Methods: A quasi-experimental study was conducted among SLE patients with SM according to the ATP III criteria at Systemic Autoimmune Diseases Research Unit of the Regional General Hospital No. 36 of the Mexican Institute of Social Security, Puebla. Clinical educational intervention in emotional and cognitive domains in the experimental group included classroom activities and outpatient consultation, evaluating healthy lifestyle knowledge that included physical activity, feeding habits and stress management with FANTASTIC instrument. Basal and final measurements were analysed with the Wilcoxon test with SPSS v21.

Results: Eighty nine patients were included. Age 46.1 ± 12.6 years,¹⁷⁻⁷⁰ weight 64.2 ± 14.5 kg,⁴²⁻¹³⁷ 20.2% overweight and 38% obesity, 50% education over 12 years, 49.4% housewife, 39% employed, 67% lived with a partner, SLE disease evolution 12.1 ± 6.9 years and prednisone dose 10.2 ± 10.8 mg/day (0–50). In the retest, disease and comorbidities knowledge was modified. The domains of lifestyle such as physical activity, family-friends and nutrition showed statistical significant changes after the intervention $p < 0.05$.

Conclusions: The educational intervention modified the conceptual perception of SLE and MS as well as some domains of lifestyle.

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AB1389

HOW DO WE LEARN TO COMMUNICATE TO OUR PATIENTS? AN INVENTORY STUDY AMONGST RHEUMATOLOGISTS IN TRAINING IN THE NETHERLANDS HOW THEY TRAIN COMMUNICATION SKILLS

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Background: Effective doctor-patient communication, more specific 'Shared Decision Making (SDM)', is essential in high-quality health care. Physicians value the principles of SDM, but the practice is disappointing. Difficult subjects are avoided, options are not equally explained or patients' values remain unclear. As a rheumatologist, communication is an essential and powerful competency. Guidelines endorse SDM for the management of various rheumatic diseases. What we do not know is how we acquire the right communication skills for the task. As rheumatologists we learn a lot about pathophysiology, diagnostic approach and treatment options, but not how to explain these aspects in comprehensible language to our patients.

Objectives: Objective of this study is to investigate how rheumatologists in training acquire communication skills, more specific skills in SDM. How do they rate their communication competency and what can be done to improve.

Methods: An online survey was developed with questions dedicated to evaluate the posed questions. The survey was distributed amongst aspirant members of the Dutch Society for Rheumatology by email with a link to the survey. The survey consists of questions asking for self-reflection and rating on various communication skills regarding different aspects of communication.

Results: These are preliminary results based at the first 23 responses, which is 33% of the total number of rheumatologists in training. From the received responses eleven fellows were in their fourth year, four in their fifth year and seven were in their final year of education. Fellows believe communication is the most important CanMEDS competency after 'Medical Expert'. Self-assessment of communication competency shows an average score of 3.7 on a five-point scale (5=most experienced). When a new diagnosis is explained, fellows rate their skills at levels to be expected for their years of education, except for the diagnose SLE, Systemic Sclerosis and M. Sjögren. Items that are always discussed are the diagnosis and the treatment, but other aspects such as implications for pregnancy, work, social life and sexual intercourse are only discussed on request. Regarding the explanation of treatment options the right words to explain different biological DMARDs seem to run short. When presenting details about treatment fellows always communicate possible treatment effect and side effects, but do not always mention frequency of side-effects. Furthermore, alternatives and preferences of the patient are not always discussed but only on request by 68% of the respondents. Fellows indicate that they think communication and SDM are very important and are interested to acquire further skills. They prefer videos with examples of how to explain certain diagnoses, treatment options and how to deal with various patient types. A specific request was made for a training in Somatic Unexplained Complaints.

HOW DO WE LEARN TO COMMUNICATE TO OUR PATIENTS?

AN INVENTORY STUDY AMONGST RHEUMATOLOGISTS IN TRAINING IN THE NETHERLANDS HOW THEY TRAIN COMMUNICATION SKILLS

Abstract AB1389 – Figure 1

Conclusions: Rheumatologists in training highly value good doctor-patient communication. In daily practice the explanation of certain diseases and treatment options seems difficult. Diagnoses and drugs with possible (side) effects are always explained, but social implications and patients' preferences are only discussed on request. Therefore, additional training of SDM seems important.

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AB1390

OSTEOPOROSIS ASSOCIATED MORBIDITY ANALYSIS CAN REVEAL TARGETS FOR BETTER DISEASE DIAGNOSIS AND MANAGEMENT

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Background: Osteoporosis accounts for more disability and life years lost than rheumatoid arthritis. It brings an elevated risk of mortality, morbidity and re-hospitalisation due to fractures and a significant financial and social burden.

A rationale use of diagnostic and therapeutic resources is useful and should be encouraged at all intervention levels. For admitted patients, clinical risk factors for fractures and conditions that are causes for secondary osteoporosis should trigger either the diagnosis approach or the referral to a (Rheumatology/Endocrinology) specialist and treatment should be started during hospitalisation.

Objectives: We aimed to identify targets for educational or protocol interventions in order to improve inpatient osteoporosis diagnosis and subsequent management.

Methods: A retrospective three years (2014–2016) cross-sectional prevalence analysis of comorbidities in all hospitalised patients with osteoporosis in our general hospital was conducted. We used the medical records database of our hospital.

Results: Osteoporosis as a principal diagnosis was found in 46 cases, mostly from the Endocrinology Department (65%). Osteoporosis as a secondary diagnosis was found in 2464 cases, and only 11% were diagnose-associated with fractures. 23% of all comorbidities are of endocrine or diabetic etiology. A small percent of osteoporosis cases have simultaneous skeletal disease, mostly vertebral fractures, osteomalacia or degenerative disease. Only 8,77% of secondary osteoporosis was diagnosed in the Orthopaedic Department. No osteoporosis was mentioned in association with COPD or oncologic disease. Only 65% of patients leaving the hospital had specific recommendation for anti-osteoporotic medication.

Conclusions: Osteoporosis should be mentioned in all cases in the patients medical records that are further sent to the general practitioner. Osteoporosis may be better diagnosed in diabetic, oncologic, COPD, Parkinson disease patients and in a large percent of fracture patients if internal referral protocols will be implemented. Appropriate therapy should be recommended from the hospital specialists.