Conclusions: Despite the increased attention and awareness of the benefits of being physically active, the percentage of RA patients who meet the recommended level of physical activity did not increase between 2014 and 2017. This could be caused by the fact that the effect of the developed exercise programmes typically wear off after the exercise interventions have stopped. Another reason could be that patients with RA need to be more assisted to overcome barriers to implement physical activities in their daily life. A more personalised approach, based on coaching and shared-decision making to set personal physical activity goals, could increase compliance and reduce barriers to being physically active. Half of the inactive RA patients of the outpatient clinic are motivated to become more physically active. Therefore a new study will examine whether a personalised physical activity programme is effective to increase and sustain the level of physical activity in inactive RA patients.

Disclosure of Interest: None declared

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THU0730-HPR A SYSTEMATIC REVIEW OF ONLINE INTERVENTIONS FOR ADDRESSING PSYCHOLOGICAL DISTRESS IN RHEUMATOID ARTHRITIS AND OTHER LONG-TERM CONDITIONS

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Background: Psychological distress in rheumatoid arthritis (RA) is associated with severity of disease activity and poor treatment outcomes. Online interventions have the potential to reach large numbers of patients.

Objectives: The aims of this study were to identify online interventions for psychological distress and determine their effectiveness in RA and other long-term conditions.

Methods: The following databases were searched: MEDLINE, EMBASE, CINAHL and PsychINFO Jan 2007-Jul 2017). Inclusion criteria were randomised controlled trials (RCTs) of effectiveness of interventions to address psychological distress in adults. Titles and abstracts were screened independently by 2 reviewers. Methodological quality was assessed by 3 reviewers using Cochrane's Risk of Bias tool. Data were extracted independently by 4 reviewers. Meta-analysis was not possible due to clinical heterogeneity of the included studies.

Abstract THU0730HPR – Table 1. Presents the studies and evidence of their effectiveness.

Study	Condition	Effectiveness
Boeschoten 2017	Multiple sclerosis	Not effective BDI: Effect size d=0.01; p=0.953
Bond 2010	Diabetes	Effective CESD: Effect size d=0.7; p<0.05 PAID: Effect size d=0.6; p<0.05
Cohn 2014	Type 2 diabetes	Mixed CESD: Effect size d=-0.44; p=0.05 Diabetes Distress Scale: Effect size not shown
Ferwerda 2017	Rheumatoid arthritis	Effective BDI: Effect size d=0.54; p=0.001 IRGL-Negative mood: Effect size d=0.38; p=0.01 IRGL-Anxiety: Effect size d=0.48; p=0.001
Fischer 2015	Multiple sclerosis	Effective BDI: Effect size d=0.53; p=0.01
Hunt 2009	Irritable bowel syndrome	Effective Anxiety Sensitivity Index -GI: Effect size d=0.63; p<0.01 Anxiety Sensitivity Index -non GI: Effect size d=0.70; p<0.01
Lorig 2008	Rheumatoid arthritis, osteoarthritis and fibromyalgia	Effective Health Distress Scale RA: d=0.5 Health Distress Scale OA: d=0.4 Health Distress Scale FM: d=0.03
Newby 2017	Type 1 and type 2 diabetes	Effective Patient Health Questionnaire: Effect size g=0.78; p<0.001 PAID: Effect size g=0.80; p=0.01
Nobis 2015	Type 1 and type 2 diabetes	Effective CESD: Effect size d=0.89; p<0.001
Rondags 2016	Type 1 and type 2 diabetes	Not effective Hypoglycaemia Fear Survey: RR=0.80; 95% CI 0.64 to 1.01; (p=0.059).
Van Bastelaer 2011	Type 1 and type 2 diabetes	Effective CESD: Effect size d=0.70; p<0.001.

Effectiveness of interventions is reported with effect sizes based on between-group differences in the primary outcomes at the end of each study.

Results: The review included 11 RCTs in the following conditions: arthritis,² multiple sclerosis,² diabetes⁶ and irritable bowel syndrome.¹ The quality of most RCTs was poor due to attrition, selective reporting and limited follow-up. Eight disease-specific and 3 generic interventions were identified. Cognitive behavioural therapy was the most common intervention type. All interventions were online but support delivery and outcome measures varied significantly. Nine of the 11 interventions were shown to be effective, including 2 for RA. Most interventions were not available outside of the trial.

Conclusions: The findings are inconclusive due to the overall bias of the included studies and insufficient evidence in RA. More good quality RCTs are required to determine effectiveness of online interventions in RA.

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THU0731-HPR THE ABDOMINAL HYPOPRESSIVE TECHNIQUE CAN BE USED TO TREAT LOW BACK PAIN?

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Background: In 1980, Dr. Marcel Cautriez created the abdominal hypopressive technique (AHT) with the goal of reprogramming the core muscles. The term hypopressive refers to the decrease of the pressure related to the thoracic, abdominal and pelvic cavities. However most traditional exercises are hyperpressive – they increase the internal pressure. In addition, conventional core exercises train conscious control, but the core is designed to cope at a subconscious level. Publications testing AHT are surprisingly low and are mostly published in not indexed journals. Despite the lack of scientific evidence to support its benefits, AHT is gaining popularity among European physiotherapists as a recommended treatment for a wide spectrum of disorders.

Objectives: To test the effect of a structured AHT program on low back pain intensity and disability in women and the retention of effect after two-month.

Methods: A cross-over intervention trial with random assignment and blind assessments was carried-out. The experimental sequence included a first period of intervention or control (rest), and a second period in which the initial groups were switched to the complementary. The exercises included in the AHT program were standardised by two Doctors in Physiotherapy trained in this technique. Measures were taken by a trained physiotherapist blinded to the group allocation at baseline, after finishing the first period, and after completing the entire sequence. Efficacy was defined as changes between groups in low back pain intensity and disability, measured with a visual analogue scale (VAS) and the Oswestry Disability Index (ODI) respectively.

Results: Overall, 42 participants were randomly assigned to a sequence (n=21 for each group). From the initial sample, 88% have been diagnosed by a physician with low back pain at least once in their lives and 100% of them self-reported low back pain at baseline. Baseline low back pain intensity measures did not differ between groups. The VAS for the group that started as control was 4.0 (2.5 to 5.4) vs 4.3 (2.8 to 5.7) for the group that started with the AHT program (p=0.774). However, the difference (Δ) after two months was statistically significant between groups (group that started as control, 0.3 (-0.1 to 0.6) vs the group that started with AHT, -2.7 (-3.9 to -1.6); p<0.001). Improvements decayed by 0.87 after a two-month follow up (p=0.094).

Regarding low back pain disability, similar results were found. ODI baseline measures between groups were not significantly different with 10.3 (5.7 to 14.9) for the group that started as control and 7.7 (4.1 to 11.3) for the group that started with the AHT program (p=0.368). The Δ after two months showed that both groups improved (started as control, -0.2 (-2.7 to 2.4)) but the improvement in the AHT group was greater (-3.5 (-7.1 to 0.3)); p=0.120. Improvements were maintained after a two-month follow.

Is important to highlight that a sequence effect was noted, with residual effect of AHT; therefore, only results from the first sequence were analysed.

Conclusions: A structured AHT program produce benefits on low back pain intensity (short-term) and disability (long-term). However, further research is needed to test its effectiveness in comparison with conventional core exercises.

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