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 Universitario 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, Gartrnave General Hospital, Rheumatology, Glasgow, United Kingdom

Background: The use of musculoskeletal ultrasound (MSUS) 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, and at the time of the post-acute phase. Over-diagnosis and overtreatment in inflammatory arthritis is a major concern for the clinician and patient alike. This presentation will discuss the evidence for the over-diagnosis of inflammatory arthritis, the implications for clinical practice, and the potential for the implementation of strategies to prevent over-diagnosis and overtreatment.

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 osteoarthritis. 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, ARCTIC 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 impossible 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:
The multiple rheumatological faces of PsA (or PsA is more than just poly-artthritis? – Consequences for management in daily practice)

CASE 1 PRESENTER: A PATIENT WITH PERSISTING MONO/OLIGO-ARTHRITIS (NEITHER AT START OR REMAINING AFTER TREATMENT OF POLY-ARTICULAR DISEASE)

William Tillett. Royal National Hospital for Rheumatic Diseases, Rheumatology, Bath, United Kingdom

Background: The varied clinical phenotypes of psoriatic arthritis present treatment challenges in clinical practice. The dominant phenotype represented in clinical trials is polyarthritis with little representation of oligoarticular or monarticular disease.

Objectives: To review the phenotypes of psoriatic disease and treatment of resistant oligo/monarthritides in the context of a clinical case.

Methods: Clinical case history

Conclusion: The clinical phenotype of arthritic disease in psoriatic arthritis can evolve over time. There is limited data to inform the treatment of resistant oligo/monarthritides.

Disclosure of Interests: None declared


CASE 1 DISCUSSANT: HOW IS TACKLING OLIGO-ARTICULAR DISEASE DIFFERENT FROM POLYARTHRITIS? CAN WE USE TRIAL RESULTS FROM POLYARTICULAR PSA IN A PATIENT WITH MONO/OLIGO-ARTHRITIS?

Laura C Coates. University of Oxford, Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences, Oxford, United Kingdom

Background: Oligoarthritis is a well recognised phenotype in psoriatic arthritis (PsA) where less than 5 joints are involved with active arthritis. In cohort studies, the proportion of patients presenting with mono/oligoarthritis varies from 20-70% depending on the timeframe studied and duration of disease. However, most studies of therapeutic agents in PsA have focused on polyarticular disease. Although the majority of studies accept a minimum of 3 active joints for inclusion, the average tender and swollen joint counts are usually over 10 at baseline.

Objectives: To review data supporting treatment of psoriatic mono/oligoarthritis including comparisons of response rates in therapeutic trials in PsA and the differential performance of outcome measures in this subtype of disease.

Results: When considering the applicability of RCT data to mono/oligoarthritides in PsA it is important to address the populations included in these studies. Nearly all large therapeutic studies exclude monarthritides, and while some oligoarthritides patients are eligible for inclusion in most RCTs, the demographics of the population included suggest that this is a minority. Unfortunately most clinical trials have not reported the efficacy results separately for oligoarthritides and polyarthritides patients. The other key consideration is that the outcome measures used in the majority of trials are developed and validated on patients with polyarticular PsA. Thus assessing effectiveness of therapies may be limited in the oligoarthritides population as the response measures are less sensitive to change.

Conclusion: Although data from polyarticular RCT populations is often used to choose therapies in oligoarthritic PsA, there is a real paucity of data to ensure that we are treating these patients optimally. Future research is needed to address the variable prognosis seen in mono/oligoarthritic PsA, to ensure that appropriate outcome measures are used to test different therapies and to provide clear evidence on the efficacy of drugs in this important subtype of disease.

Disclosure of Interests: None declared


Cannabis for arthritis: hype or hope?

Serge Perrot. France, France

Cannabis-based medicines have been approved for pain management in a number of countries. However, there are uncertainties and controversies about their role and the appropriate use of these medicines for the management of chronic pain, particularly in musculoskeletal conditions. These ancient drugs are now being rediscovered and considered as modern analgesics in the context of cannabis legalization in more and more countries. The fight for cannabis legalization is frequently confused with the search for new analgesics in medical context. Furthermore, there is a confusion between herbal cannabis, medical cannabis and cannabinoids. Therefore, it is important to differentiate products and measures used in the majority of trials are developed and validated on patients with polyarticular PsA. Thus assessing effectiveness of therapies may be limited in the oligoarthritides population as the response measures are less sensitive to change.

Conclusion: Although data from polyarticular RCT populations is often used to choose therapies in oligoarthritic PsA, there is a real paucity of data to ensure that we are treating these patients optimally. Future research is needed to address the variable prognosis seen in mono/oligoarthritic PsA, to ensure that appropriate outcome measures are used to test different therapies and to provide clear evidence on the efficacy of drugs in this important subtype of disease.

Disclosure of Interests: None declared


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