SP0116 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 admittance, 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 of the thoracic spine could be seen to be present. Mrs A has never previously been assessed nor treated for osteoporosis.

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SP0117 CASE 2 DISCUSSANT: AUTOMATED (IMPLEMENTED IN ELECTRONIC MEDICAL RECORD SYSTEMS) SHORT-TERM FRACTURE RISK PREDICTION

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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, FRC, 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.

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13:30:00 – 15:00:00

Primary and secondary fibromyalgia; are they different?

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.

Objectives: To get insight into the pros and cons of the fibromyalgia diagnosis.

Methods: The scientific literature was reviewed with a focus on homogeneity and heterogeneity within the group diagnosed as fibromyalgia.

Results: That fibromyalgia is not a stable diagnosis of a homogeneous group is reflected in the ongoing development of new classification and diagnostic criteria; the newest including diagnostic criteria, common features, comorbidities, consequences, and putative mechanisms (Arnold et al., 2019). Moreover, treatment recommendations progressed from a focus on pharmacological treatment in 2008 to a focus on nonpharmacological therapies in 2017 (Macfarlane et al., 2017). Also, several studies showed that the group is quite heterogeneous with respect to type, number and severity of symptoms and comorbidities (e.g., Davis et al., 2018) as well as with respect to adaptation profiles covering a spectrum of severely maladjusted to quite well adjusted in terms of objective and subjective management (Estevez-Lopez et al., 2018).

Conclusion: Although diagnostic classifications such as fibromyalgia help to examine underlying mechanisms and interventions and to define treatment recommendations, in clinical practice and research account should be taken of heterogeneity of patients in terms of symptoms and disorder-transcending biopsychosocial factors that influence the disorder. This suggests that fibromyalgia is an acceptable diagnosis to the extent that individuality is accepted as part of the diagnosis.

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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.

Results: In 2010, the ACR published provisional criteria for the diagnosis of FM [2]. These allowed FM to be diagnosed by using questionnaire removing the need for tender point examination. One of the major advantages of the criteria is that the diagnosis of FM can be made by primary care physician and the first-line treatment be initiated without referral to secondary care. Such an approach was

recommended by the Canadian guidelines [3], which recommended "patients should undergo a physical examination which should be within normal limits except for tenderness on pressure of soft tissues however the specific tender point examination according to the 1990 ACR diagnostic criteria is not required to confirm a clinical diagnosis of fibromyalgia". Furthermore, it stated that "Fibromyalgia should be diagnosed as a clinical construct, without any confirmatory laboratory test, and with testing limited to simple blood testing including a full blood count, erythrocyte sedimentation rate, C-reactive protein, creatine kinase, and thyroid stimulating hormone. Any additional laboratory or radiographic testing should depend on the clinical evaluation in an individual patient that may suggest some other medical condition." However, many primary care physicians do not feel competent/confident to exclude other rheumatic conditions by physician examination.

Over the last decade, comorbid FM is increasingly recognized in many chronic musculoskeletal diseases including patients with inflammatory arthritis. A systematic review found that the prevalence of FM is 21%, 13% and 18% in RA, axSpA and PsA respectively [4]. Patients with comorbid FM have higher diseases activity score and more severe pain.

In 2016, the ACR diagnostic criteria for FM were modified and stated that "A diagnosis of fibromyalgia is valid irrespective of other diagnoses. A diagnosis of fibromyalgia does not exclude the presence of other clinically important illnesses." [5].

Conclusion: The motion that "FM is a diagnosis of exclusion" is no longer valid. FM should be a positive diagnosis and does not exclude other rheumatic diagnosis.

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SP0120 PERSONALISED TREATMENT FOR FIBROMYALGIA; THE IMPACT OF COMORBIDITIES

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Background: The heterogeneity of the clinical presentation, the co-morbidities and the pathophysiologic mechanisms associated with fibromyalgia (FM), and the modest results on average for any therapy, call for a more individualized management strategy.

How to develop personalized treatment?

Individualized treatment can be developed on the basis of subgrouping of patients according to associated conditions and co-morbidities (mental health problems, chronic overlapping pain conditions, other somatic diseases) or on disease severity. Personalizing treatment needs to classify FM in specific subgroups. It can be proposed on the basis of clinical assessment (eg, degree of daily functioning), on co-morbidities or on dedicated questionnaires. Lastly, shared decision-making regarding treatment options can be directed according to patient preferences, co-morbidities, and availability in various health care settings.

What is currently recommended as a personalized approach?

The European League Against Rheumatism guidelines recommend a tailored approach directed by FM key symptoms (pain, sleep disorders, fatigue, depression, disability), whereas the German guidelines recommend management tailored to disease severity, with mild disease not requiring any specific treatment, and more severe disease requiring multicomponent therapy (combination of drug

treatment with aerobic exercise and psychological treatments). When indicated, treatments should follow a stepwise approach beginning with easily available therapies such as aerobic exercise and amitriptyline. We will present how successful application of a tailored treatment approach that is informed by individual patient characteristics should improve outcome of FM.

Key points: This presentation will presents suggestions for an individualized treatment strategy for FM patients on the basis of symptoms, disease severity and co-morbidities.

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Joint EULAR – EFIS: Combatting or harnessing ILC in the battle against autoimmunity

SP0121 DEBATE: ILC AS INNOCENT BYSTANDER

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Innate lymphoid cells (ILC) are recently (10 years ago) described tissue-resident lymphoid populations [1]. They lack adaptive antigen receptor (generated by the recombination of genetic elements) and are innate counterparts of T lymphocytes. Indeed ILC1s, ILC2s, and ILC3s mirror CD4⁺ T helper (Th)1, Th2, and Th17 cells, respectively, in terms of transcription factor expression and cytokine production.

In this lecture, an overview of the different protective immunological functions of these helper ILC will be provided, in particular their role for maintenance of gut homeostasis, for control of parasitic, bacterial or viral infections, for anti-tumor immune responses, for metabolism, or for tissue repair mechanisms. The concept of ILC plasticity, which represents the capacity of these cells to change their phenotype and functional capacities in response to diverse microenvironment stimuli, will be also addressed. It directs the heterogeneity of these cells in the tissues, and may be important for their effective immune responses.

In this context, targeting ILC for therapeutic use, for example in the battle against autoimmune or inflammatory diseases in which they may also play roles [2], could be associated with deleterious consequences. However, recent data concerning patients with a profound and selective ILC deficiency and no susceptibility to disease will be also presented here. This last observation suggests that most protective functions mentioned above may be redundant and potentially dispensable for human health, at least in modern conditions of hygiene and medicine, when T cell and B cell functions are preserved.

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Optimizing the access to new treatments for RMD patients

SP0122 OPTIMIZING HOLISTIC TREATMENTS: THE CHALLENGE OF IMPLEMENTATION

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International guidelines present recommendations for holistic care for RMDs, building upon best evidence. However, there is still a gap between what we know about best care and what we do to implement best care in our clinical services. Having EULAR guidelines alone (and multiple updates and revisions) is not enough to change complex systems. European funders are now investing in projects to accelerate the uptake of best care across multiple European partners.