CASE 2 PRESENTER: BREAKING BAD AND TRAGICALLY HIP: A CASE OF A MISSED OPPORTUNITY AFTER VERTEBRAL FRACTURE

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Mrs A is a 78-year-old woman, admitted to the emergency room after a same level fall in her home earlier the same day. She has a history of Chronic Obstructive Pulmonary Disease with recurrent exacerbations, and hysterectomy at the age of 41. At admission, she is complaining of agonising pain localised to her right hip, and she is unable to move the leg. Upon the physical examination, the right leg is shortened and outwardly rotated. Upon further questioning, Mrs A reveals that she has lost four or five cm of height during the past years. An X-ray of the hip demonstrates a neck of the femur fracture. Mrs A has surgery the following day and two screws are inserted. Due to a hospital-acquired pneumonia, Mrs A stays in the hospital for an additional 9 days after the operation, upon which she is discharged for a temporary placement at a nursing home for further rehabilitation.

Two months following discharge, Mrs A was called for a clinical evaluation by the hospital Fracture Liaison Service. Assessment with DXA confirms the osteoporosis diagnosis and VFA shows lower thoracic vertebral fractures. The FLS coordinator noted that Mrs A, related to a hospital admission for an acute exacerbation of her COPD 3 years before, had had a chest x-ray performed, on which vertebral fractures in the thoracic spine could be seen to be present. Mrs A has never previously been assessed nor treated for osteoporosis.

Disclosure of Interests: None declared

CASE 2 DISCUSSANT: AUTOMATED (IMPLEMENTED IN SEARCHING FOR PATHOLOGY; HOW HARD SHOULD FIBROMYALGIA; AN ACCEPTABLE DIAGNOSIS?)

SP0117

Identification of patients at high risk of osteoporotic fractures is commonly based on fracture history, bone mineral density or a combination of the two. However, vertebral fractures are very often either missed or not acted upon by our health systems and DXA scanning to measure BMD in itself requires a coherent case finding strategy.

Current EPR systems may have built-in features to capture signs of sepsis or warnings to alert clinicians to cases with a diagnosis of atrial fibrillation with no apparent prescription for anti-coagulation. Building on the same principle, EPR systems or even national databases can be set up with appropriate decision rules to alert physicians to diagnoses such as RA, AS or COPD that we know strongly increases the risk of osteoporosis and to flag out medication patterns known to predict a high risk of osteoporotic fractures. This can then be checked against the presence of referrals for DXA and/or prescriptions for anti-osteoporosis medications and a clinical decision aid triggered to alert healthcare professionals. The mechanism powering such a tool can be an existing clinical risk algorithm such as qFracture, FRAX, FREM, Garvan FRC or others, depending on the nature of routinely collected data, the setting and the timescale required, or a bespoke risk tool developed for the healthcare system in question. It is important to appreciate that risk tools need careful calibration to be appropriate across countries and clinics and that the trigger risk level is ultimately a trade-off between clinical judgment and health economics. Vertebral fractures represent a particular challenge. It has been established in the past that vertebral fractures often are not mentioned in radiology reports even if clearly present, or reported using unclear terminology that does not make it sufficiently clear to clinicians that a vertebral fracture is present. Moreover, even when vertebral fractures are called out in the radiology report it is not uncommon for this to go unnoticed. Opportunistic identification of vertebral fractures by software tools is a possible new avenue for narrowing the treatment gap in osteoporosis. With increasing integration of DICOM images into EPR systems, DICOMs of CT scans and other modalities containing spine images could be used either for automated case finding with alert boxes in the EPR system itself or employed in radiology departments to automatically populate reports with additional information about the presence of vertebral fractures.

REFERENCES:

Disclosure of Interests: None declared

SP0118

FIBROMYALGIA; AN ACCEPTABLE DIAGNOSIS?

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Background: Neither patients nor clinicians and researchers fully embrace the fibromyalgia diagnosis. A core objection relates to the huge overlap with other polysymptomatic distress disorders such as somatic symptom disorder and chronic fatigue syndrome. Another objection has to do with the classification of fibromyalgia as a rheumatic disease, which may hamper research and treatment of psychosocial factors.


Disclosure of Interests: None declared

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

Primary and secondary fibromyalgia; are they different?

SEARCHING FOR PATHOLOGY; HOW HARD SHOULD WE LOOK?

Somatopsychic distress disorders such as somatic symptom disorder and chronic pain. This led to the view that FM is a diagnosis of exclusion. This is no longer the case in 2019.

REFERENCES:

SP0119

SEARCHING FOR PATHOLOGY; HOW HARD SHOULD WE LOOK?

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Background: The 1990 American College of Rheumatology (ACR) classification criteria for Fibromyalgia (FM) was intended to facilitate research by defining a homogenous patient population [1]. Two key features of the criteria are tender point examination and exclusion of other conditions that may cause widespread pain. This led to the view that FM is a diagnosis of exclusion. This is no longer the case in 2019.

Disclosure of Interests: None declared

REFERENCES:

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