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HPR Patients’ perspectives, functioning and health (descriptive: qualitative or quantitative)

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HPR Measuring health (development and measurement properties of PROs, tests, devices)

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Background: Clinical cardial signs and symptoms of axSpA include inflamma-
tory pain, stiffness and impaired mobility in the axial region and to a lesser extent the peripheral joints. Although these features are thought to reflect local disease processes, bottom-up or top-down amplification of nervous system signalling may alter this relationship and may induce widespread pain.1 There is a remarkable lack of detailed knowledge on pain areas in axSpA and its clinical relevance is unknown. Also, gender differences in pain area may exist in axSpA and may confound disease activity outcomes.

Objectives: Firstly, pain locations in axial axSpA were detailed and gender differ-
ences were assessed. Secondly, the relationship of regional pain definitions as well as widespread pain with clinical outcomes was evaluated. Finally, the role of pain area in the assessment of disease activity was explored, taking gender into account.

Methods: Body charts informed on axial, peripheral articular and non-articular pain in 170 (108 men, 62 women) patients with axSpA. Multivariable odds ratios compared genders. General linear models explored clinical differences in disease activity (BASDAI, Bath Ankylosing Spondylitis Disease Activity Index), activity lim-
itations (BASFI, Bath Ankylosing Spondylitis Functional Index), fear of movement (TSK-11, Tampa Scale for Kinesiophobia 11-item version), anxiety (HADS-D, Hospital Anxiety and Depression Scale subscale anxiety) and depression (HADS-D, HADS subscale depression) between four subgroups classified by widespread non-articular pain (WNAP+) and physician-reported global disease activity (PGDA+). Principal component analysis explored gender differences in the structure of disease activity outcomes.

Results: Axial thoracic pain was least prevalent (lumbar: 74.4%, cervical: 47.6%, cervicothoracic: 47.6%, thoracic: 32.4%), but about three times more likely in women (OR: 2.92, p = 0.009). Axial cervicothoracic junction pain spread more diffusely in women (OR: 2.48, p = 0.018). Women exhibited a two to three-fold increased likelihood of widespread axial pain (OR: 3.33, p = 0.007) and peripheral artic-
ular (OR: 2.34, p = 0.023) pain. A subgroup of WNAP+PGDA- combined with low PGDA (27% of all patients) was associated with worse BASFI, BASDAI, HADS-A and HADS-D in men and worse TSK-11 and HADS-A in women (p < 0.05). Disease activity outcomes showed a two-factor structure in women, but not in men.

Conclusions: In patients with axSpA, the location and spread of pain was different between genders and is related to worse clinical status. Based on pain area and physician-reported global disease activity, meaningful clinical subgroups were identified with a remarkably distinct health status. Outcome instruments such as BASDAI should acknowledge gender differences to ensure structural validity.

REFERENCE:
[1] Latremoliere A, Woolf CJ. Central sensitization: a generator of pain hyper-

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HPR Epidemiology and public health (including prevention)

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Objectives: The aims of this study were to identify homogeneous subgroups with distinct trajectories of pain and physical function in patients with symptomatic knee and/or hip osteoarthritis. The KOALA cohort.

Methods: The KOALA cohort is a French population-based multi-center cohort of 878 patients with symptomatic knee and/or hip OA, aged between 40 and 75 years old. Pain and function were measured annually with the WOMAC questionnaire. Baseline comorbidities were assessed by the Functional Comorbidity Index (FC1), perceived vitality was measured with SF-36 and psychosocial distress with the General Health Questionnaire (GHQ). Using the follow-up data over 5 years, latent class growth analyses (LCGA) were used to identify homogeneous sub-
groups with distinct trajectories of pain and function. The selection of the optimal model was based on maximisation of the Bayesian information criterion, the pro-
portion of patients in each trajectory group (>5%) and the statistical significance of the equation modelled (intercept only, linear, quadratic or cubic). Multinomial logistic regressions were performed to identify the predictive baseline characteris-
tics associated with each trajectory and were adjusted for socio demographic and clinical factors.

Results: Among the 878 patients, 609 (69.4%) were women, 222 (25.3%) had hip OA, 607 (69.1%) knee OA and 49 (5.6%) both hip and knee OA.
LCA revealed 4 distinct linear and stable trajectories of pain: “no pain” (n=131, 16.2%), “mild pain” (n=269, 33.3%), “moderate pain” (n=247, 30.5%), and “severe pain” (n=162, 20.0%). Compared with the “no pain” group, subjects belonging to the “severe pain” group were more likely to be female (Odds ratio [OR]=5.13, 95% confidence interval [CI]=2.46–10.70), with a high body mass index (BMI) (OR=1.13, 95%CI=1.07–1.20), a high number of comorbidities (OR=1.42, 95%CI=1.13–1.78), a low vitality score (thus a high level of fatigue; OR=0.94, 95%CI=0.91–0.96), a high disease duration (OR=1.06, 95%CI=1.02–1.10), and a low GHQ score (thus a high psychosocial distress; OR=0.94, 95%CI=0.91–0.96). For physical function, 4 distinct stable trajectories were identified: “no functional limitations” (n=239, 29.6%), “low functional limitations” (n=266, 32.9%), “moderate functional limitations” (n=208, 25.7%), “severe functional limitations” (n=95, 11.8%). In multivariate analyses, female sex (OR=5.11, 95%CI=2.04–12.81), increasing age (OR=1.13, 95% CI: 1.08–1.18), a high BMI (OR=1.15, 95% CI: 1.08–1.21), a high number of comorbidities (OR=1.28, 95%CI=1.12–1.61), a low vitality score (thus a high level of fatigue; OR=0.91, 95%CI=0.88–0.93), and a low GHQ score (thus a high psychological distress; OR=0.96, 95%CI=0.93–0.99) were associated with the trajectory of “severe functional limitations”.

Conclusions: Based on the 5 year follow-up data, we identified 4 distinct trajectories of pain and 4 trajectories of physical function. None of the trajectories demonstrated worsening or improvement over time, confirming that OA is a chronic persistent disease that does not inevitably worsen.

Disclosure of Interest: None declared


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HPR Professional education, training and competencies.

THU014-HPR INTERPROFESSIONAL COLLABORATION IN RHEUMATOLOGY REHABILITATION – THE CLASH BETWEEN IDEOLOGY AND PRACTICE
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Background: Interdisciplinary collaboration in rheumatology rehabilitation is pivotal in order to meet the complex and multifaceted needs of the patients.1 However, in practice, an interprofessional approach is hard to achieve.2 Objectives: To explore how health professionals working with inpatient rehabilitation at a Danish hospital for rheumatic diseases, experience the interdisciplinary collaboration in practice compared to their ideals. Further, to explore what fosters or prevents interprofessional collaboration.

Methods: In total six focus groups and two individual interviews were conducted with 32 health professionals (HPs) working with rehabilitation. The HPs included occupational therapists, physiotherapists, rheumatologists, nursing staff, a social worker and a dietician. The composition of the focus groups were monodisciplinary, except from one group where nurses and doctors from the outpatient unit were interviewed together. The individual interviews were conducted with a social worker and a dietician, as they were sole employers within these disciplines. The interviews were transcribed ad verbatim and a thematic condensation and indexing was used in the analysis of the data.

Results: The analysis revealed a clash between ideals about interdisciplinary teamwork and the dominant monodisciplinary work practice. Physical, organisational and cultural factors were perceived as important barriers. Lack of common physical facilities hindered both informal and formal interdisciplinary cooperation. The organisational set up with only one interdisciplinary team meeting before the patients were admitted to hospital and with a lack of rheumatologists’ involvement during admission did not support interdisciplinary teamwork. The existing monodisciplinary work culture acted as a barrier towards both formal and informal collaboration. All these factors led to a lack of knowledge about the contributions from other HPs.

Common physical work and meeting facilities and informal networking fostered interprofessional collaboration.

Conclusions: To support the development of interprofessional teamwork in rehabilitation practice, it is important to consider both common physical work facilities and to change the organisational and cultural factors acting as barriers towards collaboration. Further knowledge about the contributions from other HPs is a prerequisite to interprofessional collaboration.

REFERENCES:

Disclosure of Interest: None declared