(table 1): perseverance, avoiding threatening thoughts, social support connection, pursuing valued activities, positive reframing, maintaining a sense of control, acceptance, humor, equanimity, and flexibility. Nine patients were categorized as high-resilience and 9 patients as low-resilience cases. High-resilience patients tended to have more years' experience of living with RA compared with low-resilience patients. Although low-resilience patients sometimes struggled to cope, they made efforts to improve their capacity to face their personal challenges.

Table 1 Strategies described by RA patients for building/maintaining resilience

Strategy	Definition
Perseverance	Habitually enduring difficult situations
Avoiding threatening thoughts	Avoiding emotionally threatening thoughts and information
Social support connection	Receiving or giving emotional or instrumental social support
Pursuing valued activities	Deep engagement in valued activities
Positive reframing	Finding positive meaning in difficult experiences
Maintaining a sense of control	Adopting actions or thoughts to promote a sense of control over one's condition
Acceptance	Acknowledging the realities of living with RA
Humor	Joking about stressful situations due to RA
Equanimity	Staying calm in stressful situations
Flexibility	Adjusting to changes in physical limitations

Conclusions: Participants used a combination of behavioral and emotion management strategies to build and maintain resilience when facing challenges of living with RA. Awareness of these strategies may benefit patients, healthcare providers and researchers developing behavioral interventions and social support programs in the context of RA and other chronic diseases.

REFERENCE:

1. Sinclair VG, Wallston KA. Assessment 2004;11:94–101.

Disclosure of Interest: Y. Shaw Grant/research support from: Bristol-Myers Squibb, M. Bradley: None declared, A. Dominique Employee of: Bristol-Myers Squibb, K. Michaud Grant/research support from: Bristol-Myers Squibb, Pfizer and Rheumatology Research Foundation, Employee of: University of Nebraska Medical Center and National Data Bank for Rheumatic Diseases, D. McDonald Grant/research support from: Bristol-Myers Squibb, T. Simon Shareholder of: Bristol-Myers Squibb, Employee of: Bristol-Myers Squibb
DOI: 10.1136/annrheumdis-2018-eular.3730

FRI0741-HPR DISCUSSIONS OF LIFESTYLE HABITS AS AN INTEGRAL PART OF CARE MANAGEMENT IN PATIENTS WITH ESTABLISHED RHEUMATOID ARTHRITIS.

K. Malm^{1,2}, S. Bergman^{1,3}, A. Bremander^{1,4}, I. Larsson^{1,5}, M.L. Andersson^{1,4} on behalf of The BARFOT study group. ¹R&D-CENTRE, SPENSHULT, ²Rheumatology, Capio Movement, Halmstad, ³Primary Health Care Unit, Department of Public Health and Community Medicine, Institute of Medicine, The Sahlgrenska Academy, University of Gothenburg, Gothenburg, ⁴Department of Clinical Sciences, Section of Rheumatology, Lund, ⁵Halmstad University, School of Health and Welfare, Halmstad, Sweden

Background: Rheumatoid arthritis (RA) is associated with an increased risk of developing comorbidities which are known to be associated with lifestyle-related habits; such as having a sedentary lifestyle, having an unhealthy diet, smoking, and over-consumption of alcohol. In 2010, the European League Against Rheumatism (EULAR) published general guidelines on risk management in patients with RA, with an update 2017 (1,2) in which health professionals are encouraged to prioritize discussions with patients regarding their lifestyle and it is of interest to study the extent to which these discussions actually occur.

Objectives: To study if lifestyle habits; physical activity, diet, smoking and alcohol had been discussed with patients having RA during health care visits.

Methods: A cross-sectional postal survey in 2017 included 1542 eligible patients from the BARFOT (Better Anti-Rheumatic Pharmacotherapy) study. All patients received a questionnaire including lifestyle habits (physical activity, diet, smoking, and alcohol), and whether these habits had been discussed during health care visits. There was also a question regarding if they would have wanted such a discussion.

Results: 1,061 patients (68%) responded to the survey (mean age 67 years (SD 13); 73% women). Physical activity was discussed with 49% of the patients (figure 1A). Those who reported that they were active on a health-enhancing level were more likely to have discussed physical activity with health professionals. Diet had been discussed with 23% of the patients (figure 1B). Patients who reported a non-traditional mixed diet were more likely to have discussed diet. Smoking was discussed with 25% of the patients (figure 1C). Current smokers had more often

discussed smoking habits with healthcare professionals compared with never smokers (32% vs. 17%; p=0.000). Alcohol had been discussed with 17% of the patients (figure 1D). Of the patients with hazardous drinking habits, 77% had not had a discussion regarding alcohol.

Figure 1 Rate of patients reporting that they had had a discussion regarding life-style-related habits and whether they had wanted to have a discussion. Panel A relates to physical activity, panel B relates to diet, panel C relates to smoking, and panel D relates to alcohol consumption.

Conclusions: Physical activity had been discussed at least once with every second patient with established RA. Diet, smoking, and drinking habits had been discussed with about a quarter of them. There is a need for improvement, since lifestyle habits are especially important in a long-standing disease such as RA. Discussions concerning lifestyle habits should be an integral part of care management and an interactive process.

REFERENCES:

1. Peters MJ, Symmons DP, McCarey D, et al. EULAR evidence-based recommendations for cardiovascular risk management in patients with rheumatoid arthritis and other forms of inflammatory arthritis. Ann Rheum Dis. 2010 Feb;69(2):325–31.
2. Agca R, Hoeslinga SC, Rollefstad S, et al. EULAR recommendations for cardiovascular disease risk management in patients with rheumatoid arthritis and other forms of inflammatory joint disorders: 2015/2016 update. Ann Rheum Dis. 2017 Jan;76(1):17–28.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.3559

FRIDAY, 15 JUNE 2018

HPR Service developments, innovation and economics in healthcare

FRI0742-HPR EULAR RECOMMENDATIONS FOR THE ROLE OF THE NURSE IN THE MANAGEMENT OF CHRONIC INFLAMMATORY ARTHRITIS: 2018 UPDATE

B. Bech¹, J. Primdahl², M. Scholte-Voshaar³, H.A. Zangi⁴, A. van Tubergen⁵, Y. van Eijk-Hustings⁵. ¹Center for Rheumatology and Spine Diseases, Centre for Head and Orthopaedics, Rigshospitalet – Glostrup, Copenhagen, ²King Christian X's Hospital for Rheumatic Diseases, Graasten; Hospital of Southern Jutland, Aabenraa and University of Southern Denmark, Odense, Denmark, ³Department of Psychology, Health and Technology, University of Twente, Netherlands, ⁴Department of Rheumatology, National Resource Centre for Rehabilitation in Rheumatology, Diakonhjemmet Hospital, Oslo, Norway, ⁵Department of Internal Medicine, Division of Rheumatology, Maastricht University Medical Centre, Netherlands

Background: During the past years an increasing number of papers regarding rheumatology nursing have been published, which may contribute to a higher level of evidence and increased insight into the nurses' roles.

Objectives: To update the EULAR recommendations for the role of the nurse in the management of chronic inflammatory arthritis (IA) (1).

Methods: The EULAR standardised operating procedures were followed to integrate available higher level of evidence and new insights of nursing care in the

treatment of patients with IA. The EULAR Task Force comprised 15 nurses, 2 patient research partners, 1 physiotherapist, 1 psychologist, 1 occupational therapist, 1 medical student and 2 rheumatologists of whom one was also methodologist. A total of 17 European countries were represented. The systematic literature review included available literature from 2010 until December 2017 and was performed in the databases Medline, EMBASE, Cochrane Central, CINAHL, PsycINFO and in the 2016/2017 ACR and EULAR conferences abstracts. The original search strategy was used with no limitations applied with regard to publication type, research type or language. Titles, abstracts and full texts were screened for eligibility independently by the fellow and the convenor. Results were shared with the task force to check for comprehensiveness. Subsequently, the steering committee prepared proposals for update and rewording of the ten recommendations. The proposals were discussed with the Task Force in a one day consensus meeting and final agreement was obtained by voting.

Results: A total of 51 studies was included. Some studies added to existing evidence with a higher level of evidence to nurses' contribution regarding patients' satisfaction with care, cost-effectiveness, and self-efficacy, and also for the benefit of nurses' extended roles to patient outcomes as well as structured training aiming at improving nurses' skills. Additional evidence was found for needs-based patient education and telemonitoring. Two recommendations remained unchanged, six were reworded, two were merged and one recommendation was deleted and reformulated as an overarching principle together with the formulation of two additional overarching principles (figure 1). The level of agreement from each Task Force member will be retrieved by email.

Overarching principles			
Rheumatology nurses are part of a healthcare team			
Rheumatology nurses provide evidence based care			
Rheumatology nursing is based on shared decision making with the patient			
Recommendations	Level of evidence*	Strength of recommendation*	
1 Patients should have access to a nurse for needs-based education to improve knowledge of CIA and its management throughout the course of their disease	1B	A	
2 Patients should have access to nurse consultations in order to enhance satisfaction with care	1A	A	
3 Patients should have the opportunity of timely access to a nurse for needs-based support; this includes telehealth	1B	B	
4 Nurses should participate in comprehensive disease management to control disease activity, reduce symptoms, and improve patient preferred outcomes; this leads to cost-effective care	1A	A	
5 Nurses should address psychosocial issues to reduce patients' symptoms of anxiety and depression	1B	A	
6 Nurses should support self-management skills to increase patients' self-efficacy	1A	A	
7 Nurses should have access to and undertake continuous education in the specialty of rheumatology to improve and maintain knowledge and skills	2C	B	
8 Nurses should be encouraged to undertake extended roles after specialized training and according to national regulations	1A	A	

According to the Oxford Centre for Evidence-based Medicine, CEBM Levels of Evidence 1

Figure 1 EULAR recommendations for the role of the nurse in the management of CIA: 2018 Update

Conclusions: A total of three overarching principles and eight evidence- and expert opinion-based recommendations have been formulated, that provide an up-to-date guidance of nursing care in rheumatology.

REFERENCE:

1. van Eijk-Hustings Y, van Tubergen A, Bostrom C, et al. EULAR recommendations for the role of the nurse in the management of chronic inflammatory arthritis. *Ann Rheum Dis* 2012;71(1):13–9.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.4482

FRI0743-HPR NURSE-LED OUTPATIENT MANAGEMENT FOR IMPROVED TREATMENT OF GIANT CELL ARTERITIS (GCA) AND POLYMYALGIA RHEUMATIC (PMR) IN A RHEUMATOLOGY OUTPATIENT CLINIC

M.T. Poder¹, B.A. Esbensen¹, M.B.T. Pedersen¹, N.G. Andersen¹, J. J. Lykkegaard¹, A.M. Johansen¹, T. Lundbak¹, B. Bech¹. ¹Center for Rheumatology and Spine Diseases, Centre for Head and Orthopaedics, Rigshospitalet, Glostrup, Denmark

Background: GCA and PMR are challenges with regard to diagnosis and effective treatment because of varied and vague symptom presentations and overlapping pathologies that often require specialist for diagnostic investigations and specific treatment. Long-term glucocorticoids (GC) dependency is common, and

GC side effects occur in approximately 50% of patients emphasizing the need for continued monitoring and symptom control (1).

Objectives: To present the development and the implementation of a nurse-led, rheumatologist-supported model of care in the outpatient management of adults diagnosed with GCA or PMR.

Methods: Initially, available evidence about symptom regulated GC tapering in the treatment of GCA and PMR was identified. Subsequent, a fixed phase-out schedule for high dose GC therapy following either of three pathways (GCA with/without eye symptoms and PMR) was agreed on in a multidisciplinary working group. Furthermore, the group developed a nurse-managed protocol for nurse-led outpatient consultations to ensure systematic treatment and proper response to relapse. Prior to the implementation rheumatology nurses were taught and trained by rheumatologists in pertinent regulation of medication and identification of adverse signs and symptoms essential for providing appropriate support and patient education. Overall patient satisfaction was assessed on-site by an anonymous iPad questionnaire.

Results: An individual, initial GC dose are set by the rheumatologist based on clinician diagnosis, supported by currently available diagnostic and classification criteria. Subsequently, a nurse-led protocol reassures patient education and support during approximately one year of steroid therapy. The protocol includes close and continues observation and assessment by planned rheumatology nursing consultations followed by reassuring telephone calls. A rheumatologist can be consulted if doubt arises. Further, the rheumatology nurse is responsible for allocating final tapering (approximately 24 weeks) in the individualized PMR-management-plan for general practitioner. Patient overall self-reported satisfaction first nine month was high indicated by patients' experience of confidence, being heard and having questions resolved. Within the first 18 months, n=190 patients (GCA, n=82/PMR, n=108) with a mean aged of 73.2 (SD 8.4) years have been enrolled into nurse-led managed protocols for GC tapering.

Conclusions: A nurse-managed protocol for systematic and individualized GC tapering and patient support was developed as well as implemented successfully for individualized treatment of GCA and PMR. The extensive supportive patient education and involvement in symptom management secured by the rheumatology nurse provided high satisfaction. Also, the protocol executes rapid and direct access to advice for patients as recommended by EULAR for the management of PMR (2).

REFERENCES:

1. Buttgerit F, Dejaco C, Matteson EL, et al. Polymyalgia Rheumatica and Giant Cell Arteritis. A Systematic Review. *JAMA* 2016;315(22):2442–2458.
2. Dejaco C, Singh YP, Perel P, Hutchings A, Camellino D, Mackie S, et al. Recommendations for the management of polymyalgia rheumatica: a European League Against Rheumatism/American College of Rheumatology collaborative initiative. *Ann Rheum Dis*. 2015;74:1799–1807.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.6557

FRIDAY, 15 JUNE 2018

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

FRI0744-HPR THE ASSOCIATION OF LOCAL DISEASE ACTIVITY AND FOREFOOT DEFORMITIES WITH PLANTAR PRESSURE IN PATIENTS WITH RHEUMATOID ARTHRITIS AND FOREFOOT SYMPTOMS: A CROSS-SECTIONAL STUDY IN THE AMSTERDAM FOOT COHORT

A. Konings-Pijnappels¹, M. Tenten-Diepenmaat¹, R. Dahmen¹, J. Dekker², J. Twisk³, L. Roorda⁴, M. van der Leeden^{1,2}. ¹Amsterdam Rehabilitation Research Center, Reade, ²Department of Rehabilitation Medicine, VU University Medical Center, ³Department of Clinical Epidemiology and Biostatistics, VU University Medical Center and Institute of Health Science, Amsterdam, Netherlands

Background: In patients with rheumatoid arthritis (RA), both high and low forefoot plantar pressures have been reported in the literature (1–3). Understanding of contributing factors to forefoot pressure alterations can help to better formulate and specify goals for treatment with foot orthoses or therapeutic footwear.

Objectives: Investigate the association of local disease activity and forefoot deformity with plantar pressure in RA patients with forefoot symptoms.

Methods: A cross sectional study was conducted in the Amsterdam Foot (AMS-foot) cohort, using data of 172 consecutive patients with RA and forefoot symptoms. Peak pressure (PP) and pressure time integral (PTI) in the forefoot were measured with a pressure platform. Forefoot deformity was measured with the Platto score. Forefoot disease activity was defined as swelling and/or pain measured by palpation of the metatarsophalangeal (MTP) joints. The forefoot was