was also safe for patients with knee OA and (severe) comorbidity[5]. At present we are implementing and evaluating the protocol in primary care.

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**THURSDAY, 15 JUNE 2017**

## Data visualisation: tables and graphs for publication and presentation I & II

### SP0091 DATA VISUALISATION: TABLES AND GRAPHS FOR PUBLICATION AND PRESENTATION

M. Boers. *Epidemiology & Biostatistics; Amsterdam Rheumatology and immunology Center, VU University Medical Center, Amsterdam, Netherlands*

This workshop (held both on Thursday and on Friday) is an introduction to the principles of good graph and table design as pioneered by Cleveland[1] and Tufte[2] and updated by Few[3] so that the participant can better answer the following questions:

*Which of the messages in my research results requires a graph or table?* Recognizing how graphs improve on simple statistics and convey much more information. Knowing when a table is better, or keeping the data in the body text.

*How can I best convey the message?* Striving for clear vision by choice of graph, scaling, discrimination of data series, minimizing non-data ink, avoiding chart junk. Striving for clear understanding through a balance between data and explanation. Using order, subheadings, formatting and rules to guide your reader through your table data.

*Is my graph/table truthful?* Creating a direct proportion between graph and data quantities, avoiding forms prone to misinterpretation, labels to prevent ambiguity; keeping data in context, avoiding more dimensions in the graph than in the data.

This year's course will extend introductory material available via YouTube clips on the ARD website (ard.com)!

Direct link: https://www.youtube.com/playlist?list=PLXU14EQbU_V9JpmolAKsaCC0VjJzbxzAN

Note that you can also sign up for a special lecture followed by a poster tour after the session, devoted to poster design!

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**Disclosure of Interest:** M. Boers Consultant for: Director of Epiconsult BV that offers training in data visualization
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## Difficult to reach patient groups

### SP0092 THE VICIOUS CIRCLE OF EDUCATIONAL LEVEL AND RISK OF POVERTY IN RHEUMATOID ARTHRITIS - RESULTS OF A CROSS-SECTIONAL MULTICENTER STUDY IN GERMANY

M. Zaenker[1,2]. *[1]Rheumatology Dept., Immanuel Klinikum Bernau & Heart Center Brandenburg, Bernau; [2]Brandenburg Medical School, Neuruppin, Germany*

This lecture will provide an overview on the dimensions of poverty in general and describe methods of assessing the risk of poverty in patients with rheumatoid arthritis (RA).

Based on results of a cross-sectional multicenter study of RA-patients from outpatient-clinics in Brandenburg and Saarland, Germany, this talk will give a rationale for how patients with RA are threatened by poverty due to treatment-related expenses, disability and early retirement compared to the general population.

It will be highlighted, that the equalized disposable income of RA patients is significantly lower than in general population and RA patients share a doubled risk of poverty, even in social-welfare well-secured countries such as Germany.

Further, the talk will demonstrate that both lower educational level and socio-economic state are associated with more severe disease course of RA and various underlying mechanisms will be discussed.

**Disclosure of Interest:** M. Zaenker Consultant for: Celgene, Hospira, MSD, Roche
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### SP0093 THE CHALLENGES AND SOLUTIONS FOR ENGAGING PATIENTS FROM ETHNIC BACKGROUNDS IN RHEUMATOLOGY CARE

K. Kumar. *University of Manchester, Manchester, United Kingdom*

Rheumatoid Arthritis (RA) is a condition with no cure and can cause disability[1]. RA affects nearly 1 in 100 adults. Early disease is characterised by pain and other features of inflammation, such as heat, swelling of joints, and loss of function. RA is associated with increased costs of co-morbid conditions (such as cardiovascular (CVD) associated with RA[2]. CVD associated with RA is the most common cause of death in RA patients. The risk of developing CVD is worse in some ethnic groups[3;3;4]. Furthermore, RA causes physical damage and social, economic, psychological and cultural problems that impact on all aspects of patient life.

There are effective treatments available for RA[5]; however, non-adherence to medicines (not taking medicines as prescribed) is a significant issue in RA[6]. Patients' perceptions play an important role in adherence to medicines. Our research in the UK, has showed differences between individuals from ethnic groups on how they view their medicines[7]. These views can potentially impact on medication adherence and patients' satisfaction with information they receive in clinic.

In the UK, we have recently shown that patients from different ethnic backgrounds with RA were disstaified with the information they receive about medicines[7]. Patients beliefs about medicines and illness pereceptions were found to be associated with satisfaction with information received by clinicans. Furthermore, the British Society of Rheumatology (BSR) led a national audit to investigate the delivery of care across UK rheumatology services. In this audit of early inflammatory arthritis service, we found patients from different ethnic backgrounds expressed greater impact of the disease on functional disability, fatigue, emotional well-being, physical well-being and coping and worse in older patients. This can impact on the way patients perceive their disease activity and information received on treatments. If we understand the needs of patients from ethnic backgrounds we can help improve the health outcomes. This session will provide the audience with insight into some solutions from the UK that might be helpful in order to improve satisfaction with information, disease enagement and treatment adherence.

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