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Rehabilitation; opening Pandora's Box

OP0079-HPR

NON-PHARMACOLOGICAL CARE IN SYSTEMIC SCLEROSIS: OPENING THE BLACK BOX

Juliane Stöcker^{1,2,3}, Julia Spierings⁴, Madelon Vonk¹, Frank van den Hoogen^{1,2}, M. W.G. Nijhuis-van der Sanden¹, J.B. Staal^{1,3}, Ton Satink³, C.H.M. van den Ende^{1,2}, ARCH. ¹Radboud University Medical Centre, Nijmegen, Netherlands; ²Sint Maartenskliniek, Nijmegen, Netherlands; ³HAN University of Applied Sciences, Nijmegen, Netherlands; ⁴University Medical Centre Utrecht, Utrecht, Netherlands

Background: Although health professional (HP) treatments are considered to be a corner stone in the management of systemic sclerosis (SSc), little is known about the referral process to and the content of non-pharmacological care in SSc. **Objectives:** To describe non-pharmacological care in SSc from the perspective of Dutch HPs, including referral reasons, diagnostic focus, interventions used and alignment in the communication between HPs and rheumatologists.

Methods: Dutch HPs were invited through their SSc patients to complete an anonymous online survey provided by the Dutch ARCH (Arthritis Research and Collaboration Hub) working group. The survey comprised multiple response and open questions covering six topics: sociodemographic questions, referral reasons, diagnostic focus, treatment targets, interventions and the assessment of quality of communication between HPs and rheumatologists based on the Consumer Quality Index (CQI) (rheumatoid arthritis, version 2.0). Referral reasons and treatment targets were examined by means of open questions, and then linked to the ICF (International Classification of Functioning, Disability and Health) following the refined ICF Linking Rules (Cieza, 2016).

Results: A total of 79 HPs, 65.8% women (N=52), with a mean age of 41.2 (SD=13.6) from 8 different professions completed the survey. Physiotherapists were the largest group represented (73%, N=58). All in all 133 different referral reasons were reported that yielded 58 different ICF codes, of which 70.7% (N = 41) could be linked to the ICF domain "body structures and functions". The reported interventions focus on body functions and structures, training of daily activities, education and advices and psychosocial interventions (Table 1). The quality of communication between HPs and rheumatologists as perceived by the HPs is shown in Table 2.

Table 1. Interventions applied by the 79 health professionals, top 4 per topic

Interventions	N (%)
Treatments focus on bodily functions and/or structures	
Physical activity promotion	38 (48.3)
Training of body functions (e.g. muscular strength, range of motion)	34 (43.0)
Aerobic capacity training	25 (31.7)
Balance/coordination training	14 (17.7)
Training of activities	
Walking/biking	45 (57.0)
Movement activities/ sports	45 (57.0)
Leisure	19 (24.3)
Household	16 (20.3)
Education/advise/instruction	
Graded activity	44 (55.7)
Physical activity	42 (53.2)
Lifestyle (e.g. smoking, cold, silver gloves)	14 (17.7)
Energy conservation	12 (15.2)
Psychosocial interventions	
Self-management/ self-monitoring	52 (67.3)
Relaxation strategies/ stress management/ biofeedback therapy	23 (29.1)
Motivational Interviewing	13 (16.5)
Problem-solving training	10 (12.7)

Table 2. Quality of communication between HPs and rheumatologists, N (%)

	always/ mostly	sometimes/ never	N/A	don't know
Do you think that the treatments for SSc patients were well coordinated between you and the rheumatologist?	32 (42.7%)	20 (26.7%)	14 (18.7%)	9 (12.0%)
Do you think that the advice you and the rheumatologist gave to the SSc patients were well coordinated?	39 (52.0%)	16 (21.3%)	13 (17.3%)	7 (9.3%)
Did you and the rheumatologist, in your opinion, make good agreements with each other?	19 (25.4%)	26 (34.7%)	26 (34.7%)	4 (5.3%)
Did you inform the rheumatologist about the goals, progress and outcomes of your treatment?	31 (41.4%)	29 (38.6%)	14 (18.7%)	1 (1.3%)

Conclusion: The results of this study show clear discrepancies between referral reasons and applied interventions, visible in the clear focus on body functions and structures on one hand and the broad spectrum of applied interventions on the other hand. It is possible that HPs make a translation of the reasons given for referral to the needs of the individual patient. Viewed from this perspective, it is questionable whether the referrals by the rheumatologists are sufficiently targeted. Further, the results describe a suboptimal communication between rheumatologists and HPs that should be targeted in practice and further research.

REFERENCE:

[1] Cieza, et al., (2016). Refinements of the ICF Linking Rules to strengthen their potential for establishing comparability of health information. Disability and rehabilitation, 1-10.

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Osteoporosis

OP0080

EFFECT OF DENOSUMAB VERSUS RISEDRONATE ON CORTICAL AND TRABECULAR BONE MICROARCHITECTURE BY HIGH RESOLUTION PERIPHERAL QUANTITATIVE COMPUTED TOMOGRAPHY (HR-pQCT) IN GLUCOCORTICOID-TREATED INDIVIDUALS

Piet Geusens¹, Stefan Goemaere², Nicola Pannacciulli³, Nancy Lane⁴, Eric Lespessailles⁵, Osvaldo Messina⁶, Roland Chapurlat⁷, Xiang Yin⁸, Rachel Wagman⁹, Joop van den Bergh¹. ¹Maastricht University, Maastricht, Netherlands; ²Ghent University Hospital, Ghent, Belgium; ³Amgen Inc., Thousand Oaks, United States of America; ⁴University of California, Davis, United States of America; ⁵University Hospital Orleans, Orleans, France; ⁶Cosme Argerich Hospital, Buenos Aires, Argentina; ⁷Hopital Edouard Herriot, Lyon, France; ⁸Amgen Inc, Thousand Oaks, United States of America; ⁹Amgen Inc., Thousand Oaks, United States of America

Background: In a study of patients initiating or continuing GC, 12 and 24 months gains in lumbar spine and total hip areal bone mineral density (aBMD) were greater with DMB vs RIS.^{1,2}

Objectives: Evaluate the effects of DMB vs RIS on cortical and trabecular bone.

Methods: Phase 3, double-blind, double-dummy, active-controlled study randomised women and men ≥ 18 years, receiving GC (≥ 7.5 mg prednisone daily or equivalent) for <3 (GC-initiating [GC-I]) or ≥ 3 months (GC-continuing [GC-C]), to DMB 60 mg every 6 months or RIS 5 mg daily for 24 months. Subjects <50 years had a history of osteoporosis (OP) fracture. GC-C subjects ≥ 50 years had lumbar spine, total hip or femoral neck BMD T-score ≤ -2.0 ; or T-score ≤ -1.0 with history of OP fracture. All subjects were to receive daily calcium (≥ 1000 mg) and vitamin D (≥ 800 IU). In a subset, HR-pQCT scans of the distal radius and distal tibia were performed at baseline and Months 12 and 24. Treatment differences (DMB-RIS) were estimated using analysis of covariance (ANCOVA).

Results: The substudy enrolled 111 subjects (57 DMB, 54 RIS). DMB was associated with significantly greater increases than RIS in cortical thickness, total volumetric BMD (vBMD) and cortical vBMD at the radius and tibia at 12 and 24 months, and in trabecular vBMD at the radius at 12 months and tibia at 24 months (Table). Change in cortical porosity did not differ between DMB and RIS (Table). Percentage Change From Baseline and Treatment Difference in vBMD and Cortical Microarchitecture

		Distal Radius		Distal Tibia	
		Month 12	Month 24	Month 12	Month 24
Total vBMD	DMAb	1.8 (0.7, 2.8)	4.1 (2.6, 5.6)	1.3 (0.4, 2.2)	2.2 (1.2, 3.1)
	RIS	-1.1 (-2.2, 0.1)	-1.7 (-3.3, 0.1)	-0.8 (-1.8, 0.1)	-1.4 (-2.4, 0.4)
Cortical vBMD	DMAb-RIS	2.9 (1.4, 4.4)†	5.8 (3.6, 7.9)†	2.2 (0.9, 3.5)†	3.6 (2.2, 5.0)†
	DMAb	0.2 (-0.4, 0.8)	1.2 (0.4, 1.9)	0.5 (-0.1, 1.1)	1.0 (0.4, 1.5)
	RIS	-0.7 (-1.3, 0.1)	-1.4 (-2.2, 0.6)	-0.7 (-1.3, 0.1)	-1.3 (-1.8, 0.7)
	DMAb-RIS	0.9 (0.1, 1.8)	2.6 (1.5, 3.6)†	1.2 (0.4, 2.1)	2.2 (1.4, 3.1)†
Trabecular vBMD	DMAb	2.3 (0.2, 4.3)	9.4 (1.4, 17.3)	0.8 (-0.3, 1.8)	1.7 (0.7, 2.8)
	RIS	-0.9 (-3.0, 1.1)	-0.7 (-9.0, 7.6)	-0.3 (-1.3, 0.7)	-0.4 (-1.5, 0.6)
	DMAb-RIS	3.2 (0.3, 6.1)	10.1 (-1.4, 21.6)	1.1 (-0.4, 2.5)	2.1 (0.7, 3.6)
Cortical porosity	DMAb	2.3 (-2.9, 7.5)	8.5 (1.1, 15.9)	1.3 (-2.5, 5.2)	3.0 (-0.7, 6.6)
	RIS	2.2 (-3.1, 7.6)	10.2 (2.5, 18.0)	2.0 (-1.9, 5.9)	1.7 (-2.1, 5.5)
	DMAb-RIS	0.1 (-7.3, 7.5)	-1.7 (-12.4, 9.0)	-0.7 (-6.1, 4.8)	1.3 (-4.0, 6.6)
	DMAb-RIS	5.2 (2.9, 7.4)†	8.6 (5.4, 11.8)†	3.5 (1.7, 5.2)†	6.0 (3.5, 8.5)†

Reported as LS mean (95% CI); p-value based on ANCOVA that included treatment, baseline value, and duration of prior GC use (<12 vs ≥ 12 months) as covariates. N = no. of subjects enrolled in substudy; n = no. of subjects with observed data p-value for treatment difference: *p<0.05; †p≤0.001