Six Months of Results of a Multidisciplinary Fracture Liaison Prevention Unit in the South of Spain

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Background: As part of the IOF recommendations and the “Capture the fracture” program a Multidisciplinary and focussed on Primary Medicine Fracture Liaison Prevention Unit (FLS) was created in May of 2018 in the Hospital Universitario Virgen Macarena, in Seville, Spain. In previous reports, the rate of osteoporosis treatment prescription after the fragility fracture was as low as 20%, with a poor communication between the medical specialties involved in the attention of this patients.

Objectives: To improve the medical attention and treatment of patients with a FF. To create a multidisciplinary FLS with the collaboration of Primary Care Medicine, Internal Medicine, traumatology, Emergency Room, Rheumatology, Rehabilitation Service and the Medicine Department of the Seville University.

Design: A prospective, observational study in the setting of usual clinical practice and with approval of the local ethics committee. The Multidisciplinary FLS started to work at may, 2018 connecting primary care with medical specialties. The FLS has 3 weekly consultations (11 first visits, 4 second visits and email consultation, each day) attended by 2 internal medicine physicians, one Rheumatologist and one nurse. All the medical specialties involved in the attention of patients with FF can refer patients and the inclusion criteria is the history of a FF in the past 18 months. In a single medical visit, the doctor and the nurse make a clinical history, assesses the risk of FF according to FRAX, the risk of falls (J.H. Dowton scale), they evaluate malnutrition (Mini Nutritional Assessment Elderly) and sarcopenia (hands dynamometry and Short Physical Performance Battery). Complete blood count and blood and urine biochemistry in order to evaluate secondary causes of osteoporosis and vertebral radiographs are done. A treatment plan agreed and discussed with the patient is started. The plan advice on diet and exercises, drugs, and a written report and medical prescription. And a phone follow-up is programmed. The data are entered and stored in a database (OpenClinica) in real time.

Results: From May to October of 2018, 170 patients have been included; 135 (89%) women. The mean (standard deviation) age was 73 ± 11.8 years old; 25% of them with ages between 83 to 94 years. The patients were referred from Perioperative Internal Medicine (46%), Traumatology and orthopedic surgery (37%), Rheumatology (6%), Primary Medicine (5%) and others medical areas (6%). The anatomical sites of the FF were hip (58%), vertebral (22%), distal radius (13%), humerus (4%) and other sites (7%). The prescribed treatment was alendronate (66%), denosumab (18%), teriparatide (10%), risedronate acid (4%) and calcium and/or vitamin D supplementation in 98% of the patients. The compliance was measured by phone call in 42 patients that completed six months after the first evaluation, and it was good in 100%.

Conclusion: The multidisciplinary FLS activity increased the rate of evaluation of risk and prescription of treatment at 100% with rates of compliance at six months of 100%. The FLS allows the creation of fluid reference circuits and improves the patient care.

REFERENCES

Disclosure of Interests: None declared

The Impact of Arthritis on Utilization of Mental Health Treatment for Comorbid Mental Disorders: Findings from a Nationally Representative Mental Health Survey

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Background: Individuals with arthritis experience an increased prevalence and incidence of mood and anxiety disorders, however, it is unclear if they are receiving adequate treatment for their comorbid mental disorders. Objectives: To conduct a population-based evaluation of the association between arthritis and utilization of mental health treatments among individuals with comorbid mental disorders.

Methods: We used nationally representative data from the 2012 Canadian Community Health Survey – Mental Health (CCHS-MH) to draw a sample of 1,810 participants with depression, anxiety, or bipolar disorder. Depression, anxiety, and bipolar disorder (bipolar I, bipolar II, or hypomania) were defined by a series of screening questions in the CCHS-MH derived from the World Health Organization version of the Composite International Diagnostic Interview. The explanatory variable was self-reported doctor-diagnosed arthritis and included all rheumatic diseases.

The outcome of interest was utilization of mental health treatments in the previous 12 months, including: 1) medications; 2) professional services (e.g. physician, psychiatrist, nurse); or 3) non-professional services (e.g. family, self-help group, internet). Multivariable binomial logistic regression was used to evaluate whether utilization of mental health treatment differs among those with and without arthritis, adjusting for the confounding effects of age, sex, race/ethnicity, and household income.

Results: A total of 447 (20.5%) participants from our study sample reported having arthritis (66.9% female). Utilization of mental health treatments in the previous 12 months was reported by 82.4% individuals with arthritis and 79.5% without arthritis. The most common treatment utilized by those with arthritis was professional services (66.5%), followed by medication (61.8%) and non-professional services (51.5%). Participants without arthritis most often received mental health treatment in the form of non-professional services (87.3%), followed by professional services (58.1%) and medication (45.6%). The point estimate of the adjusted analysis suggested a positive association between arthritis and utilization of at least one type mental health treatment (odds ratio [OR] 1.41, 95% confidence interval [CI] 0.85, 2.34), though not statistically significant. In the sub-analysis, the ORs for the association between arthritis and specific mental health treatments were increased for medications (OR 1.30, 95% CI 0.86, 1.99) and for professional services (OR 1.27, 95% CI 0.83, 1.93), but decreased for non-professional services (OR 0.81, 95% CI 0.52, 1.27).

Conclusion: These nationally representative data show that a high proportion of individuals with arthritis seek treatment for their comorbid mental disorders. Findings of this study may also suggest a positive association between having arthritis and seeking care for comorbid mental disorders, which may be explained by an already established connection with the health care system to manage arthritis. Opportunities to improve mental health treatment among those with arthritis include optimizing access to non-professional services.

Disclosure of Interests: None declared

Changing Trends and Prescribing Patterns in Opioid-Treated Primary Care Patients with Non-Cancer Pain

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Background: The opioid epidemic in the U.S. has led to similar concerns about prescribed opioids in countries within Europe. In new users, the rate of escalation to more potent opioids is likely to contribute to long-term prescriptions, which in turn may be associated with opioid dependence, addiction and overdose. The scale of such escalation however is unclear in the U.K for non-cancer pain.
Objectives: We sought to: (i) describe trends of prescribed opioids for non-cancer pain in the UK primary care setting over a 10-year period (ii) assess the sequential transition of opioid strength from index date over a 2-year period.

Methods: We conducted a retrospective observational study over a 10-year period from 1/1/2006 to 31/12/2015 using the Clinical Practice Research Datalink (CPRD). CPRD collects de-identified patient data from a network of GP practices across the UK. New users of opioids, 18 years or over, without cancer in the 2 years prior to index date were included. The number of prescriptions for each drug were calculated by each calendar year accounting for the number of eligible patients registered in CPRD for that year. Sunburst plots were created to evaluate the sequential transition of opioids over time. A 4-state hidden Markov model was used to estimate the transition probability for individuals escalating to more potent opioids over a 2 year period. States were defined as (i) no drug (ii) weak opioid (codeine, dihydrocodeine) (iii) moderate opioid (tramadol) (iv) strong opioid (all others in CPRD). Methadone prescriptions were excluded for the purposes of this analysis.

Results: 1,028,955 opioid users were included; mean age (SD) was 55 (18) years; 58% being female. New users of opioids were most commonly prescribed codeine (n=723,102; 70.8%), followed by dihydrocodeine (n=179,831; 17.6%), tramadol (n=93,338, 9.1%) with n=24,808 (2.4%) strong opioid prescriptions. The rate of prescribing strong opioids/10,000 population increased 12 fold from 2006-2013, followed by a gradual decline till 2015 (Figure 1). This trend was most marked with certain opioids: morphine, oxycodone, buprenorphine and fentanyl (28.5 prescriptions per 10,000 population to a peak of 353.0 prescriptions per 10,000 population in 2013 and 303.1 prescriptions per 10,000 population in 2015). Using sunburst plots, of the new users prescribed weak opioids (i) codeine, (ii) morphine, (iii) dihydrocodeine, (iv) oxycodone, (v) fentanyl, (vi) tramadol, (vii) buprenorphine and (viii) methadone, we categorized the patients into 8 groups: 15% of opioid prescriptions were for codeine, 10% for fentanyl, 8%, tramadol, 7% oxycodone, and 7% morphine. Methadone prescriptions comprised 5% of the total prescriptions.

Conclusion: Strong opioid prescribing increased till 2013-14 gradually decreasing following UK initiatives to improve monitoring and use of controlled drugs. Although less potent codeine prescriptions made up the majority of first prescriptions, the transition probability of staying on a strong opioid at 2 years remained high if prescribed first as a new user.

Disclosure of Interests: None declared


Figure 1. Strong opioid prescribing trends over 10 years

Figure 2: Sunburst diagram demonstrating opioid prescribing pathway over 2 years

Table 1. Patients characteristics of our cohort

<table>
<thead>
<tr>
<th></th>
<th>RA (n=424)</th>
<th>axSpA (n=145)</th>
<th>PsA (n=132)</th>
<th>SLE (n=41)</th>
<th>Other diseases (n=233)</th>
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<tbody>
<tr>
<td>Age, years</td>
<td>60.7</td>
<td>43.7</td>
<td>51.3</td>
<td>48.4</td>
<td>56.1 (16.9)</td>
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<tr>
<td>Gender, male, n (%)</td>
<td>137 (32.3)</td>
<td>103 (70.8)</td>
<td>55 (41.7)</td>
<td>4 (9.8)</td>
<td>64 (27.5)</td>
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<tr>
<td>Current use of bDMARDs, n (%)</td>
<td>163 (38.4)</td>
<td>71 (10.0)</td>
<td>76 (57.6)</td>
<td>9 (22.0)</td>
<td>59 (25.3)</td>
</tr>
<tr>
<td>Physical function*</td>
<td>1.30</td>
<td>4.0</td>
<td>1.28</td>
<td>1.12</td>
<td>1.03 (0.69)</td>
</tr>
<tr>
<td>CRP (mg/dl), median (IQR)</td>
<td>0.3 (0.1-0.7)</td>
<td>0.2 (0.1-0.6)</td>
<td>0.2 (0.1-0.6)</td>
<td>0.2 (0.0-0.7)</td>
<td>0.3 (0.1-0.6)</td>
</tr>
<tr>
<td>Vaccination card available</td>
<td>230 (54.2)</td>
<td>76 (52.4)</td>
<td>46 (30.0)</td>
<td>28 (60.1)</td>
<td>140 (60.1)</td>
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<tr>
<td>Received information about vaccination</td>
<td>273 (101)</td>
<td>81 (16.5)</td>
<td>28 (66.3)</td>
<td>146 (62.7)</td>
<td>86 (38.3)</td>
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<tr>
<td>Complete pneumococcal vaccination status</td>
<td>129 (33.2)</td>
<td>26 (18.8)</td>
<td>12 (28.3)</td>
<td>30 (73.2)</td>
<td>29 (39.3)</td>
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<tr>
<td>Complete influenza vaccination status</td>
<td>85 (20.7)</td>
<td>20 (15.2)</td>
<td>8 (18.8)</td>
<td>50 (21.5)</td>
<td>37 (15.9)</td>
</tr>
</tbody>
</table>

*Physical function was assessed with HQA except in axSpA patients in whom the BASFI was used.