Background: Intestinal lung disease (ILD) can be the first manifestation of connective tissue disease (CTD) and rheumatoid arthritis (RA). Pulmonologists are usually the first referral in these patients.

Objectives: To determine: 1) the prevalence of ILD as initial manifestation of CTD or RA 2) clinical characteristics of such patients.

Methods: From a database of consecutive patients with CTD or RA referred to our academic hospital from 2009 and 2017, we selected all the patients with ILD as initial manifestation of the disease. Periodic multidisciplinary evaluations were performed during a median follow-up of 48 (35-50) months.

Results: 1) Fifty-four of the 427 patients with CTD or RA (12.6%) had ILD as initial manifestation (mean age: 63.9±12.9 yrs, F/M ratio: 20/34). Autoimmune myositis was diagnosed in 16/54 patients (29.6%), systemic sclerosis in 11 patients (20.4%), RA in 9 patients (16.7%), Sjogren syndrome in 9 patients (16.7%) and SLE in 3 patients (5.5%). Six patients remained classified as IPAF (11.1%). Among the Rheumatology patients we followed-up in the same period, autoimmune myositis had the highest prevalence of ILD as initial manifestation (36.5%), followed by Sjogren syndrome (20.5%), systemic sclerosis (20.5%), RA (3.4%), and SLE (3.3%). 2) Patients with initial ILD were all firstly evaluated by the Pulmonologist and the main reasons for Rheumatology referral were positivity for CTD and rheumatoid arthritis (RA). Pulmonologists are usually the first referral in these patients.

Conclusion: In our study population, the prevalence of ILD as initial manifestation of CTD or RA was 12.6%. Autoimmune myositis, systemic sclerosis and Sjogren syndrome were the most frequent diagnosis. As our data confirmed, ILD is a major cause of death in patients with systemic autoimmune diseases and can progress despite immunosuppressive drugs. Therefore, clinical features may become evident even months after the disease onset. A multidisciplinary evaluation is therefore essential, not only at the time of diagnosis but also during the follow-up [2].

References:

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HPR Interventions (educational, physical, social and psychological)

PATIENT EDUCATION AND BASIC BODY AWARENESS THERAPY VERSUS PATIENT EDUCATION ONLY IN PATIENTS WITH HIP OSTEARTHRITIS: A RANDOMIZED CONTROLLED TRIAL.

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Background: Patients with hip osteoarthritis tend to develop stereotypes and energy demanding movement strategies with potential negative effects on disease progression and daily life functioning. A multi-perspective view on movement quality is applied in the physiotherapy modality Basic Body Awareness Therapy (BBAT), with its movement awareness learning pedagogy. BBAT has been found beneficial for functional movement quality, symptoms, and psychological aspects of health in patients with various long-lasting conditions.

Objectives: To investigate the short-term (6 months) effects of BBAT, added to Patient Education (PE) compared with PE only in patients with hip osteoarthritis.

Methods: A block-randomized controlled trial with 6 months follow-up was conducted. Patients were allocated to 3.5 hours of PE plus 12 weekly sessions of BBAT, each lasting 90 minutes (intervention group), or to PE only (comparison group). Primary outcomes: Numeric Rating Scale (NRS) for pain during walking and Hip Osteoarthritis Outcome Score, subscale Activities of Daily Life (HOOS A). Secondary outcomes included physical capacity tests: Chair test, Stairs test, six-minutes walking test (6MWT), movement quality evaluation: Body Awareness Rating Scale – Movement Quality and Experience (BARS-MOE), and self-reported measures: Activity level (UCLA), function (HOOS subscales P, S, SP, QL and Harris Hip Score (HHS), self-efficacy (Arthritis Self-Efficacy Scale, AES), and health (EuroQol, EQ-5D-5L). Patient Global Impression of Change (PGIC) on pain and function was registered at 6 months.

ANCOVA of change was used in intention-to-treat and per protocol analysis.

Results: 101 patients were included, average age 63 years, 80% female. There was no difference in change between the groups on the primary outcomes at 6 months. However, movement quality (BARS-MOE) improved more (p<0.001) in the intervention group, and the patients reported more improvement in pain (PGIC) than the comparison patients (p=0.031). In per protocol analysis, including 30 patients who attended at least 10 BBAT sessions, intervention patients had statistically significant better scores on self-efficacy (AES) pain, p=0.049, health (EQ5D VAS, p=0.037) and function (HHS, p=0.029) than the comparison patients.

Conclusion: Patients with hip osteoarthritis were not found by the primary outcome measures to improve more by BBAT added to PE than by PE alone. Movement quality improved, however, significantly more in the intervention group. With sufficient compliance to BBAT, significant more improvement in additional health indicators was demonstrated.

References:

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