immunosuppression or i.v. pulse cyclophosphamide? And if so, on the basis of what criteria should treatment intensity be stepped up? Second, how can patient selection be optimised so as to avoid transplanting dCSSc patients with little chance of responding? Third, is there a window of opportunity where the immune system can be rebooted? Last but not least, how can potentially eligible dCSSc patients gain access to HSCT? The latter may be the most (de)pressing one, as HSCT is only available in a small number of centres. Until efficacious disease-modifying drugs with a better risk-benefit ratio become available, HSCT will continue to be the only therapeutic option to reverse the disease course in dCSSc patients.

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FRIDAY, 14 JUNE 2019
13:30–00 – 15:00:00

Predicting short-term fracture risk: can we foresee the (close) future?

SPO114
CASE 1 PRESENTER: IMMINENT FRACTURE RISK: ASSESSMENT AND DOES IT HELP CLINICAL MANAGEMENT

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A 60 year old female was under long-term follow-up for rheumatoid arthritis, for which she took methotrexate. Ten years previously she had been found to have a single vertebral fracture and her fracture risk, assessed using The WHO Fracture Risk Assessment Tool (FRAX®), was calculated as a 13% risk of major osteoporotic fracture over the next 10 years. According to The National Osteoporosis Guideline (NOGG) recommendations, she was under-powered for osteoporosis. Bone mineral density (BMD) was performed with dual-energy X-ray absorptiometry (DXA) which demonstrated a bone mineral density T-score of -1.7 at the femoral neck. Lifestyle, vitamin D and calcium intake were optimised and follow-up arranged for 6 months. Prior to her next appointment she fell and sustained a fracture of the distal radius. On fracture liaison review her FRAX® risk of fracture was 14% (rising due to an increased year of age) despite the recent change in clinical circumstances. This case serves to emphasise the clinical conundrum associated with imminent fracture risk (the 2 years after a fracture when the patient is at a significantly higher risk of fracture) and the difficulties with the decision to treat.


SPO115
CASE 1 DISCUSSANT: IMMINENT FRACTURE RISK: ASSESSMENT AND DOES IT HELP CLINICAL MANAGEMENT

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With an estimated 520,000 fragility fractures every year in the UK, delivering effective and efficient healthcare for this patient group has significant consequences for patients, families, the NHS, and society. A fragility fracture is a major risk factor for further fractures, and healthcare systems are now beginning to recognise the benefits of secondary fracture prevention. Despite this, less than 50% of patients receive effective secondary fracture prevention after a fragility fracture. This has led to national and international initiatives to improve clinical services by implementing fracture liaison services (FLSs). Successful funding of a new FLS is usually influenced by the number of fractures it is expected to prevent in the first few years after an index fracture. The expected number of fractures prevented is in turn determined by the baseline risk of subsequent fracture, the number of patients at high enough fracture risk to warrant anti-osteoporosis medication (AOM), and the degree of fracture risk reduction by AOMs. Underestimating fracture risk in the post-fracture period will lead to fewer expected fractures prevented and lower perceived benefit of the FLS by patients, and importantly also by patients, families, healthcare providers, and payers. Tools are available to determine the long-term risk of fracture based on patient factors, including previous fracture. Of these, FRAX and QFracture have been incorporated within UK NICE clinical guidance, and the FRAX-derived intervention threshold is used to guide recommendations for AOM in the NHS.