Results: 7180 subjects were included in the study (Romo, n=3589; Pbo, n=3591). At month 12, the mean change from baseline in LS BMD T-score was 0.88 for Romo and 0.03 for Pbo. At month 24 (after both treatment groups received DMAb in the second year) mean increases in LS BMD T-score were 1.11 for Romo/DMAb and 0.38 for Pbo/DMAb. At month 12, the mean changes in TH BMD T-score were 0.32 for Romo and 0.01 for Pbo. At month 24, mean changes in TH BMD T-score were 0.45 for Romo/DMAb and 0.17 for Pbo/DMAb. In the Romo group, 99% of subjects showed an increase in LS BMD at month 12, with 89% achieving $\geq 6\%$ gains (figure 1). Administration of Romo during the first year led to reductions versus Pbo in the relative risk of fractures during the second year, despite both groups receiving DMAb in the second year (reductions of 81% for vertebral fractures [$p<0.001$]; 32% for clinical fractures [$p=0.052$]; 39% for major osteoporotic fractures [$p=0.034$]).

Conclusions: Romo versus Pbo resulted in substantially higher BMD T-score increases after one year. After transition to DMAb, BMD gains in both treatment groups were similar in the second year. One year of Romo treatment, followed by transition to DMAb, resulted in unprecedented gains in BMD and substantially reduced fracture rates during the second year even though subjects in both groups received DMAb. These data support the clinical benefit of rebuilding the skeletal foundation with Romo treatment before transition to DMAb.

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OP0345

DENOSUMAB COMPARED WITH RISEDRONATE IN GLUCOCORTICOID-TREATED SUBJECTS: RESULTS FROM THE FINAL 24-MONTH ANALYSIS OF A RANDOMISED, DOUBLE-BLIND, DOUBLE-DUMMY STUDY

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Background: Denosumab 60 mg subcutaneously Q6M increased spine and hip BMD significantly more than risedronate 5 mg orally QD at 12 months in glucocorticoid-treated subjects (as previously reported¹).

Objectives: This analysis compared the BMD effects of denosumab vs risedronate and further characterised denosumab safety in this population at 24 months.

Methods: This phase 3, randomised, double-blind, double-dummy study enrolled adults ≥ 18 years receiving ≥ 7.5 mg daily prednisone (or equivalent) for <3 months (glucocorticoid-initiating subpopulation) or ≥ 3 months (glucocorticoid-continuing subpopulation). All subjects <50 years had history of osteoporotic fracture. Glucocorticoid-continuing subjects ≥ 50 years had lumbar spine (LS), total hip (TH), or femoral neck BMD T-scores ≤ -2.0 , or ≤ -1.0 and history of fracture. Subjects were randomised 1:1 to denosumab 60 mg subcutaneously Q6M or risedronate 5 mg orally QD for 24 months. This analysis assessed denosumab superiority over risedronate for percentage change from baseline in LS and TH BMD at 24 months.

Results: Of 795 randomised subjects, 590 (74.2%) completed the 24 month study (glucocorticoid-initiating: 109/145 denosumab, 117/145 risedronate; glucocorticoid-continuing: 186/253 denosumab, 178/252 risedronate). Denosumab

was superior to risedronate for increases from baseline in LS and TH BMD at all timepoints assessed through 24 months in each subpopulation (figure 1). Adverse events, serious adverse events (including infection), and fractures were similar between groups.

Abstract OP0345 – Figure 1 Bone mineral density percentage change (95% CI) from baseline through month 24

Conclusions: In conclusion, denosumab was superior to risedronate for increases in spine and hip BMD through 24 months. The overall safety profile was similar between groups. Denosumab may offer a valuable osteoporosis treatment option for patients receiving glucocorticoids.

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FRIDAY, 15 JUNE 2018

What's new: latest advances in treatment in JIA and osteoarthritis

OP0346-PARE

A PARTNERSHIP IN IMPLEMENTATION: ADAPTING AN OSTEOARTHRITIS GUIDEBOOK ACROSS EUROPEAN CULTURES – WITH PATIENTS, FOR PATIENTS

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Background: A guidebook for patients with osteoarthritis (OA) was co-developed with UK patients during an OA research study.¹⁻³ The JIGSAW-E project is now disseminating and implementing the OA management guidelines and Guidebook in clinical practice in UK, Netherlands, Norway, Denmark and Portugal.⁴

Objectives: To study the translation and cultural adaptations of the OA Guidebook appropriate for local context and use by patient champions and health professionals together.

Methods: A project launch meeting led to the creation of an international panel of Patient Champions and the adaptation of the OA Guidebook as a priority project. 15 Patient Champions with OA were collaborative partners of the project's local Communities of Practices (CoP) (UK:2, Norway:2, Netherlands:5, Denmark:5, Portugal:1) (figure 1). CoPs also engaged with OA patient organisations. Cultural adaptation of the OA Guidebook by CoPs: 1) review of UK OA Guidebook and existing written patient information; 2) translation; 3) cultural adaptation: review of content, images and layout; 4) consistency check with national guidelines; 5) production; 6) review and approval; 7) shared learning across countries via Skype. Each CoP adopted a process appropriate to their specific context

Results:

Abstract OP0346-PARE – Table 1 Development of culturally adapted versions of the OA Guidebook in each country.

Country	Developments to date
Netherlands	The Dutch team produced a full version of the OA Guidebook, revised the translated text and recommended new images to better reflect Dutch patients. Now available in hard copy and on a OA patient website: www.poly-artrose.nl/
Norway	The Norwegian CoP supplemented an existing OA handbook ('ActiveA') with a 'Feeling Positive' chapter from the UK version. The Patient Champions commented on the new chapter which will be made available on the JIGSAW-E website.
Denmark	The Danish team produced a concise version of the OA Guidebook, containing vital written information for patients at first consultation. The Patient Champion helped to adapt translations for the short version.
Portugal	The Portuguese team are working with the local health administration and patient organisations to culturally adapt a full Portuguese translation of OA Guidebook

Abstract OP0346-PARE – Figure 1 The JIGSAW-E international panel of patient champions

Conclusions: It is feasible and effective to involve patient champions in the cultural adaptation and dissemination of consistent and accurate patient information to support the implementation of OA guidelines in clinical practice.

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OP0347

SHARE DECISION MAKING AID FOR JUVENILE IDIOPATHIC ARTHRITIS: MOVING FROM INFORMATIVE PATIENT EDUCATION TO INTERACTIVE CRITICAL THINKING

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Background: Shared decision making (SDM) is an emerging trend in paediatrics. Currently available SDM interventions are mere information on the disease or medication and often fail to engage the children in the medical decision process. It has been suggested that future decision aids should consider developing separate more appropriate tools in order to better engage the children.

Objectives: To develop, and evaluate an illustrated and interactive evidence-based SDM aid for children living with inflammatory arthritis, able to inform them about the pros and cons of their disease as well as the available treatment options, and help them to make an informed shared decision.

Methods: A multidisciplinary team defined criteria for the SDM as to design, medical content and functionality, for children. Development was according to the international standard (IPDAS). Eight categories emerged as highly important for shared decision making: 1. What is arthritis; 2. Why do we treat arthritis; 3. What are my targets?; 4. What are the available treatment options?; 5. Progressometer/ my chances of improvement; 6. How soon will the medications kick in and how to take them; 7. Potential side effects; 8. For how long shall I take the medication. Each category is supported by simple illustrations showing the state of the joint in the different scenarios whether the child take treatment or not, whereas at the end of each category the child is asked to make a decision in view of the information given. 94 children with juvenile idiopathic arthritis, evaluated the tool, in a randomised controlled study, in comparison to control group composed of 95 patients treated according to standard protocols.

Results: The shared decision making aid was developed to offer information about the disease, the risks and benefits of treatment. 97.5% of the children included reported comprehensibility of >90/100. the progressometer helped the children identify the importance of taking treatment for their disease. The patients' adherence to anti-rheumatic therapy was significantly ($p<0.01$) higher in the SDM group, whereas stopping DMARDs for intolerance was significantly ($p<0.01$) higher in the control group at 12 months of treatment. There was significant improvement in the functional ability as well as quality of life measures in the SDM group ($p<0.01$), whilst absence from school was significantly higher in the control group ($p<0.01$)

Conclusions: This Illustrated-interactive SDM aid for children living with idiopathic inflammatory arthritis was found to be a simple, user-friendly tool which can be implemented in standard clinical practice. The illustration and interactive style made it more attractive to the children. The developed SDM offered the children evidence-based information about the pros and cons of treatment options, improved their understanding of the disease, communication with their treating clinician as well as their ability to make an informed decision.

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High-end imaging: Looking for the invisible

OP0348

MASS SPECTROMETRY IMAGING ANALYSIS OF SYNOVIAL DIFFERENTIATE PATIENTS WITH PSORIATIC AND RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) and Psoriatic arthritis (PsA) are systemic inflammatory diseases characterised by a chronic form of arthritis, often leading to