Results: Between the groups there was no difference in demographic data.We showed significant improvement in all parameters except lateral flexion, tragus wall distance measurements for spinal mobility and beck depression index scores at second week ($p<0.05$) in physical therapy group. This improvement in all parameters was discontiniued for intermalleolar distance, cheek manubrium distance, cervical rotation,finger floor distance and BASFI at 6th week measurements. We also showed significant improvements mental capasity and social function subgroups of SF-36 at 6th week when compared with begining ($p<0.05$). We detected significant improvement in second week and sixth week for VAS rest and general health subgroup of SF-36 at physical therapy group when comparing two groups.

Conclusions: Physical therapy may have benefical effects on pain, spinal mobility and quality of life in patients with AS.

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Disclosure of Interest: A. Ünal Enginar Shareholder of: none, Grant/research support from: none, Consultant for: none, Employee of: none, Paid instructor for: none, Speakers bureau: none, H. Uğurlu Shareholder of: none, Grant/research support from: none, Consultant for: none, Employee of: none, Paid instructor for: none, Speakers bureau: none
DOI: 10.1136/annrheumdis-2018-eular.3143

THU0723-HPR NICE GUIDANCE ON SPONDYLOARTHRITIS: RECOMMENDATIONS SUPPORTING RECOGNITION AND REFERRAL BY PHYSIOTHERAPISTS & PODIATRISTS

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Background: Physiotherapists and podiatrists are key to earlier diagnosis of spondyloarthritis (SpA) and have an essential role in assessing for signs, symptoms and risk factors in people with joint, tendon or back pain. Spondyloarthritis can be a challenge to recognise and often mistaken as chronic back pain or unrelated tendon and joint problems. Symptoms can move around, flare and settle, and links between back pain, peripheral problems and extra-articular conditions can be missed.

Objectives: This presentation raises awareness of recent NICE guidelines on Spondyloarthritis[1] and provides an overview of recommendations on recognition and referral relevant for physiotherapists and podiatrists.

Methods: The guideline was developed using standard NICE guideline methodology. Quality ratings of evidence applied GRADE methods based on quality of available evidence for assessed outcomes. When standard methodology could not be applied, customised quality assessments provided narrative summaries or customised GRADE tables. Recommendations were developed by a multispecialty development group which included people with SpA and review by stakeholder organisations informing the final version.

Results: NICE guidance offers recommendations for suspecting axial and peripheral presentations and when to refer to rheumatology for assessment. These are based on the evidence for signs, symptoms and risk factors that increase the likelihood that a person may have SpA. The guidance highlights that SpA can occur with negative HLA B27, normal inflammatory markers and not to exclude SpA based on any one sign, symptom or test result.

Referral is recommended for suspected axial spondyloarthritis with back pain lasting >3 mths with onset before 45 years of age plus four or more additional features: Onset before 35 years; Woken second half of night by symptoms; Buttock pain; Improves with movement; Improves within 48 hours of taking NSAIDs; First-degree relative with SpA or psoriasis; Current/past enthesitis; Current/past psoriasis; Current/past uveitis plus psoriasis or if HLAB27 positive).[1 2] Morning stiffness lacked specificity as a referral criterion for axial SpA however prolonged morning stiffness remains important in suspecting inflammatory disease.

Referral is recommended for suspected peripheral SpA if a person presents with dactylitis; or with persistent or multiple-site enthesitis (inflammation at tendon/ligament attachment to bone) without apparent mechanical cause plus if any of the following: back pain without apparent mechanical cause; current/past psoriasis, inflammatory bowel disease or uveitis; first degree relative with SpA or psoriasis; or symptom onset following gastrointestinal or genitourinary infection.

Conclusions: Recognising possible signs, symptoms and risk factors of spondyloarthritis is an essential aspect of clinical practice for clinicans assessing musculoskeletal probblems. Recent NICE guidance offers advice on suspecting SpA and when to refer to rheumatology for assessment to support earlier diagnosis, treatment and reduce the significant impacts of these conditions.

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Acknowledgements: Dr Carol McCrum was on the guideline development committee and has a NICE Fellowship to raise awareness and support implementation of these guidelines
Disclosure of Interest: None declared
DOI: 10.1136/annrheumdis-2018-eular.1412

THU0724-HPR INVESTIGATION OF IMMEDIATE EFFECT OF CERVICAL STABILISATION EXERCISES ON PROPRIOCEPTION IN PATIENTS WITH NECK PAIN

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Background: Reduced ability to maintain and upright posture, may reflect impaired muscle endurance and proprioceptive accuracy required to control the postural position in patients with neck pain. A recent study investigated the effect of cervical stabilisation exercises on proprioception of neck pain patients. But in mentioned study the joint position change was evaluated for only cervical flexion movement.

Objectives: The aim of our study is determine the acute effect of cervical stabilisation exercises on joint position sense in all ranges of neck movement in patients with idiopathic chronic neck pain.

Methods: 20 patients (27–45 ages, 80%female and 4 men 20% male) with neck pain for more than 3 months were participated in this study. Exercise training was performed only one session. Patients with any neurological deficits, any recent injuries to neck and were excluded from the study Training included craniocervical flexion, deep cervical extensor muscle activation, isometric flexion-extension exercises in upright position and shoulder flexion with neutral cervical position in upright position. Each exercise were performed five times. The measured variables included joint repositioning errors in the sagittal and horizontal directions. Visual Analogue Scale (VAS), Neck Disability Index (NDI) were implemented for determining the personal characteristics of patients. Cervical joint repositioning error was evaluated by laser pointer in flexion, extension, rotation and lateral flexion of cervical movement directions at sitting position before and after exercise session. Wilcoxon test was used to compare to differences between repeated assessments

Results: VAS values for pain intensity were (mean ±SD) 5.56±3.17, NDI values were 14.06±6.83 and HADS scores were 18.27±2.23. In comparison to baseline values, joint position error was significantly lower in flexion, extension, rotation and lateral flexion directions at horizontal and sagittal planes ($p<0.001$) except right lateral flexion at sagittal plane ($p>0.05$) (table 1).

Abstract THU0724HPR – Table 1. Comparison of joint position errors

Variable (degree)	Before exercise Median±SD	After exercise Median±SD	p value
JPE in flexion horizontal	1.71±0.66	0.57±0.80	**<0.001**
JPE in flexion sagittal	1.14±0.43	0.68±0.40	**<0.001**
JPE in extension horizontal	0.85±0.48	0.57±0.42	**<0.001**
JPE in extension sagittal	0.85±0.55	0.28±0.22	**<0.001**
JPE in right rotation horizontal	1.05±0.53	0.57±0.31	**<0.001**
JPE in right rotation sagittal	0.76±0.73	0.28±0.30	**<0.001**
JPE in left rotation horizontal	1.14±0.39	0.28±0.42	**<0.001**
JPE in left rotation sagittal	0.95±0.49	0.29±0.28	**<0.001**
JPE in right side bend horizontal	1.05±0.56	0.57±0.28	**<0.001**
JPE in right side bend sagittal	0.19±0.36	0.19±0.22	0.209
JPE in left side bend horizontal	1.19±0.54	0.47±0.37	**<0.001**
JPE in left side bend sagittal	0.19±0.39	0.38±0.23	**<0.001**

JPE=Joint position error, p values are based on Wilcoxon Signed Ranks Test