AB1364-HPR PRELIMINARY CASE REPORT ON SHARING PATIENT HISTORY IN CLINICAL TREATMENT OF RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) is a chronic disease with periods of flare-ups and remissions, affecting daily life. Therefore, this disease requires lifelong management and support by the patients social circle and health professionals (HP).

Objectives: The aim of this study was to follow up the history of patients with RA, and demonstrate an improved understanding at each point in their disease trajectory, whilst encouraging them to cope, and enabling HP to optimize support provided.

Methods: We conducted two 30minute interviews with patients with RA. Interview questions included the patients perspective of their disease and disease information, effects on daily life, as well as psychological considerations using the Corbin and Strauss Chronic Illness Trajectory Framework approach [1].

This study was approved by the ethics committee of our hospital and informed consent was obtained.

Results: The first case; An unmarried 68 year old female living alone. The patients mother also suffered from RA. The patient was vaguely aware of the hereditary nature of RA (pretrajectory phase) and did not result in a big shock to her and she accepted her the diagnosis relatively smoothly (trajectory onset phase). She was prescribed initially prescribed methotrexate but this proved ineffective and infliximab was commenced. Remission was achieved and at that time she was satisfied with her relationship with her primary physician (stable phase).

Two years after beginning infliximab, she developed chest pain. However, her primary physician did not explore the problem and advised her that she had depression. She began to distrust him (unstable). She asked for infliximab to be stopped and requested her care be transferred to B university hospital where her mother was being treated. However, she was refused treatment due to the non-severity of her condition. She was unable to come to terms with refusal, and her physical and mental state deteriorated (downward phase).

Her mother advised the patient to go to D hospital, where she was put on Etanercept achieving remission with no complications (comeback phase). At D Hospital; (1) her condition and the need for treatment were clearly explained to her, and she was able to actively participate in shared decision making; and (2) she was given access to support from Health Professionals (HP) such as nurses, who offered a patient centered approach listening to her concerns and advising her appropriately whilst offering general psychological support.

A further 4 patients were interviewed. We will show the key phases of trajectories of their illnesses, the patients opinions about sharing their information with HP through interviewing, and the possibility of behavior change in the patients journeys.

Conclusion: This study shows that a patient centered approach taking into account the stages of the illness trajectory benefits patients perceptions of their disease and ability to cope with their condition. It also highlights the importance of having the support of ones social circle, particularly at challenging times.

Making a thorough record of the patients disease and QOL trajectory allows the patient to understand their disease process and associated life changes, and assist health professionals to provide the optimal support and resolve problems when they arise.

This preliminary study focuses on understanding the value of different phases of the trajectory of illness and sheds more light on the relationship between patients and HP and how the disease process and patients perspectives of their disease can facilitate mutual trust and smooth future treatment.

REFERENCES

- Corbin JM. Sch Inq Nurs Pract 1998;12: 341.

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AB1365-HPR INVESTIGATION OF THE ACUTE EFFECTS OF TAPING ON TISSUE TEMPERATURE, MUSCLE STRENGTH, FUNCTION AND BALANCE IN PATIENTS WITH KNEE OSTEOARTHRITIS

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Background: Osteoarthritis (OA) mostly affects knee joint. It causes tissue temperature changes, muscle weakness, functional and balance impairments. Taping can be used to support knee joint. However, contradictory results presented in the literature (1-3).

Objectives: The aim of this study was to investigate the acute effects of taping on tissue temperature, muscle strength, function and balance in patients with knee OA.

Methods: Thirty-four patients with unilateral OA (34 females, age=60.118.29 years, height =159.765.27m; weight=80.1112.29 kg) were included. The patients were treated with a flexible kinesiology tape (Thera-Band Kinesiology tape, Cramer, USA). Supporting techniques for quadriceps muscle, patellar position and patellar tendon were applied. Before taping and after 30 min of application, tissue temperature with a thermal camera (Testo882, Germany), knee flexor and extensor muscle strength with a dynamometer (Lafayette, USA), function with timed up and go test and balance with computerized balance system (ProKin PK-254P, Tecnobody, Bergamo, Italy) were assessed. The paired samples t-test and Wilcoxon test used for analyses.

Results: The tissue temperature of the effected (34.661.16) and non-effected sides (34.871.08) of the cases were different (p=0.033). However, no significant difference was observed for tissue temperature before and after the taping (p=0.145). In the comparison of the effected side and non-effected side muscle strength, a significant difference was found for extensors (p=0.035). After taping the effected side, differences were found for extensor and flexor muscle strength (p=0.00; p=0.001) in comparison to before taping. While there was a significant difference in the time walking test before and after taping (p = 0.026), there was no difference for the balance scores (p> 0.05). The values of the cases before and after taping showed at Table 1.

Conclusion: It was observed that taping might not affect tissue temperature and balance. However, muscle strength and function could be affected positively with the acute supporting effect of taping.

REFERENCES

- Castrogiovanni P, Di Giunta A, Guglielmino C, Roggio F, Romeo D, Fidone F, Musumeci G. (2016). The effects of exercise and kinesio tape on physical limitations in patients with knee osteoarthritis. *Journal of Functional Morphology and Kinesiology*, 1(4), 355-368.
- Mutlu EK, Mustafaoglu R, Birinci T, Ozdinciler AR. (2017). Does Kinesio taping of the knee improve pain and functionality in patients with knee osteoarthritis?: a randomized controlled clinical trial. *American journal of physical medicine & rehabilitation*, 96(1), 25-33.
- Wageck B, Nunes GS, Bohlen NB, Santos GM, de Noronha M. (2016). Kinesio Taping does not improve the symptoms or function of older people with knee osteoarthritis: a randomised trial. *Journal of physiotherapy*, 62 (3), 153-158.

Abstract AB1365HPR Table 1. The changes of the parameters before and after the tape application

Parameters	Before Taping	After Taping	p
Tissue temperature (degree)	34.661.16	34.430.90	0.145
Extensor muscle strength (Newton)	14.333.19	16.82.94	0.000
Flexor muscle strength (Newton)	10.071.89	11.032.5	0.001
Time up and go (seconds)	12.573.13	11.822.69	0.026
Eyes open balance*	158.56 (84.52/420.24)	183.20 (98.73/459.48)	0.091
Eyes close balance*	230.05 (111.91/567.97)	207.68 (128.08/412.56)	0.620
Limit of stability score*	64.29 (49.64/74.36)	64.62 (54.73/78.05)	0.673

* Wilcoxon test, Median (Percentiles%25-%75).

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