Background: Orthoses and footwear can play an important role in managing foot pathology in patients whose systemic disease is controlled. Foot orthoses are frequently prescribed in clinical practice as an intervention for people with rheumatoid arthritis (RA).

Objectives: The aim of our study is to evaluate the impact of thermofusible orthoses on the functional index of the foot (FFI) in patients with rheumatoid arthritis.

Methods: We conducted an open clinical trial, having consecutively included 14 patients (85.7% female, average age 54.8 ± 10 years) suffering from rheumatoid arthritis (median progression time of 9 years [5-12]). The average DAS28 was 2.7 ± 1.2 and the functional impact objectified by the Health Assessment Questionnaire (HAQ) was on average 0.9 ± 0.7.

The median deadline from the start of RA and the onset of the foot problem was 3 years [0-7.75]. The foot problem was bilateral in 100% of the cases and inaugural in 85.7% of the cases.

We evaluated the functional impact of foot injury for all our patients at baseline and 8 weeks after the use of thermofusible orthoses, based on the FFI (Foot function index) measuring the impact of foot pathology on function in terms of pain, disability and activity limitation.

The comparision of the FFI domains before and after the use of orthoses was carried out using parametric or nonparametric paired tests using The SPSS statistical software.

Results: With the use of foot orthoses, FFI values decreased in all subscales (p<0.024) (pain, disability and activity limitation). This reduction was significant for disability (0.011) but not for pain and activity limitation.

There were no significant correlations between the global FFI and the progression of RA, the duration of foot damage and the functional impact measured by the HAQ.

Table 1. The comparison of the FFI domains before and after the use of orthoses.

<table>
<thead>
<tr>
<th></th>
<th>Before orthoses</th>
<th>After orthoses</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain scale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain in the morning</td>
<td>4.7 (3.6)</td>
<td>2 (1.3)</td>
<td>0.046</td>
</tr>
<tr>
<td>Pain when walking barefoot</td>
<td>6.7 (5.1)</td>
<td>6.2 (5.1)</td>
<td>0.791</td>
</tr>
<tr>
<td>Pain when standing barefoot</td>
<td>6.7 (3.9)</td>
<td>5.1 (3.9)</td>
<td>0.223</td>
</tr>
<tr>
<td>Pain when walking with shoes</td>
<td>5.2 (5.2)</td>
<td>3.2 (5.2)</td>
<td>0.178</td>
</tr>
<tr>
<td>Pain when standing with shoes</td>
<td>7.1 (7.1)</td>
<td>5.2 (5.2)</td>
<td>0.342</td>
</tr>
<tr>
<td>Pain when walking with orthoses</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0.517</td>
</tr>
<tr>
<td>Pain when standing with orthoses</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0.317</td>
</tr>
<tr>
<td>Pain at the end of the day</td>
<td>6.8 (4.8)</td>
<td>6 (4.8)</td>
<td>0.027</td>
</tr>
<tr>
<td><strong>Disability scale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty walking at home</td>
<td>4.1 (5.1)</td>
<td>2 (2)</td>
<td>0.002</td>
</tr>
<tr>
<td>Difficulty walking outside</td>
<td>4.7 (3.7)</td>
<td>2 (1.3)</td>
<td>0.019</td>
</tr>
<tr>
<td>Difficulty descending stairs</td>
<td>5.5 (5.5)</td>
<td>3 (2)</td>
<td>0.022</td>
</tr>
<tr>
<td>Difficulty standing on tiptoe</td>
<td>6.5 (8)</td>
<td>4 (5.5)</td>
<td>0.087</td>
</tr>
<tr>
<td>Difficulty getting up from a chair</td>
<td>2.4 (6)</td>
<td>1 (1)</td>
<td>0.023</td>
</tr>
<tr>
<td>Difficulty climbing a sidewalk</td>
<td>4.2 (5)</td>
<td>3 (2)</td>
<td>0.137</td>
</tr>
<tr>
<td>Difficulty walking fast</td>
<td>3.2 (6)</td>
<td>3.5 (6)</td>
<td>0.484</td>
</tr>
<tr>
<td>Star all day at home</td>
<td>21 (15.3)</td>
<td>0 (0)</td>
<td>0.077</td>
</tr>
<tr>
<td>Star all day tolying down</td>
<td>20 (4)</td>
<td>0 (0)</td>
<td>0.123</td>
</tr>
<tr>
<td>Limitation of activity</td>
<td>2 (2)</td>
<td>0 (0)</td>
<td>0.2</td>
</tr>
<tr>
<td>Use of indoor walking aids</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>1</td>
</tr>
<tr>
<td>Use of walking aid outside</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0.18</td>
</tr>
<tr>
<td><strong>Pain scale</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Background: Methotrexate (MTX) is the first choice disease-modifying anti-rheumatic drug (FAME) in the treatment of rheumatoid arthritis among other rheumatic diseases. It is therefore very important that patients are aware of this treatment and have an adequate management of it.

Objectives: The development of a recommendation leaflet for patients with rheumatic diseases in treatment with methotrexate.

Methods: A systematic review of the literature was conducted, defining the criteria for inclusion and exclusion of content. The coordinators of the work generated preliminary recommendations that were evaluated and discussed in GESVR meetings and 10 recommendations on the use of MTX were accepted, which were later ratified by the Valencian Society of Rheumatology.

Results: The final document with a brief introduction indicates that MTX can be administered orally or subcutaneously, depending on the prescribed dose and its tolerance. In the case of subcutaneous administration, pre-filled syringes or pen needles are used which do not require any preparation, so there is no risk of handling and/or inhalation toxicity. The proposed recommendations are described below:

MTX should be taken or administered ONLY once a week, and always on the same day of the week. It is important to follow these recommendations to ensure adequate effectiveness and avoid side effects.

It is common to add a folinic acid supplement the day after MTX is taken to avoid certain side effects of the drug. In some cases it may be necessary to increase the dose to other days of the week.
**Background:** Self care is an important management strategy for people with inflammatory arthritis (IA). Focused education should enable people to manage their life with IA and optimise their health and well-being. Several studies have shown positive effects of dedicated health programs on a range of patient reported outcomes such as self-efficacy, pain, fatigue, quality of life and overall well-being. However these benefits are only achievable and long lasting if people are provided with professional support to stay motivated and make appropriate adjustments to obtain better health.

**Objectives:** The objective of our intervention was to assess the outcomes of a dedicated health education program delivered in a diverse community setting represented by minorities with poor educational and socio-economic background.

**Methods:** We partnered with our local authority to establish a dedicated rheumatology community health hub for our patients with long term rheumatic conditions. Both clinical and paramedical staff in rheumatology clinics advertised the service and those who consented were referred. They were offered a 1:1 assessment with a health and well-being practitioner who would refer onwards based on the needs of the patient. In this pilot study we analysed the outcomes achieved at one year.

**Results:** 187 patients were referred to the service. 158 had IA and 29 had osteoporosis. 57 (30%) were White, 86 (46%) Asian, 28 (14%) Afro-Caribbean and 18 (10%) of other ethnicities. Mean age was 64 years (range 36-96). Interventions included weight management (10%), general health check (4%), dedicated exercise program (30%), physical activities (46%) and talking therapies (8%) and smoking cessation (2%). 100% responded to the contact and signed up for the intervention. 80% completed a minimum of 12 week intervention. 89% continued smoking cessation (2%). 100% responded to the contact and signed up for the intervention. 80% completed a minimum of 12 week intervention. 89% continued smoking cessation (2%). 100% responded to the contact and signed up for the intervention. 89% continued smoking cessation (2%).

**Conclusion:** This leaflet is intended to resolve common doubts of patients receiving treatment with MTX, and thus help to improve the therapeutic adherence and avoid errors in the drug taking.

**Disclosure of Interests:** None declared

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**Table 1. The effect of perceived social support on quality of life in fibromyalgia and rheumatoid arthritis patients (FMS: Fibromyalgia, RA: Rheumatoid arthritis, *p<0.05*** and **p<0.01)**

<table>
<thead>
<tr>
<th>SF-36</th>
<th>SF-36</th>
<th>SF-36</th>
<th>SF-36</th>
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<tbody>
<tr>
<td>Physical functioning</td>
<td>Pain</td>
<td>General health</td>
<td>Social functioning</td>
<td>Mental health</td>
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<tr>
<td>FMS-MSPSS</td>
<td>r</td>
<td>-0.034</td>
<td>0.015</td>
<td>-0.187</td>
</tr>
<tr>
<td>Family</td>
<td>p</td>
<td>0.816</td>
<td>0.195</td>
<td>0.104</td>
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<tr>
<td>FMS-MSPSS</td>
<td>r</td>
<td>0.154</td>
<td>0.192</td>
<td>0.221</td>
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<tr>
<td>Friend</td>
<td>p</td>
<td>0.285</td>
<td>0.181</td>
<td>0.123</td>
</tr>
<tr>
<td>FMS-MSPSS</td>
<td>r</td>
<td>0.163</td>
<td>0.248</td>
<td>0.119</td>
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<tr>
<td>Significant others</td>
<td>p</td>
<td>0.258</td>
<td>0.082</td>
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<tr>
<td>RA-MSPSS</td>
<td>r</td>
<td>0.181</td>
<td>0.290</td>
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<tr>
<td>Family</td>
<td>p</td>
<td>0.173</td>
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<tr>
<td>RA-MSPSS</td>
<td>r</td>
<td>0.367</td>
<td>0.392</td>
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</tr>
<tr>
<td>Friend</td>
<td>p</td>
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<tr>
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<td>0.310</td>
<td>0.310</td>
<td>0.329</td>
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<tr>
<td>Significant others</td>
<td>p</td>
<td>0.018</td>
<td>0.018</td>
<td>0.017</td>
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<tr>
<td>RA-MSPSS</td>
<td>r</td>
<td>0.334</td>
<td>0.366</td>
<td>0.350</td>
</tr>
<tr>
<td>Total</td>
<td>p</td>
<td>0.010</td>
<td>0.005</td>
<td>0.007</td>
</tr>
<tr>
<td>Total</td>
<td>p</td>
<td>0.144</td>
<td>0.251</td>
<td>0.003</td>
</tr>
<tr>
<td>Total</td>
<td>p</td>
<td>0.320</td>
<td>0.279</td>
<td>0.519</td>
</tr>
</tbody>
</table>

Disclosure of Interests: None declared

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