Objectives: The aim of this study was to describe patients' experiences of nurse-led care tight control.

Methods: Qualitative design was used in order to receive deeper understanding of the phenomenon. Interviews were conducted with 12 informants (with strategic sample) that participated in the intervention group of a randomized controlled trial exploring the effect of patient centered care, the Got-Net study. The interviews were analyzed using phenomenography approach.

Results: The informants' experiences of nurse-led care tight control emerged in three categories. The three categories describe the process, the relationship between the concepts. The first step describes the *Meeting of competence*, the next step that the informant experienced was *Relationship building* and the last step to have *Made a personal journey*.

Conclusions: Patients with RA who got the opportunity of nurse-led care and tight control became strengthen, got extended knowledge about their illness. Patients have been treated on their own level, knowledge and needs, by using a person-centered approach.

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SATURDAY, 17 JUNE 2017

HPR interventions (educational, physical, social and psychological)

SAT0725-HPR GOTHBURG NURSE LED TIGHT CONTROL STUDY - GOTNET. A STUDY COMPARING "CARE AS USUAL" WITH NURSE LED CLINIC, TIGHT CONTROL AND PERSON CENTRED CARE IN PATIENTS WITH RHEUMATOID ARTHRITIS (RA) AND WITH MODERATE/HIGH DISEASE ACTIVITY

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Background: The treatment guidelines of EULAR recommend treatment according to "tight control" (TC), clear treatment goals (Treat-to-Target, T2T) and patient involvement. Despite this, the care for patients with RA needs to be improved as demonstrated by the fact that as many as that 45% of patients with RA in Sweden (according to the Swedish Rheumatology Quality Register in 2015) do not reach the level of low disease activity. One way to overcome this could be nurse led clinics of RA patients, which for patients in remission have shown positive effects on patient's pain, knowledge and self-efficacy. We hypothesized that a nurse-led clinic based on the above principles of TC, T2T and Person-centered care would result in better outcome compared to care as usual.

Objectives: The aim of the study was to compare the effect of such nurse-led clinic with frequent visits and person-centered care with regular care of patients with established RA and a moderate to high disease activity.

Methods: This was a randomized, controlled, blinded assessor study that aimed to compare the effect of nurse-led clinic with regular care of patients with the established RA. Inclusion criteria were; duration of RA >2 yrs., DAS28>3.8, age <85 yrs. and not having experience with all available csDMARDs and bDMARDs. Patient with any severe current comorbidity were excluded. Intervention Group (IG): intervention included two elements; 1) disease activity control every 6th week, with clear treatment goals (DAS28 <2.6) and escalation of pharmacological therapy according to existing Swedish guidelines, 2) a written person-centered care health plan with shared goal setting and decision making between patient and nurse. Control Group (CG): Patients in the control group were followed by a physician once every 3 to 6 month. Evaluation was done at w 26 both per protocol (shown) and according to intention to treat (ITT) with LOCF. Primary outcome was change in DAS28 at week 26 and secondary outcome the proportions of good/moderate EULAR response. Pre study power calculations estimated group sizes to 60 patients in each group. Due to difficulties in the recruiting process the study was stopped preterm.

Results: The study included 70 patients of which (IG: 36 and CG: 34) with similar baseline characteristics as a result of the randomization. Sixty-two patients completed the study at w 26 (IG: 29 and CG: 33). Both groups improved significantly in DAS 28 (Table 1). The change in DAS 28 was not significantly different between groups, although the numerical improvement was larger in the IG compared to CG (Table 1). Furthermore, significantly more patients in the IG improved according to EULAR Good or Moderate response (Table 1). Results were similar when analyzing according to ITT with LOCF.

Table 1. Primary outcome (delta DAS 28) and secondary outcome (good/moderate EULAR response)

	IG	CG	Difference (95% CI)
ΔDAS 28 (95% CI)	1.5 (-2.0,-1.0)	1.1 (-1.6,-0.6)	- 0.43 (-1.13,0.27)
EULAR Good/Moderate (%)	22/29 (76%)	16/33 (48%)	27% (3-51%)

Conclusions: This controlled trial suggest that a nurse-led clinic for RA patients

with moderate/high disease activity may be effective. Although not shown, it likely to be cost-effective and possible to implement in clinical care.

Disclosure of Interest: None declared

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HPR patients' perspectives, functioning and health (descriptive: qualitative or quantitative)

SAT0726-HPR FUNCTIONAL IMPAIRMENT IN PATIENTS WITH RA IN AN EIGHT YEAR PERSPECTIVE

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Background: In people with Rheumatoid arthritis (RA) impaired physical functioning is an acute as well as long term effect of the disease. Observational performance tests reflecting range of motion in upper as well as in lower extremities should be easy to perform in the clinic as well as in research as a complement to self-reported measures of physical functioning. The Signal Of Functional Impairment (SOFI)¹ is a performance test which so far has been applied only in Sweden but commonly used in the clinic and in long term follow-up clinical studies.

Objectives: The aim was to study performance-based function assessed with SOFI over 8 years and, secondly, to study which items included in SOFI that were associated with change in functioning over time.

Methods: An inception cohort of 1 052 patients with early RA, from the BARFOT-study, recruited 1992–2006 was investigated, mean (SD) age was 54 years (14), 70% were women. The patients were followed by a structured protocol at baseline, 3 and 6 months and at 1, 2, 5, and 8 years. SOFI consists of 3 parts measuring hand, arm (upper), and leg (lower) function (1). Hand function is tested by 4 movements; cylinder grip (H1), pen grip (H2), pincer grip (H3) and opposition of the thumb (H4). Arm function is assessed by 3 movements; hand behind the head and the ability to touch the cervical spine processes with fingers (A1), elbow supination (A2) and elbow extension (A3). Leg function is tested by 4 movements; the ability to touch the opposite knee with the heel while sitting (L1), knee extension in supine position (L2), dorsiflexion of the foot standing on a balance board (L3), and the ability to stand on tip toes without shoes (L4). An assessor scores the patient's ability to perform the different tests on an ordinal scale (0=normal, 1= partly impaired and 2= unable to perform). The range of SOFI scores is 0–44 (best to worst).

Results: At baseline the mean (SD) SOFI was 7.2 (5.8), and at 1 year follow-up the improvement was 2.75 (5.65), $p<0.001$. From 1 year to 8 year follow-up the deterioration was 1.5 (4.6), $p<0.001$. When studying hand, upper and lower function separately, the pen grip and the ability to stand on tip toes improves most during the first year. From 1 to 8 year the pincer grip and the ability to stand on tip toes are the items that deteriorate most (Figure). Assessment of the pen grip, the pincer grip and the ability to stand on tip toes explain 58% to 70% of the SOFI score over time, with the highest rate at 5 (65%) and 8 years follow-up (70%).

Conclusions: Functioning as assessed by SOFI improved during the first year in patients with early RA and then deteriorated slowly. Over a longer period, pincer grip and the ability to stand on tip toes seemed to be the two most important items to measure when assessing functional impairment over time.

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SAT0727-HPR THE EFFECT OF INSPIRATORY MUSCLE TRAINING ON AEROBIC CAPACITY, PULMONARY FUNCTION AND FUNCTIONAL STATUS IN PATIENTS WITH ANKYLOSING SPONDYLITIS: A RANDOMIZED CONTROLLED STUDY

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Background: In ankylosing spondylitis (AS) the chronic inflammatory process mainly affects the axial skeleton with ensuing pain and limitation of thoracic and spinal mobility. Most of the AS patients have the complaint of reduced exercise capacity. Pulmonary function impairment, chest wall restriction, weak respiratory muscle performance, peripheral muscle weakness and deconditioning have been reported as the hypotheses for reduced exercise capacity.

Objectives: The aim of this study was to evaluate the effects of inspiratory muscle training on aerobic capacity, pulmonary function and functional status in patients with AS.

Methods: A total of 32 patients (18 female, 16 male; mean age: 37.3±10.4 years) were included in this study. The patients were randomized as two groups; Group I consisted of 16 patients, received inspiratory muscle training (IMT) in addition to conventional exercise (CE), Group II consisted of 16 patients, received only CE. All assessments were done before and after the training (8 weeks) for every patient. Standard pulmonary function tests were applied for pulmonary volumes. Maximum inspiratory pressure (P_{Imax}), maximum expiratory pressure (P_{Emax}) were also measured as respiratory muscle strength. Six-minute walk test (6MWT) was used for the assessment of aerobic capacity. For the evaluation of functional status, the Bath Ankylosing Spondylitis Functional Index (BASFI), Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Bath Ankylosing Spondylitis Metrology Index (BASMI) were used. CE training program consisted of 20 exercises: motion and flexibility exercises of the cervical, thoracic, and lumbar spine; stretching of the hamstring muscles, erector spine muscle, and shoulder muscles. IMT training load was based on 50% of the patient's sustained maximum inspiratory pressure. The patients started by performing ten loaded inspiration with a 60 second rest period between each inspiration for three sets in each session. Four sessions of IMT was applied in a day. The exercises were performed as home program for five days per week, 40 minutes per session. Wilcoxon test was used to compare groups.

Results: After eight weeks follow-up, patients in Group I had a significant increase in P_{Imax} (p=0.000), P_{Emax} (p=0.05), and 6MWT (p=0.041) compared with Group II (p=0.134, p=0.020, p=0.281, respectively). There were no significant differences of spirometric measurements. Comparison of the groups showed significantly superior results for group I in BASDAI (p=0.049).

Conclusions: Ankylosing spondylitis patients who performed eight weeks of inspiratory muscle training in addition to conventional exercise training, had an increased respiratory muscle strength, a better aerobic capacity, and disease activity than those who performed conventional exercise only. Inspiratory muscle training should be disseminated with these patients due to advantages.

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Acknowledgements: Inspiratory muscle training should be disseminated with these patients due to advantages.

Disclosure of Interest: None declared

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SAT0728-HPR A PATIENT SATISFACTION SURVEY: PATIENTS' PERCEPTIONS OF BIOLOGIC DOSE TAPERING

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Background: Evidence shows that remission can be maintained in selected patients whose biologic medication is dose tapered¹. In June 2015 we began tapering the doses of selected rheumatoid arthritis, ankylosing spondylitis and psoriatic arthritis patients in disease remission. The process was agreed with the local commissioners and a protocol² was devised to guide safe and evidence based biologic dose tapering. Benefits include reduced medication burden for patients, fewer day-case infusions and financial savings. However, there is a lack of knowledge of patients' perceptions of the process.

Objectives: Our department proposed to investigate patients' perceptions of their experience of dose tapering. We wanted to assess patients' understanding and acceptance of the process and ensure they felt included in decision making. Patient feedback enables reflection and improved practice.

Methods: An anonymous, tick-box, patient satisfaction survey was devised. It requested that patients stated the extent to which they agreed with a statement, also allowing free-text comments. The survey was posted to relevant patients after their identification from our biologics database. A stamped addressed envelope was provided for return of the completed survey.

Results: 56 surveys were posted, 46 (82%) were returned. 31 (67%) of patients were pleased to taper their medication, 35 (76%) felt fully included in decision making and 36 (78%) agreed that they had the opportunity to ask questions. Of the 13 patients whose disease flared post-taper, 8 (62%) agreed that they were promptly reviewed in clinic, 1 patient (8%) disagreed.

Some admitted to anxiety prior to dose tapering, however once established on their new dose, continuing disease remission was reassuring. Patients felt that they could contact the rheumatology helpline if required. Some also expressed that their quality of life had improved due to the decreased medication burden.

6 (37.5%) of the 16 rituximab patients who replied, disagreed that they were included in the decision to dose taper. Therefore, clinicians must ensure information provided is clear, that a full discussion occurs and the patient has an opportunity to ask questions. On review, it was evident that the wording of the survey may have caused confusion for rituximab patients. The term "dose reduction" may have suggested that the dose of medication in their infusion was reduced. In practice, the patient decreased from two infusions to one.

Conclusions: The majority of patients expressed that they were content with the biologic dose tapering process and felt sufficiently included in decision making. Importantly, a large proportion of patients were of the opinion that they were reviewed quickly when their disease flared.

Practice can be improved from the knowledge that some patients would appreciate more communication regarding the decision to dose taper. Also, when undertaking further patient surveys, questions must be clear and unambiguous.

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SAT0729-HPR PSYCHOLOGICAL PROFILE OF PATIENTS WITH FIBROMYALGIA SYNDROME

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Background: Fibromyalgia (FM) is a chronic non inflammatory condition characterized by pain and fatigue as well as physical and psychological symptoms. Management can be particularly challenging and a combination of pharmacological and non pharmacological treatments are recommended.

Objectives: The aim was to study the level of anxiety and depression in fibromyalgia patients and whether these were associated with symptom severity, functional status, social or demographic factors.

Methods: A cross sectional survey of 155 consecutive patients attending the nurse-led fibromyalgia clinic was carried out. Patients were diagnosed using the 2010 ACR diagnostic criteria. Demographic data, Widespread Pain Index (WPI), Symptom Severity Score (SSS), VAS pain and VAS fatigue were recorded. Patients filled in the self-administered questionnaires including the Revised fibromyalgia impact questionnaire (FIQR), Hospital Anxiety and Depression Scale (HADS). Patients were classified as suffering from high anxiety or depression if HADS was ≥ 11, moderate if 8–10 and low ≤ 7 for each scale respectively.

Cross tabs and chi squared were used to study associations between anxiety and depression and social and demographic factors. Logistic regression analysis was performed to identify whether WPI, SSS, FIQR, VAS pain and VAS fatigue were predictors of severe anxiety and depression.

Results: One hundred fifty five patients (92% female) participated in the survey. The average age was 50.3 years (SD 11.5) and mean duration of symptoms 13.4 years (SD 11.3). The mean HADS-A (anxiety) was 11.8 (SD 4.13), HADS-D (depression) 9.1 (SD 3.8) and FIQR 60.3 (SD 17.6).

High levels of depression were reported by 31.5%, moderate 32.1% and low 30.3%. High levels of anxiety were reported by 60%, moderate 21.2% and low 13.3%. Both high levels of anxiety and depression were found in 25.2% of patients.

SSS was the single best predictor for anxiety (p=0.001) while disease duration (p=0.01), SSS (p=0.02) and FIQR (0.04) predicted depression. VAS pain and VAS fatigue were not good predictors of severe anxiety and depression. When patients with high levels of anxiety and depression were compared with those with moderate and lower levels no association was found with age or social factors including occupation, marital status, level of education and family support.

Conclusions: Both severe anxiety and depression were highly prevalent in our FM cohort, particularly anxiety. All FM patients need to be screened for anxiety and depression particularly those with high SSS and FIQR scores and longer disease duration.

A psychiatrist and psychotherapist with a special interest in FM are essential members of the multidisciplinary team to ensure that anxiety and depression are addressed early prior to starting further interventions for FM.

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