frequent impairment on work (66%) and personal life (87%) and the highest use of analgesics (60% NSAIDs, 25% opioids and 40% others). In the regression analyses, BMI per 5 units and WHO-5 per 10% worsening were associated with an increase in WOMAC values of 3-4 points, irrespective of the joint manifestations.

	Parameter	Reference	WOMAC			
			Polyarthrosis	Hip OA	Knee and Hip OA	Knee OA
Model 1	Age	per 10 years	0,7 (-0,6 ; 2,0)	0,7 (-1,2 ; 2,6)	2,0 (-0,5 ; 4,4)	-0,1 (-3,5 ; 3,3)
	Gender: Male		-3,8 (-6,7 ; -1,0)	0,8 (-3,5 ; 5,0)	-3,7 (-8,1 ; 0,6)	-0,5 (-7,6 ; 6,6)
Model 2*	BMI, kg/m ²	per 5 units	4,4 (3,2 ; 5,5)	3,1 (1,1 ; 5,2)	4,2 (1,8 ; 6,6)	4,1 (0,6 ; 7,6)
Model 3*	Symptom duration	per year	0,3 (0,2 ; 0,5)	0,4 (0,2 ; 0,6)	0,2 (-0,0 ; 0,4)	0,4 (0,0 ; 0,8)
Model 4*	WHO-5 (0-100)	per 10% worsening	4,4 (3,8 ; 5,0)	3,2 (2,2 ; 4,1)	4,1 (3,3 ; 5,1)	3,9 (2,1 ; 5,9)

Table: Results of four separate multiple linear regression models with the WOMAC as the dependent variable. Regression coefficients with 95% confidence intervals are shown.

*Model adjusted for age, gender. BMI: Body Mass Index, OA: Osteoarthritis, WOMAC: Western Ontario and McMaster Universities Osteoarthritis Score.

Abstract THU0429 – Figure 1. Patient reported use and claims data prescriptions of analgesics and physical therapy. NSAID: Non-steroidal anti-rheumatic drugs, OA: Osteoarthritis.

Conclusion: Disease burden is high in persons with concomitant knee and hip OA, going along with frequent prescription of analgesics. The pattern of joint affection, BMI and depressive symptoms need to be considered when using the WOMAC as an outcome instrument.

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THU0430 PREPARING AN ORTHOPAEDIC CONSULTATION USING AN EHEALTH TOOL: A RANDOMIZED CONTROLLED TRIAL IN PATIENTS WITH HIP AND KNEE OSTEOARTHRITIS

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Background: Hip and knee OA patients who are referred to an orthopaedic surgeon often expect action to be taken.¹ However, the majority who of those patients is not (yet) eligible for a joint replacement.^{2,3} We hypothesized that a solid preparation using the eHealth tool is likely to streamline patients' expectations and increase satisfaction, irrespective of the outcome of the consultation.

Objectives: To evaluate the effect of a stand-alone mobile and web-based educational intervention (eHealth tool) compared to usual preparation of a first orthopaedic consultation of patients with hip or knee osteoarthritis (OA) on patients' satisfaction.

Methods: A two-armed unblinded randomized controlled trial involving 286 patients with (suspicion of) hip or knee OA, randomly allocated to either

receiving an educational eHealth tool to prepare their upcoming consultation (n=144) or usual care (n=142). Satisfaction with the consultation on three subscales (range 1-4) of the Consumer Quality Index (CQI - primary outcome) and knowledge (assessed using 22 statements on OA, range 0-22), treatment beliefs (assessed by the Treatment beliefs in OsteoArthritis questionnaire, range 1-5), pain medication use (yes/no), assessment of patient's involvement in consultation by the surgeon (assessed on a 5-point Likert scale) and patient satisfaction with the outcome of the consultation (numeric rating scale), were assessed.

Results: No differences between groups were observed on the 3 subscales of the CQI (group difference (95% CI): communication 0.009 (-0.10, 0.12), conduct -0.02 (-0.12, 0.07) and information provision 0.02 (-0.18, 0.21)). Between group differences (95% CI) were in favour of the intervention group for knowledge (1.4 (0.6, 2.2)), negative beliefs regarding physical activities (-0.19 (-0.37, -0.002) and pain medication (-0.30 (-0.49, -0.01)). We found no differences on other secondary outcomes.

Conclusion: An educational eHealth tool to prepare a first orthopaedic consultation for hip or knee OA does not result in higher patient satisfaction with the consultation, but it does influence cognitions about osteoarthritis.

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THU0431 FREQUENCY OF TENDON INVOLVEMENT AND ITS EFFECT ON HAND FUNCTION IN HAND OSTEOARTHRITIS

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Background: Tenosynovitis and consequent tendon damage are common findings in inflammatory arthritides. In contrast to rheumatoid arthritis (RA) and psoriatic arthritis, little is known about the frequency of tendon involvement in hand osteoarthritis (HOA) and the influence thereof on hand function. Ultrasound has been reported to have a high specificity in diagnosing tenosynovitis and tendon damage.

Objectives: We aimed to appraise the frequency of tendon involvement in HOA and to assess the agreement between ultrasound (US) and clinical diagnosis of tenosynovitis and tendon damage in HOA. In addition, we wanted to assess the influence of tendon involvement on hand function.

Methods: We included 73 patients with HOA in the study. Each patient underwent a clinical as well as a US examination of the 6 extensor tendon compartments and 6 flexor tendons of the hand (fig. 1). They were assessed for US signs of tenosynovitis and tendon damage as well as osteophytes (presence/absence) by a sonographer blinded to clinical information, as well as for clinical tendon involvement (presence/absence) by a biometrician blinded to the US results. Difference in frequency of sonographically detected tendon involvement between flexor and extensor tendons and between right and left hand were calculated by Chi-Square test. Osteophytes were also evaluated on standard radiographs. Agreement between US and clinical examination was calculated by Cohen's kappa. Hand function was quantified using the Score for the Assessment and Quantification of Chronic Rheumatoid Affections of the Hands (SACRAH) questionnaire as well as the Moberg pick-up test (MPUT). Correlation between MSACRAH and tendon involvement was calculated by Spearman's correlation.

Results: In 41 patients (56.2%), at least one tenosynovitis was observed and in 8 (11%) patients, at least one tendon damage was detected by US. Tendon damage was found more often in flexor tendons (0.2% vs. 2.2%, p<0001), while tenosynovitis was found more often in extensor