medication were: performing DXA scan (aOR = 9.9, 95% CI [7.7, 12.6]), fragility fracture (aOR = 2.8, 95% CI [1.8, 4.5]), and osteoporosis or osteopenia diagnosis (aOR = 2.5, 95% CI [2.0, 3.1]).

Conclusion: We describe temporal trends in bisphosphonate discontinuations and factors associated with discontinuation of alendronate and restart of osteoporosis therapy. From 2010 to 2015, approximately one-third of women with long-term bisphosphonate treatment discontinued treatment for ≥ 12 months. We observed an increasing trend in discontinuation from 2010 to 2012, which remained steady through 2015. Factors associated with discontinuation of alendronate were associated with worsening of overall health status, while factors traditionally associated with worsening bone health were associated with restart of osteoporosis medication.

Figure 1. Temporal trends of Bisphosphonate Discontinuation in U.S. Medicare women beneficiaries by calendar year

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OP0083

PREVALENCE OF VERTEBRAL FRACTURES IN POSTMENOPAUSAL WOMEN WITH RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) is a risk factor for the development of fragility fractures, but there is little quality data on its prevalence. Conversely, osteoporosis is one of the most frequent comorbidities of RA.

Objectives: To determine the prevalence of vertebral fractures in postmenopausal women with RA and to analyse their characteristics and associated risk factors.

Methods: We included 346 postmenopausal women diagnosed with RA according to the ACR/EULAR 2010 criteria in 19 Spanish Rheumatology Departments, randomly selected from the registry of RA patients in each center, recruited during 2018. Lateral radiographs of the dorsal and lumbar spine were obtained from all patients, to evaluate morphometric vertebral fractures. Expert rheumatologists identified vertebral fractures and classified them into mild (grade 1: reduction of height of 20-25%), moderate (grade 2: reduction of 26-40%) and severe (grade 3: reduction > 40%), according to the Genant grading scale. The spinal deformity index (SDI) was calculated by assigning numbers 1, 2 and 3 to each fractured

vertebra and adding the total score of each patient. The study variables were: a) age, body mass index (BMI), b) factors related to RA: time of evolution, FR, ACPA, and c) fracture risk factors: prior fragility fracture, parental hip fracture, glucocorticoids, smoking, alcohol intake ≥ 3 units daily, secondary osteoporosis and time since menopause.

Results: The mean age was 66.8 (SD: 10.1) years and the median evolution of the disease, 8.00 [RIQ: 3.00-15.5] years. 77.2% (n: 267) and 75.7% (n: 252) had FR and ACPA +, respectively. The mean duration of the postmenopausal period was 15.0 (SD: 9.6) years. 23.4% (n: 79) of patients had at least one vertebral fracture; 10.7% (n: 36) had a single fracture and 12.7% (n: 43), multiple fractures. The most fractured vertebrae were D12, L1 and L2 (fractured in > 5% of patients). The median SDI was 3 [RIQ: 2-5]. The vertebrae with the highest mean IDE were D8, D10, D11 and L1 (all mean IDE ≥ 2). An association was found between the presence of vertebral fractures and age, height, postmenopausal period, time of disease progression, glucocorticoid treatment and parental hip. No linear association was found between SDI and age, time of evolution of the disease, BMI and time since menopause.

Conclusion: One out of every 4 postmenopausal women with RA has at least one vertebral fracture. Vertebrae of the dorso-lumbar hinge are the most frequently involved and the magnitude of the spinal deformity is relevant. Vertebral fractures are related to the time of evolution of RA and to the risk factors for fracture.

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OP0084

FRAGILITY HIP FRACTURES – DOES DESTINATION AFTER HOSPITAL DISCHARGE HAVE AN IMPACT ON PATIENT'S OUTCOME?

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Background: In Osteoporosis, hip fractures account for significant disease burden, with increased morbi-mortality. Because of this, patients are referred to rehabilitation and specific health care units, in order to regain autonomy and health. However, there is few evidence about patients' outcome, considering destination after inpatient discharge.

Objectives: To evaluate if destination after hospital discharge for a osteoporotic hip fracture has impact in the outcome (mortality and new fracture).

Methods: Patients referred to a Fracture Liaison Service from March 2015 until March 2017 with a fragility hip fracture were considered for this study. Clinical/demographic variables were retrospectively collected until January 2018, including destination at discharge (home, nursing home (NH), inpatient rehabilitation unit (RU)) and outcome (death, new fracture, lost to follow-up). Kaplan Meyer curves with log-rank test were used for statistical analysis (SPSS statistics 23); $p < 0.05$ was considered statistically significant.

Results: From a total of 522 patients, 437 patients were discharged with a known destination: 58.1% to home (n=254), 27.7% to a RU and the remaining to a NH. Table 1 summarizes clinical and demographic characteristics of the sample. Seventy-four patients died (median time = 264 days, range 22-1049) and 43 suffered a new fracture (median time 301, 15-946); 129 patients maintained follow-up. Mortality rates within each group of discharged patients were: 15.4% in the group destined home, 22.6% in the group forwarded to a NH and 17.4% in those referred to a RU. No statistically significant difference was found in cumulative survival between groups (figure 1A). The event refracture was observed in 10.2% of those discharged home, 6.5% in the group forwarded to a NH and 10.7% of those referred to a RU. Again, no statistically significant difference was observed (figure 1B).