by the physician as quantitative data. Quantitation only of inflammation, while damage and distress are recorded only as narrative descriptions, may limit the capacity to document optimally both clinical status and the rationale for clinical decisions, such as non-intensification of therapy according to "treat-to-target" in patients who may have moderate or high scores on an RA index¹. We have used 0–10 visual analogue scales (VAS) to score not only physician global assessment (DOCGL), but also levels of inflammation, damage, and distress.

Objectives: To analyse 0–10 VAS for DOCGL, as well as for levels of inflammation, damage, and distress in patients with rheumatoid arthritis (RA).

Methods: At one academic site, rheumatologists complete four 0–10 VAS for overall physician global assessment (DOCGL), as well as for inflammation or reversible findings (DOCINF), joint and other organ damage or irreversible findings (DOCDAM), and patient distress such as fibromyalgia, depression, etc. (DOCSTR). In a cross-sectional study, mean values of 4 physician VAS were computed in RA patients, and 3 subgroups were compared according to whether scores for inflammation were 2/10 units higher than for damage, similar for inflammation and damage (within 2/10 units), or 2/10 units higher for damage than for inflammation. Mean levels of the 4 VAS in the 3 groups were compared, using analysis of variance (ANOVA).

Results: In 50 unselected RA patients, mean 0–10 DOCGL VAS was 4.2, inflammation VAS 2.2, damage VAS 3.5, and distress VAS 2.2 (table 1). Only 9/50 patients had an inflammation VAS more than 2/10 units greater than damage VAS; in these patients, mean VAS for DOCGL=4.6, inflammation=4.9, damage=2.1, and distress=1.1. In 21 patients in whom inflammation=damage, mean VAS for DOCGL=3.9, inflammation=1.8, damage=2.1, and distress=3.2. In 20 patients with damage >inflammation, mean VAS for DOCGL=4.4, inflammation=1.4, damage=5.7, and distress=1.7.

Abstract AB0312 – Table 1

	DOC/INF> DOCDAM	DOC/INF= DOCDAM	DOC/ DAM> DOCINF	TOTAL
N	9	21	20	50
VAS DOCGL	4.6	3.9	4.4	4.2
Mean subscale VAS				
Scores:				
VAS DOCINF	4.9	1.8	1.4	2.2
VAS DOCDAM	2.1	2.1	5.7	3.5
VAS DOCSTR	1.1	3.2	1.7	2.2

Conclusions: Physician VAS scores indicated that a damage VAS was 50% higher than an inflammation VAS in all 50 RA patients (3.5 vs 2.2), and identical (2.1) in the 9 with an inflammation VAS 2 units higher than a damage VAS or 21 with an inflammation VAS within 2 units of a damage VAS. A mean distress VAS was identical to an inflammation VAS (2.2) in the 50 patients. Control of inflammation remains a primary concern for rheumatologists, but has improved considerably in recent years, as damage and distress may have become more prominent in routine patient care. Systematic quantitative VAS assessment of damage and distress, in addition to inflammation, appears of value to document patient status and support clinical decisions.

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AB0313

PHYSICIAN GLOBAL ASSESSMENT OF THE STATUS OF PATIENTS WITH RHEUMATOID ARTHRITIS (RA) AT THEIR FIRST VISIT TO AN ACADEMIC ROUTINE CARE SETTING ARE EXPLAINED AS MUCH BY DAMAGE AND DISTRESS AS BY INFLAMMATION, ACCORDING TO PHYSICIAN RATINGS: SHOULD THE STRUCTURE OF RHEUMATOLOGY CARE BE MODIFIED?

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Background: A physician global assessment (DOCGL) on a 0–10 visual analogue scale (VAS) reflects inflammatory activity in patients who meet criteria for RA clinical trials, in which DOCGL is more efficient than laboratory tests or joint counts to distinguish active from control treatments.¹ However, in routine clinical

care, patients are not selected for inflammatory activity, and may have joint damage and/or distress (fibromyalgia, depression, etc.) as important clinical problems. Some rheumatologists consider damage and distress in assigning a 0–10 DOCGL; others consider only inflammation. One approach to resolve this matter is for physicians to estimate the proportion of DOCGL attributed to inflammation, damage, or distress (total=100%).

Objectives: To analyse a physician 0–10 VAS overall global assessment for estimates of the proportions attributed to inflammation, damage, or distress (total=100%).

Methods: Rheumatologists at one academic setting complete a 0–10 VAS for DOCGL, and estimates of the proportion of DOCGL attributed to inflammation, damage, and/or distress (total=100%). These scales were analysed in 38 new patients with RA seen between April and November 2017, using cross-tabulations to compare patients whose DOCGL was 0–4 vs 4.1–10 vs the proportion of inflammation, damage, or distress (total=100%) as 0%–40% or 41%–100%.

Results: Physician global assessment was 4–10 in 23/38 patients (61%) at first visit, and 0–4 in 15/38 (39%) (table 1). In all 38 patients, inflammation was rated as explaining 41%–100% of DOCGL in 11/38 (29%), compared to damage in 18/38 (47%), and distress in 6/38 patients (16%). Among the 23/38 patients with DOCGL 4–10, inflammation was rated as explaining 41%–100% of DOCGL in 6/23 (29%), versus 10/23 (43%) for damage, and 5/23 (22%) distress. Therefore, inflammation appear to account for >40% of DOCGL only in a minority of new RA patients, which were explained more by either damage or distress (or both).

Abstract AB0313 – Table 1. Number of patients in whom a 0–10 physician global assessment VAS was attributed by the physician to inflammation, damage, or distress (total=100%) at the initial visit of 38 patients with RA

Physician global assessment	All	0–4.0	4.1–10	All	0–4.0	4.1–10	All	0–4.0	4.1–10
% attributed by rheumatologist to...	Inflammation			Damage			Distress		
0%–40%	27	10	17	20	7	13	32	18	14
41%–100%	11	5	6	18	8	10	6	5	1
Total	38	15	23	38	15	23	38	15	23

Conclusions: At one academic rheumatology site, a physician global assessment VAS at the initial visit of patients with RA was explained as much by damage and/or distress as by inflammatory activity. One important limitation of the study is that some patients had already received treatment at other rheumatology sites. Nonetheless, the data indicate that damage and distress appear as prominent as inflammation in contemporary management of RA, reflecting a well-known delay in diagnosis and patient management. The findings suggest a possible need to restructure rheumatology practice to see patients more urgently, including education of primary care physicians, in order to improve outcomes for patients with RA. The data also support the possible value of physician estimates of the proportion of DOCGL attributed to inflammation, damage, or distress.

Disclosure of Interest: T. Pincus Shareholder of: Dr. Pincus holds a copyright and trademark on MDHAQ and RAPID3 for which he receives royalties and license fees. All revenue is used to support further development of quantitative questionnaire measures for patients and doctors in clinical rheumatology care., I. Castrejón: None declared, J. Block: None declared

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AB0314

SETTING TREATMENT TARGET FOR JOINT SURGERY IN LOWER LIMBS IN PATIENTS WITH LONG-STANDING RHEUMATOID ARTHRITIS BASED ON MULTICENTER PROSPECTIVE COHORT STUDY; VALIDATION AND RELIABILITY OF OBJECTIVE INDEX OF ACTIVITY SPEED, TIMED UP AND GO TEST, FOR MEASURING PHYSICAL FUNCTION

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Background: Total management including reconstructive joint surgery and rehabilitation should be needed for further improvements of physical function for long-