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Background: Rheumatoid arthritis (RA) is a chronic immune mediated systemic disease known to affect multiple organs. It is known that cardiovascular disease accounts for nearly half the mortality among RA patients^{1,2,3}. Osteoarthritis (OA), on the other hand, is not an inflammatory arthritis. No prior study has compared the prevalence of cardiovascular disease (CVD) among these two groups of patients.

Objectives: The purpose of this study was to compare the prevalence of CVD among U.S. veterans with RA versus those with OA.

Methods: The study was conducted in a metropolitan Veterans Affairs Medical Center in the U.S. Information was collected from 125 consecutive patients with RA and 125 consecutive patients with OA as they presented to the clinic. Patient characteristics were noted as well as the presence of CVD and certain subgroups: Cardiac arrhythmias⁴, coronary artery disease (CAD), congestive heart failure (CHF), cerebrovascular accident (CVA), abdominal aortic aneurysm (AAA), peripheral vascular disease (PVD), deep vein thrombosis (DVT), pulmonary embolism (PE), or any other form of embolism. The chi square test and the mann-whitney test were used for statistical analyses.

Results: Patient characteristics did not differ between the two groups for age, race, smoking status, or for the presence of hypertension or diabetes. There were more women in the RA group. The OA group had a higher BMI and a higher prevalence of hyperlipidemia. RA patients compared to OA patients had a higher incidence of CVD as a whole (60% vs. 42%, $p < 0.004$) and of cardiac arrhythmias (33.6% vs. 13.6%, $p = 0.001$). There was no difference between the 2 groups for the incidence of CAD, CHF, CVA, AAA, PVD or DVT/PE. RA seropositive and seronegative patients did not differ in the prevalence of CVD. RA duration was not related to the increased prevalence of CVD. Among the cardiac arrhythmias, patients with RA had a higher prevalence of atrial fibrillation (19.2% vs. 8.8%, $p < 0.03$), and arrhythmias requiring pacemaker or defibrillator implant (12.8% vs. 4.0%, $p < 0.02$).

Conclusion: The findings of this study demonstrate that our patients with RA have a statistically higher prevalence of CVD compared to OA patients. Among the subgroups, RA patients had a higher prevalence of cardiac arrhythmias, specifically atrial fibrillation and arrhythmias requiring pacemaker or defibrillator implant.

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FRIDAY, 05 JUNE 2020

HPR Interventions (educational, physical, social and psychological)

FRI0644-HPR PATIENT EDUCATION AND BASIC BODY AWARENESS THERAPY VERSUS PATIENT EDUCATION ONLY IN PATIENTS WITH HIP OSTEOARTHRITIS: A RANDOMIZED CONTROLLED TRIAL.

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Background: Patients with hip osteoarthritis tend to develop stereotype 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-MQE), 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, ASES), and health (Euro-QoL, 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-MQE) 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 (ASES pain, $p = 0.049$), health (EQ5D5L 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.

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HPR Patients' perspectives, functioning and health (descriptive: qualitative or quantitative)

FRI0645-HPR QUALITY OF DUTCH KNEE OSTEOARTHRITIS CARE: THE PATIENT'S PERSPECTIVE

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Background: In the Netherlands over 1.2 million people have OA of which almost half have knee OA. Recently, several international and national guidelines and quality standards have been developed and adopted to improve the quality of knee OA care. Mapping the patient perspective is a valuable and important step to get insight into the current status of the quality of knee OA care and the uptake of the quality of care standards endorsed by current guidelines.

Objectives: To investigate the quality of knee osteoarthritis care from the patients' perspective in the Netherlands.

Methods: Members of a large observational prospective cohort (n=622), consisting of people clinically diagnosed or suspected with knee OA, were invited to complete an online survey. Besides demographic characteristics participants were inquired whether they contacted a health care professional(s) in the last year for their knee OA and, to fill in a slightly adapted version of the "OsteoArthritis Quality Indicator (OA-QI) questionnaire. In addition, participants rated the quality of knee osteoarthritis care in the Netherlands on a 10-point scale (1: very poor - 10: excellent), and were invited to make recommendations for knee OA healthcare improvement via open-ended questions.