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LOW-BACK PAIN CHRONICITY IN A PRIMARY CARE SETTING IS ASSOCIATED WITH MALADAPTIVE PSYCHOSOCIAL FACTORS, OTHER CHRONIC PAIN CONDITION AND HIGH LEVELS OF PAIN AT BASELINE

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Background: Low back pain (LBP) is the leading cause of disability in Portugal and worldwide. The majority of the patients use primary health care services but the treatment outcomes are unknown. Findings of prognostic studies indicate that a marked reduction in mean pain and disability is expected in the first 6-8 weeks, for acute or persistent LBP. Beyond that time frame period, improvement slows and thereafter the probability to develop a persistent disabling back pain condition improves. Therefore, it seems important to measure the patients' outcomes at this time-point to better assess the effectiveness of the care provided.

Objectives: This study aims to describe the short-term outcomes for LBP patients treated in a primary health care centre in Portugal and to identify the prognostic factors for non-recovery and poor health related quality of life (HRQoL).

Methods: 116 patients with LBP were consecutively recruited from 7 different primary care units in Portugal. Baseline assessment includes socio-demographic and clinical data, psychosocial factors, pain, disability, and HRQoL. Pain, disability and HRQoL were then assessed at 8-weeks follow-up. A Global Rating of Change Scale to assess patient perception of improvement with treatment was added in the follow-up reassessment. Recovery criteria were determined according to the Minimal Clinically Important Difference established for pain and disability (reduction of $\geq 30\%$ from baseline). The EQ-5D,3L index was dichotomised into 'poor' HRQoL (< 0.6) and 'good' HRQoL (≥ 0.6), based on a proposed cut-off for having sufficient capacity to be able to work for a population with LBP. The relationship between variables on baseline and non-recovery/poor HRQoL was modulated through logistic regression.

Results: Of the 116 participants enrolled, 110 completed the 8-weeks follow-up. (mean age of 48.06 ± 11.41). Approximately half of the participants (53.4%) were acute presentations of LBP. The main treatment strategy was medication (83.5%), with only 8.3% of patients having been referred for physiotherapy. At 8 weeks follow-up, there were statistically significant improvements on pain, disability and HRQoL ($p \leq 0.05$). However, 38% of the patients reported they felt the same or worse, 76.4% had a poor HRQoL, and only half of the patients reached the established recovery criteria (49% in disability and 50% in pain). In the adjusted model, the probability of non-recovery ($p \leq 0.05$) was associated with the presence of maladaptive psychosocial factors (OR: 1.65, 95% CI 1.13-2.40, for pain; OR: 1.61, 95% CI 1.15-2.24, for disability), a chronic pain condition (OR: 1.71, 95% CI 1.33-1.88, for pain; OR: 1.76, 95% CI 1.43-1.89, for disability), and high levels of pain at baseline for pain (OR: 1.26, 95% CI 1.09-1.39). Poor HRQoL was associated to the female gender (OR: 1.88, 95% CI 1.61-1.96), chronic pain condition (OR: 1.68, 95% CI 1.03-1.89) and high levels of pain intensity at baseline (OR: 1.36, 95% CI 1.11-1.67).

Conclusion: These results suggest there is a room for improvement in the healthcare delivered to LBP patients in the Portuguese primary healthcare setting.

Disclosure of Interests: None declared

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SELF-PERCEPTION OF CARDIOVASCULAR RISK IN RHEUMATOLOGIC DISEASES; CASE-CONTROL STUDY

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Background: Several immune-inflammatory diseases are associated with an increased prevalence of cardiovascular diseases. Risk reduction through improved control of traditional cardiovascular risk (CVR) factors and the adoption of healthy lifestyle behaviors are critically important to reduce the CVR, although the general population must be aware of their CVR to make healthy sound decisions. Individuals who perceive an

increased risk are more likely to adopt behaviors to reduce it, such as smoking cessation, exercise, weight loss, and medication compliance.

Objectives: The aim of this study is to assess the awareness of the CVR in patients with/without rheumatic diseases (RD).

Methods: Observational, cross-sectional study was design. Subjects with RD attending an outpatient clinic were consecutively recruited (RA, SLE, PsA OA, Sjögren syndrome, fibromyalgia, scleroderma, osteoporosis and osteopenia). A complete clinical history was made and a self-applied questionnaire (Precaution Adoption Process Model) was used to assess the awareness of the CVR in patients with RD. Comparisons were made to controls without RD. Frequencies (%), media and median values (q25-q75) were used for descriptive analysis and Chi Square test for comparisons.

Figure 1

Results: 250 patients were included with 76 controls and 174 cases. Demographic characteristics shown in table 1. The majority of the patients located themselves in stage 1 of their CVR perception 31.6% in cases vs. 30.3% in controls ($p > 0.05$), other results are shown in figure 2. In the case group, 69.5% have not made any changes to reduce their CVR and the same was seen in controls. Most of the individuals are unaware of their higher CVR even though they have traditional CVR factors. Only 30.5% of the group of RD have received information from a health care provider about their CVR.

Abstract AB1255 Table 1. Demographic Characteristics

	Rheumatic Diseases (n=167)	Controls (n=60)	p
Age, n (%)	58 (47-60)	51.5 (34-65)	0.001
Female, n (%)	156 (89.7)	51 (67.1)	0.000
Family history CVD, n (%)	79 (45.4)	29 (38.2)	NS
Hypertension, n (%)	43 (24.7)	16 (21.1)	NS
T2DM, n (%)	16 (9.2)	13 (17.1)	NS
Dyslipidemia, n (%)	52 (29.9)	26 (34.2)	NS
Myocardial infarction, n (%)	3 (1.7)	2 (2.6)	NS
Stroke, n (%)	5 (2.3)	0	NS
Kidney disease, n (%)	6 (3.4)	4 (6.6)	NS
Active smoking, n (%)	12 (6.9)	8 (10.5)	NS
Inactive lifestyle, n (%)	92 (52.9)	36 (47.4)	NS

Abstract AB1255 Table 2. Source of Information of Cardiovascular Risk

	Rheumatic diseases (n=167)	Controls (n=60)	p
None, n (%)	62 (35.6)	24 (31.6)	NS
Health care provider, n (%)	53 (30.5)	19 (25)	
Television, n (%)	18 (10.3)	8 (10.5)	
Magazine, n (%)	4 (2.3)	2 (2.6)	
Internet, n (%)	14 (8)	14 (18.4)	
Books, n (%)	0	1 (1.3)	
More than 1, n (%)	11 (7.7)	5 (5.3)	
No answer, n (%)	12 (6.8)	3 (3.9)	

Conclusion: Even though patients with RD have and increased CVR, most of the individuals perceived it the same as the control group. The majority of the individuals (69.5%) haven't made any changes to reduce their CVR and many of them didn't have any source of information about their CVR, and according to EULAR recommendations the rheumatologist is the one responsible. Therefore, they should commit to give a better education to their patients.