Using one example of a completed EIT-Health funded implementation project, JIGSAW-E (Joint Implementation of Guidelines for osteoArthritis in Western Europe), this presentation will highlight some of the challenges of implementation such as: understanding the context; competing priorities; lack of time and funding; stability of the workforce; and differing health care systems. It will describe the use of Knowledge Mobilization and Communities of Practice as methods for overcoming these challenges and optimizing holistic treatments.

The presentation will offer some of the key factors for implementation such as: ‘leading from the middle’ and brokering across silos; working with patients and the public. ‘Patients are the most under-used resource in any health care system; using theories, models and frameworks to plan, understand and evaluate implementation; using pilot sites to build momentum with dedicated Communities of Practice; and agreeing what success should look like.

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**REFERENCES:**


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**HOW TO ASSESS PATIENT WITH SUSPECTED VASCULITIS**

Raashid Luqmani. University of Oxford, Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences, Oxford, United Kingdom

**Background:** Systemic vasculitides are multi-organ, multi-system conditions which can mimic many other diseases. They are rare but very significant because they can rapidly lead to end organ damage or death if left untreated. The difficulty faced by clinicians in diagnosing a patient with vasculitis is further compounded by the presentation of limited forms of vasculitis, which can be difficult to recognise as due to vasculitis, the effects of co-existing co-morbidity and the use of drugs either for medicinal or recreational purposes. Giant cell arteritis is one of the most common serious forms of vasculitis in adults, leading to blindness if untreated. In view of this risk, many clinicians will initiate treatment of any patients with suspected giant cell arteritis before definitive investigations have been performed. Unfortunately this can result in inadequate outcomes form diagnostic tests such as ultrasound or biopsy of the temporal artery. There are no diagnostic criteria for most forms of vasculitis apart from Behcet’s syndrome. Some tests can be very useful in ruling out other causes as well as helping to confirm a diagnosis of vasculitis. We will review some of the strategies for diagnosing vasculitis, complementing a thorough history and examination with selected investigations to improve diagnostic certainty.

**Objectives:** To consider the strategies used to assist the diagnosis of systemic vasculitis; to assess the frequency of multi-system involvement in systemic vasculitides; to critically evaluate the role of diagnostic testing in systemic vasculitides.

**Methods:** A review of current literature on the approach to diagnosis and classification of vasculitis.

**Results:** Table 1 summarises the clinical manifestations of some forms of primary systemic vasculitis, comparing the different frequencies of the common presenting features. Patients with large vessel vasculitis are usually more distinct as a clinical group from other forms of vasculitis but increasingly we see an overlap between GCA and older patients (especially males) with Takayasu arteritis. There is considerable overlap of clinical features amongst the small vessel vasculitides, despite different immuno-pathogenetic pathways. Amongst the anti-neutrophil cytoplasm antibody (ANCA) associated vasculitides (AAV), the presence of active nephritis characterises most patients with GPA; it is less common in GPA and least common in EGPA. Lung involvement is prevalent in all three forms of AAV, has different characteristics: bronchial wall inflammation with ulceration plus nodules and infiltrates in GPA; transient infiltrates and bronchoscapm in EGPA; lung haemorrhage at presentation in MPA, with subsequent risk of developing lung fibrosis. The different patterns of disease activity help in differentiating...