Abstract SP0084 Figure 1. Functional characteristics of post-activated B cells from autoimmune patients.

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THURSDAY, 13 JUNE 2019

15:30:00 – 17:00:00

Fracture liaison service: an opportunity for rheumatologists to focus on secondary fracture prevention

SP0085 WHOM TO IDENTIFY AND INVITE TO AN FLS? WHO IS THAT FRACTURE PATIENT?

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Background: Though osteoporosis can be diagnosed through the presence of fragility fractures in the absence of other aetiology such as myeloma or metastases, patients with osteoporosis are also at increased risk of high impact traumatic fractures. Further, distinguishing between fracture mechanisms through chart review is often difficult and may lead to patients with osteoporosis being missed. On the other hand, focusing on identifying and treating patients at high imminent fracture risk rather than milder degrees of osteoporosis makes for better cost utility.

Objectives: To review the demographics of patients presenting with fragility fractures and the evidence for targeting osteoporosis assessment for each category of fracture in order to balance the need for maximum risk reduction with the requirement for an evidence based strategy.

Methods: Narrative review of recent epidemiology studies and national and international guidelines

Results: Based on epidemiology data from Iceland(1) and Denmark(2,3), the risk of subsequent fractures following a sentinel fracture event is critically dependent on the recency and the site of the initial fracture, with the risk of new fractures being particularly high after major osteoporotic fractures(1) and pelvic fractures but less so after lower leg fractures(2).

In Danish women(2), 29.5% of patients suffering a pelvic fracture went on to sustain a hip fracture in the next ten years, compared with 25.9% after a vertebral fracture but only 12.5% after a lower leg fracture. Further, despite the high recurrent fracture risk in the FLS setting, it is important to appreciate that the majority of hip fracture patients have not consulted with a prior fracture in the last ten years prior to their hip fracture(3).

The following issues will be addressed in more detail

- 1) Demographics of fracture patients with particular emphasis on age, sex and BMD.
- 2) Which fracture types are indicators of elevated risk of subsequent major osteoporotic fractures?
- 3) Which fracture types will respond to osteoporosis treatment?
- 4) What is the role of DXA in FLS?
- 5) Identifying vertebral fractures

Conclusion: FLS patients are at elevated risk of sustaining additional fractures both in the long term and in the short term, with risks being particularly high in the first years after the sentinel fracture and especially if the initial fracture is a pelvic fracture or a major osteoporotic fracture.

REFERENCES:

- [1] Kanis, Osteoporos Int 2018, 29:1747–1757

- [2] Hansen, Osteoporos Int 2015, 26:513–519
- [3] Frederiksen, Osteoporos Int 2018; 29:109–114

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SP0086 ASSESSMENT: HOW TO PERSONALIZE SECONDARY FRACTURE PREVENTION?

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Background: The existing armamentarium of therapeutic options to minimise fracture risk is growing. Different therapies have different properties, and can be used for different patient targets.

Objectives: To discuss data on short-term fracture risk following an index fracture, and on the short-term efficacy of different therapies.

Methods: Narrative review of recent literature.

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SP0087 TREATMENT: HOW TO IMPLEMENT IT AND HOW TO MONITOR ADHERENCE?

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Background: The key to achieving the benefits of an FLS on the population and the patient level is to ensure enough high-risk patients are initiated and then adhere to therapy. There is a low rate of primary and secondary adherence by patients with osteoporosis. Treatment initiation requires co-developed decision making with patients and clinicians balancing locally agreed intervention thresholds with effective and efficient risk and treatment communication. Treatment adherence depends on patient, treatment and healthcare service characteristics.

Objectives: Describe the current status of treatment recommendation in the UK. Describe the current methods for improving adherence globally

Methods: Review of the data from the UK Fracture Liaison Service Database and IOF Capture the Fracture audits.

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How not to smoke like a chimney

SP0088 HOW YOU KNOW IT IS SMART NOT TO SMOKE LIKE A CHIMNEY

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Smoking is associated with a higher prevalence of many diseases. When a health professional is well informed of the risks of smoking in rheumatic diseases, the advice given to the patient about quitting smoking could be more effective.

It is known that smokers in the general population have an increased frequency of elevated rheumatoid factor (RF). Since 1987, we have known that cigarette smoking is a risk factor for rheumatoid arthritis (RA), especially in men with RF-positive who are heavy smokers. Later, it could be verified that cigarette smoking is implicated in the pathogenesis of RA particularly when associated with antibodies, cyclic citrullinated peptides (ACPA) and the shared epitope. Smoking increases the risk of both subsets of RA with a more pronounced influence on the risk of ACPA positive RA. The polyclonal immune response against modified antigens in patients with RA is not exclusively citrulline-specific, carbamylation of antigens like vimentin could be involved in the pathogenesis of the disease. Thus, smoking is a risk factor for breaking tolerance to multiple autoantigens in RA.

In RA patients, cigarette smoking correlated with an increased risk of joint erosions, extra-articular manifestations and cardiovascular disease, in addition to the established effects of longstanding disease activity on the risk of myocardial infarction and stroke.