Defining the concept of US-detected ‘minimal disease’ is crucial to enable investigators to 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 hypervascularity, synovial effusion, and Doppler enhancement will be presented.

Disclosure of Interests: None declared

SP0136 HOW TO PERFORM US-GUIDED INTERVENTIONS + DEMO

Juhani Koski, Mikkel Central Hospital, Internal Medicine, Mikkel, Finland

Background: Aspiration and injection of joints and soft tissues is an indispensible 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 sono-graphic 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 echoic 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 echoic 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 accurately performed by 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 research to discuss about the accuracy and efficacy of the ultrasound guided technique.

Disclosure of Interests: None declared

Guests are invited to attend a demonstrative session for ultrasound-guided musculoskeletal interventions and to discuss about the accuracy and efficacy of the ultrasound guided technique.

FRIDAY, 14 JUNE 2019
13:30:00 – 15:00:05
Jewels in the crown of health professionals——

SP0137 CORE COMPETENCIES
Thea Viet Vlieeld. Leiden University Medical Center, Orthopaedics, Rehabilitation and Physiotherapy, 2300 RC Leiden, Netherlands

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 competences.

Objectives: A task force (TF) aimed to develop evidence-based recommendations for the generic core competences 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 competences of HPRs were developed supported by the SLR and expert opinion. The SLR included 79 full-text papers, 20 of which addressed the competences, 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 competences 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.


REFERENCE:

Disclosure of Interests: None declared

None declared

SP0138 WHAT WE ARE BRILLIANT AT; OT PERSPECTIVE
Ingrid Kieken. Norwegian Advisory Unit on Rehabilitation in Rheumatology, Department of Rheumatology, Diakonhjemmet Hospital, 0370 Oslo, Norway

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.

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.

Disclosure of Interests: None declared
In the presentation, patient cases will be used to illustrate how occupational therapists may work to enhance occupation in individual clients with a rheumatic condition, and evidence for some of the core interventions will be discussed.

REFERENCE:

Disclosure of Interests: None declared

WHAT WE ARE BRILLIANT AT: NURSING PERSPECTIVE
Ricardo Ferreira. Centro Hospitalar e Universitário de Coimbra, EPE, Rheumatology, Coimbra, Portugal

The challenges confronting health care delivery systems worldwide are rapidly changing, and this calls for practice-defined competencies for nurses and other health care workers (Zhang, Luk, Arthur, & Wong, 2001). The definition of competency or competence in nursing has been a subject of debate (Axley, 2008; Fukada, 2018; Zhang et al., 2001). Its clarification is important and still needed to establish a foundation for realistic working behaviours, for nursing education and management. Although there has been an extensive and valuable work in the definition of core competencies of nursing profession, which includes both autonomous and inter-dependent activities within the multidisciplinary team, little scientific research has been done to clarify the way in which nursing profession is unique. This presentation will address the following questions:

- What are nurses (collectively) really brilliant at?
- What leads them to develop unique characteristics?
- How do they bring into care, that matches or complements other health professions to result in better quality care?

The presentation is informed by a scoping review, a survey of international nurse leaders and researchers.

REFERENCES:

Disclosure of Interests: None declared

Overdiagnosis and overtreatment in inflammatory arthritis
Duncan Porter. Gartnavel General Hospital, Rheumatology, Glasgow, United Kingdom

Background: The use of musculoskeletal ultrasound (US) and magnetic resonance (MR) imaging is widespread in the diagnosis and management of patients with rheumatic disease. Interpreting the images, and their implication for clinical management is challenging, particularly in the community, in mild/early disease, where there is discordance between clinical and imaging findings, and in the presence of co-morbid joint disease.

Objectives: — to review the evidence about whether the use of imaging results in over-diagnosis and over-treatment

Specifically, the following issues will be addressed, using rheumatoid arthritis as the exemplar:

- To review the prevalence of ‘abnormal’ MSUS and MR findings in the general population
- To understand the prevalence and significance of sub-clinical joint inflammation
- To summarise the evidence from clinical trials about the risks/benefits of treating to a target of imaging (rather than clinical) remission

Methods: If clinicians are to interpret the available imaging correctly, several issues are pertinent. Firstly, it is important to understand the prevalence of erosions, synovitis and bone marrow oedema in the general population, in different joints, at different ages and in the presence of co-morbid conditions such as osteo-arthritis. Secondly, in RA what are the implications of sub-clinical inflammatory changes for disease progression? Thirdly, do clinical trials support the hypothesis that ‘treat to target’ strategies should aim at a target of ‘imaging remission’ rather than clinical remission? The results of the TaSER, ARTIC and RA-IMAGINE trials will be reviewed to identify if the systematic, routine use of imaging results in over-treatment or clinical harm. Lastly, the possibility that imaging could have a role in reducing over-treatment will be discussed.

Conclusion: It is possible to interpret the results of imaging correctly, without knowing the clinical context. Clinicians need to understand the value and the limitations of imaging, and should not pursue a simplistic or binary approach when interpreting the results - otherwise over-diagnosis and over-treatment will be the result. To date, the evidence from RCTs in the management of RA suggest that a ‘treat-to-target’ approach should aim for clinical and not imaging remission.

REFERENCES: