Defining the concept of US-detected 'minimal disease' is crucial to enable investigators identify a threshold (or cut-off) to *differentiate normal physiological from minimal pathological changes* at the joint level. This threshold, subsequently, will be used to evaluate the best sensitivity to detect changes in therapeutic response and assess remission, as well as facilitate diagnosis of early disease.

In order to address this important research question, the OMERACT US SIG has formed the US Minimal Disease Taskforce at the OMERACT 2016 meeting. This collaboration between 24 OMERACT ultrasound centres in 11 countries has successfully recruited more than 600 subjects into the Minimal Disease Study. US data of healthy individuals encompassing synovial hypertrophy, synovial effusion, and Doppler enhancement will be presented.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.8580

SP0136 HOW TO PERFORM US-GUIDED INTERVENTIONS + DEMO

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Background: Aspiration and injection of joints and soft tissues is an indispensable skill used in everyday practice by the clinical rheumatologist. These tasks are usually conducted by palpation-guided techniques. These procedures are not always successful (1) and thus US-guided interventions have been developed.

Objectives: are to explain the effect of needle and sound beam angle on needle visualization, describe different techniques of needle insertion under US guidance, to identify different approaches to the target under US guidance and finally to discuss about the accuracy and efficacy of the ultrasound guided technique.

Methods: There are two common methods for US puncturing: semi-guided or indirect method (skin surface marking) and needle guidance under direct sonographic vision (2,3). The scanning plane is optimized for visualization of the target and penetration of the needle should be at least 0.5cm from the transducer. The movement of the needle in the soft tissue should be followed on the screen during the procedure. The needle appears as a bright echogenic line if the transducer is oriented longitudinally on the needle, and the needle tip may be followed as it reaches the target. If the ultrasound beam is transverse to the needle, the needle is seen as a bright echogenic dot. In case of no visualization of the needle several means are available: steering of the ultrasound beam against the needle (in new machines), curved or virtual convex probe, toeing in of the probe, shaken the needle slightly and moving the probe a bit from side to side.

Results: According to the clinical and cadaveric studies the ultrasound guided technique is more accurate than the landmark guided technique in the glenohumeral, acromioclavicular, wrist, hand, hip, knee and foot joints and in the tendons of the biceps, wrist, hand, hip, knee and ankle (4). Synovial biopsies are more accurate using an ultrasound guided method (5).

Conclusion: Ultrasound is the most applicable and feasible imaging modality for routine clinical use in guiding musculoskeletal procedures. Though many studies have examined the role of imaging guidance for injection there needs to be more examination of how the use of ultrasound prior to injection can alter the pathological and anatomical diagnosis. There is a trend towards an expanded number of advanced applications of interventional musculoskeletal ultrasound which can also be performed by a rheumatologist like nerve blocks or needling of calcifications. Which ultrasound guided technique (direct or semi-guided) is the most appropriate in different anatomical areas and clinical settings remains to be studied. More studies are needed to show the accuracy and efficacy of ultrasound guided injections in different anatomical areas (4).

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.8518

FRIDAY, 14 JUNE 2019

13:30:00 – 15:00:05

Jewels in the crown of health professionals

SP0137 CORE COMPETENCIES

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Background: To maintain and optimize the quality of care provided by health professionals in rheumatology (HPRs), adequate educational offerings are needed. Ideally, these are based on defined core competencies.

Objectives: A task force (TF) aimed to develop evidence-based recommendations for the generic core competencies of nurses, physical therapists (PTs) and occupational therapists (OTs) to serve as a basis for their postgraduate education.

Methods: The EULAR standardised operating procedures for the development of recommendations were followed. A TF including rheumatologists, nurses, PTs, OTs, patient-representatives, an educationalist, methodologists and researchers from 12 countries met twice. In the first TF meeting, 13 research questions were defined to support a systematic literature review (SLR). In the second meeting, the SLR evidence was discussed and recommendations formulated. Subsequently, level of evidence and strength of recommendation were assigned and level of agreement (LoA) determined (0-10 rating scale).

Results: Three overarching principles and 10 recommendations for the generic core competencies of HPRs were developed supported by the SLR and expert opinion. The SLR included 79 full-text papers, 20 of which addressed the competencies, knowledge, skills, attitudes or educational needs of HPRs from multiple professions. The average LoA for each recommendation ranged from 9.42 to 9.79. Consensus was reached on education and research agendas.

Conclusion: Evidence and expert opinion informed a set of recommendations providing guidance on the generic core competencies of nurses, PTs and OTs in rheumatology. Implementation of these recommendations in the postgraduate education of HPRs at the international and national level is advised, considering variation in health care systems and professional roles.

Task Force Members: L.M. Edelaar, E. Nikiphorou, G.E. Fragoulis, A. Iagnocco, C. Haines, M. Bakkers, L. Barbosa, N. Cikes, M. Ndosi, J. Primdahl, Y. Prior, P. Pchelnikova, V. Ritschl, V.S. Schäfer, H. Smucrova, I. Storvænning, M. Testa, D. Wiek, T.P.M. Vliet Vlieland

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.8616

SP0138 WHAT WE ARE BRILLIANT AT; OT PERSPECTIVE

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The unique contribution of occupational therapy is its focus on occupation, which may be defined as "groups of activities and tasks of everyday life, named, organized and given value and meaning by individuals and a culture. Occupation is everything people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities (productivity)". Occupation is further being influenced by the environment, one's social roles and one's developmental level; being client-defined; and consisting of both a performance (objective) dimension and a satisfaction (subjective) dimension (1).

Using the terminology of the International Classification of Functioning (ICF), occupational performance covers the domain of Activity and Participation in the ICF model.

In clinical practice, occupational therapists use assessment and interventions to develop, recover, or maintain the meaningful occupations of individuals, groups, or communities. Lately, occupational therapists have also been increasingly concerned with occupational injustice, which relates to conditions wherein people are deprived, excluded or denied of occupations that are meaningful to them.

Within rheumatology, the most frequently applied occupational therapy interventions are patient education concerning ergonomic principles and activity pacing, therapeutic exercise and activity programs, provision of orthoses and assistive technology, and environmental and task modifications.