGUAGE, LONGITUDINAL QUALITATIVE STUDY

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Background: Ample studies exist on outcome assessment from the patient perspective in Rheumatoid Arthritis (RA), but little is known about health and