ASSESSING THE BURDEN OF TREATED AND UNTREATED CHRONIC LOW BACK PAIN IN EUROPE

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Background: Chronic low back pain (CLBP) is estimated to affect about 20% of adults1 and is the greatest contributor to disability globally.2 Current pharmacological treatment options may provide limited pain relief or may not be appropriate for long-term use in all patients because of adverse events.3 Despite the large burden of CLBP, few studies have evaluated the humanistic and economic impact of this condition in Europe, or whether this burden varies for those being treated with prescription (Rx) treatments compared with those who are not Rx treated.

Objectives: To assess the burden of CLBP in Europe and to determine whether burden differs by pain severity and treatment status.

Methods: A retrospective, cross-sectional study was conducted using data from the 2016 and 2017 National Health and Wellness Survey (NHWS) from five European Union countries (SEU); France, Germany, Italy, Spain, and United Kingdom. NHWS respondents with a self-reported CLBP diagnosis, current pain lasting ≥3 months, and who completed the pain module were identified. Neuropathic and phantom limb pains were excluded. CLBP respondents were categorized into 4 groups by severity of pain and treatment: moderate/severe Rx treated [M/S-Treated]; moderate/severe Rx untreated [M/S-Untreated]; mild Rx treated; and mild Rx untreated (reference). Outcomes of interest included health-related quality of life (HRQoL) (SF-12v2: mental and physical component summary [MCS, PCS]), health status (EQ-5D), productivity loss (Work Productivity and Activity Impairment [WPAI] questionnaire), and health care professional (HCP) visits in past 6 months. Multivariable analyses adjusted for baseline differences between groups (e.g., demographic and health characteristics).

Results: A total of 2,086 CLBP patients were identified from the NHWS. CLBP patients reported an average age of 56.4 (SD=13.2) years and most were female (61.2%). Two-thirds of CLBP patients had M/S pain (n=1,403). Stratification by severity of pain and treatment groups resulted in the following groups: M/S-Treated=29.8%, M/S-Untreated=37.4%, Mild-Treated=19.5%, and Mild-Untreated=13.2%. Increased pain severity among both treated and untreated patients showed significantly worse HRQoL, health status, work activity impairment, and greater HCP visits compared with the reference group (Mild-Untreated) (table 1).

Table 1: Adjusted mean levels per outcome according to disease severity and prescription treatment status

<table>
<thead>
<tr>
<th>Outcome</th>
<th>M/S-Treated</th>
<th>M/S-Untreated</th>
<th>Mild-Treated</th>
<th>Mild-Untreated</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>SF12-PCS</td>
<td>59.9±7.9</td>
<td>56.8±8.7</td>
<td>59.5±7.9</td>
<td>59.7±7.9</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>EQ-5D</td>
<td>0.79±0.24</td>
<td>0.67±0.20</td>
<td>0.81±0.21</td>
<td>0.80±0.22</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Conclusions: Results suggest the majority of European patients with CLBP in this study had moderate to severe pain irrespective of treatment. Whether treated or untreated, those with moderate to severe pain demonstrated a substantial burden related to HRQoL, health status, overall work and activity impairment, and HCP visits compared with those with mild pain.

REFERENCES:


SELF-ASSESSMENT OF QUALITY OF LIFE OF PATIENTS WITH RHEUMATIC DISEASES AND OTHER CHRONIC DISEASES IN THE IEXPAC PROJECT

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Background: Improving quality of life is a goal in the treatment of patients with rheumatic diseases.

Objectives: In this work, we describe the self-assessment of quality of life made by patients with rheumatic diseases and with other chronic diseases through an anonymous survey in the context of a wider project on quality of care.

Methods: In the context of a quality of care project, focused in the perceptions of chronic patients with health care in Spain (assessed with the IEXPAC scale (“Instrument to Evaluate the EXperience of Patients with Chronic diseases”, http://www.iermac.es/expac/), a survey was handed patients with 4 different profiles of chronic diseases needing care in at least two different levels (i.e. hospital clinic and primary care): A) Patients with rheumatic diseases (rheumatoid arthritis or spondyloarthritis) from hospital clinics, B) Inflammatory bowel disease (IBD) patients from hospital clinics, C) Patients with human immunodeficiency virus (HIV) infection from HIV units and D) Patients with diabetes mellitus (DM) plus
The study group consisted of 61 patients, who underwent primary TKA because of arthrosis were stratified by obesity status using pre-operative BMI. Non-obese (n=23, mean age; 67.6±8.8 years) subjects were those with BMI <30 kg/m² and obese (n=38, mean age; 63.8±18.21 years) subjects were those with BMI ≥30 kg/m². Patients were evaluated regarding knee proprioception (in knee joint angle 15°, 30° and 60°), knee function score (Hospital for Special Surgery (HSS) score), pain (Numeric Rating Pain Scale (NPRS)), knee range of motion, length of hospital stay, the day of knee flexion angle achieved 70 degrees, quality of life (Short-Form 12 Health Survey (SF-12)). Functional activities were evaluated using the Iowa Level of Assistance Scale and walking speed was evaluated using the Iowa Ambulation Velocity Scale. Patients were evaluated preoperatively and at discharge. All patients underwent the same rehabilitation program.

Results: When the patients' proprioceptive acuity in knee joint angle 30° were compared between groups, while there were statistically differences preoperatively (p<0.001), there were no differences after surgery (p>0.05). The preproceptive acuity measured before and after surgery were compared in knee joint angle 15°, 60°, there were no differences (p>0.05) between groups. It was determined that; the non-obese group had better results in terms of length of hospital stay, the day of knee flexion angle achieved 70 degrees and both pre- and post-operative knee flexion degree (p>0.05, for all). There were no statistical differences in the pain degree, HSS score, IOWA help level and IOWA walking speed, SF-12 score between groups before and after TKA (p>0.05).

Conclusions: There were no differences in knee proprioception between groups after surgery (p>0.05). The deficits in joint position sense in patients with TKA may be due to factors other than the BMI level (being overweight). On the other hand, obesity had negative effects on inpatient rehabilitation outcomes following TKA due to osteoarthritis. These results suggest that the rehabilitation after TKA is focused on reducing hospital stay, the day of knee flexion angle achieved 70 degrees and improving knee flexion degree could be important to enhance the potential benefits of the patients' outcomes, and could be important to reduce the payment in rehabilitation hospitals.

Disclosure of Interest: None declared


THE EFFECT OF OVERWEIGHT ON KNEE PROPRIOCEPTION IN PATIENTS WITH KNEE PROSTHESIS DUE TO KNEE OSTEOARTHRITIS

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Background: Total knee arthroplasty (TKA) has been established as a valuable procedure for the management of patients with disabling knee osteoarthritis, and the rates of elective TKA are increasing steadily each year. Being overweight is a risk factor for osteoarthritis of weight-bearing joints, such as the knee joint. In literature some studies about obesity and lower limb biomechanics found that obesity will change a person's gait model to adapt weight loading. Also it is stated that obese people have to reorganized their neuromuscular function to reduce the total load on the knee joint. Therefore, the ability to reorganize neuromuscular function may be a more insightful risk factor for knee osteoarthritis. There is not any study research on the effect of overweight on knee proprioception in patients with TKA due to osteoarthritis.

Objectives: The aim of this study was to determine the effect of the overweight on knee joint proprioception in patients with TKA due to osteoarthritis.

Methods: The study group consisted of 61 patients, who underwent primary TKA because of arthrosis were stratified by obesity status using pre-operative