Pregnancy in women with APS and/or lupus is dangerous both for mother and offspring, and, in the past, patients were advised not to have children. Among complications frequently seen in women with lupus are preeclampsia (also known as toxemia of pregnancy), preterm birth, markedly underweight newborns, and fetal death. Identifying women destined for complications remains challenging and limits our ability to counsel and care for pregnant lupus patients. There is currently no effective treatment for women with these high-risk pregnancies; treatments to prevent poor pregnancy outcomes require an understanding of mechanisms of injury. Our research in an animal model that mimics the human condition shows that blockade of well-established mediators of inflammation, specifically complement and TNF-alpha, prevents adverse outcomes. To translate these discoveries to lupus patients, we launched the PROMISSE Study (Predicators of pRegnancy Outcome: biomarkers In antiphospholipid antibody Syndrome and Systemic lupus Erythematosus) to determine which pregnancies were at highest risk for adverse outcomes. Over 20% of pregnancies in patients with SLE resulted in an adverse pregnancy outcome. We discovered that the presence of a lupus anticoagulant which can be detected in the blood before pregnancy or in the first trimester, confers a 10-fold increase in risk of complications. Furthermore, we found that early in pregnancy, measurable alterations in the balance of angiogenic factors (proteins that circulate in blood, promote proper placenta development, and are required to maintain the health of the mother’s vascular system) are highly predictive of preeclampsia and other pregnancy complications.

The results of the PROMISSE Study provide models for early risk stratification to allow physicians to identify patients early in pregnancy who are at low risk and reassure them that their pregnancies were likely to be uncomplicated and their babies healthy. Conversely and importantly, we can reliably predict which patients are destined to have poor pregnancy outcomes, and we conducting a trial with a TNF-alpha inhibitor that does not cross the placenta in patients at highest risk in an experimental therapy to prevent placental dysfunction. Treatments to prevent poor pregnancy outcomes require an understanding of mechanisms of injury. Experiments in mouse models have enabled us to embark upon a trial of a potential treatment.

Disclosure of Interests: Jane E. Salmon Shareholder of: Biogen-Idec, BMS, Disclosures of Interests: None declared

What does remission in Rheumatoid arthritis mean to patient?

Ruth Williams. Kings College London, Department of Inflammation Biology, London, United Kingdom

What does remission in Rheumatoid arthritis mean to patient? This session discusses what remission means to patients. Remission holds different meaning for researchers, clinicians and patients. In addition it holds different meaning for individual patients and for individual patients at different points of time in their lives. I shall reflect on over fifty years living with Rheumatoid arthritis, as both a patient and a doctor. To consider the changes in my care, my therapy and in my own and my clinicians objectives and treatment aims, at different points in time. Looking at how things have progressed from pain relief, splinting, physical therapy, rehabilitation and surgery. To progressively more effective DMARD’s, anti-TNF’s & Biologics and an aim of complete ‘clinical remission’. However commonly ‘clinical remission’ can conflict with a patients concept of remission, as patients are individuals and the tools used to define remission are research based and consider populations not people. Disease activity scoring and ‘Treat to Target’ has had significant impact on patients, clinicians and their rheumatology consultations. The absence of inflammation does not equal remission for many patients and it is important to consider the differing needs of patients who were diagnosed pre and post biologic therapies and those with refractory disease. Currently maximal energy appears to be concentrated on the newly diagnosed and even pre-diagnosis, but has this been at the detriment of those with long established disease?

I will share my own and different patients viewpoints of what ‘remission’ means and consider the benefits of progress in effective ‘therapies’ but also to reflect upon some of the important things that may have been lost from clinical ‘care’ along the way. To list simple things that can help patients achieve remission that can easily be forgotten. I will explain the phenomenon of ‘DAS blindness’ and the potential failings it can lead to. Discuss how improved shared decision making of treatment aims might improve outcomes for patients whilst reducing risk and possibly costs; aiming to increase patient autonomy and improve the doctor patient dynamic.

In order to achieve ‘remission’ for patients we need to have a clear shared understanding of what ‘remission’ means to each individual and only then can we aim to achieve it.

Disclosure of Interests: None declared
Behaviour change in fibromyalgia

CASE1 PRESENTATION: FACILITATING BEHAVIOUR CHANGE IN FIBROMYALGIA: A CASE STUDY FROM THE UK

Yeliz Prior, University of Salford, Centre for Health Sciences Research, Manchester, United Kingdom

Background: Fibromyalgia is a chronic pain condition which, is commonly accompanied by the symptoms of fatigue, sleep disturbance, low mood and cognitive dyscognition. EULAR Revised Recommendations for the management of Fibromyalgia suggests initial management should involve patient education and focus on non-pharmacological therapies [1]. Occupational Therapists at the Rheumatology Outpatients Department, Leighton Hospital, Mid Cheshire NHS Hospitals Foundation Trust developed the Fibromyalgia Self-Management Education (FAME) Group Programme, based on the current evidence-base and patient partner involvement. The primary aim of this programme is to support self-management of Fibromyalgia using behaviour change interventions as outlined in the NICE recommendations. FAME comprises 2.5 hrs weekly sessions over six weeks (6-Wks) and core components include education about Fibromyalgia, pain, fatigue, sleep and mood management, dealing with dyscognition, physical exercise and practicing mindfulness, based on Cognitive Behavioural Therapy (CBT) and Motivational Interview (MI) approaches.

Objectives: Service evaluation aims to assess how well a service is achieving its objectives. This service evaluation was undertaken with a view to benefit patients using the FAME Group Programme and is designed and conducted with the sole purpose of defining and examining the current occupational therapy service provision for people with Fibromyalgia at the Mid Cheshire NHS Trust Hospitals. This Case Study will report on the findings of this service evaluation with reference to the NICE recommendations. FAME comprises 2.5 hrs weekly sessions over six weeks (6-Wks) and core components include education about Fibromyalgia, pain, fatigue, sleep and mood management, dealing with dyscognition, physical exercise and practicing mindfulness, based on Cognitive Behavioural Therapy (CBT) and Motivational Interview (MI) approaches.

Methods: Patients with a primary diagnosis of FM were screened and recruited patient outcomes and discuss the barriers and facilitators of implementing this service evaluation. Focus groups were transcribed and analysed by three independent researchers, not involved in the initial design or the delivery of this programme at an NHS Hospital setting. Patients self-completed postal questionnaires at home [including socio-demographic characteristics; General Health Questionnaire SF-12; Revised Fibromyalgia Impact Questionnaire; Arthritis Self Efficacy Scale; Multidimensional Assessment of Fatigue Scale] at baseline, and again at 6 and 12-week follow-up. Focus groups were held at the hospital following the completion of the FAME Group Programme, to obtain patients’ views on the programme content, delivery and the impact on their self-management. Quantitative data from the baseline, 6 and 12-week follow-up questionnaires were analysed using paired t-tests and effect sizes calculated using eta-squared. Focus groups were transcribed and analysed by three independent researchers, not involved in the initial design or the delivery of this programme, using Thematic Analysis [2].

Results: As the service evaluation is in progress at the time of submitting this abstract, the results will be presented and discussed at the annual meeting.

Conclusion: To be discussed at the meeting.

REFERENCES:

Disclosure of Interests: None declared

SATURDAY, 15 JUNE 2019
12:00:00 – 13:30:00
How to build a clinical scientist

CASE2 PRESENTATION: SCIENCE CARRIER AND MENTAL HEALTH

Annet van den Broeck, Background: Clinician scientists are at the heart of the translational medicine process. Over the last decades many reports and studies have shown that they risk becoming extinct, and that efficient career pathways are lacking. Recently more reports show that alarming numbers of clinicians and clinical scientists suffer from burn out and depression. To address this issue, next to thorough study of the root factors leading to mental problems it is important to develop career pathways for clinician scientists and educational programs to improve resilience. New educational programs such as those offered by the Eureka Institute help to build networks of translational scientists and help to strengthen resilience, needs to overcome the challenges they face while pursuing translational research.

Disclosure of Interests: None declared