Methods: Retrospective review of patients seen between July 2018 and July 2019 at Purley Memorial Hospital, covering a large urban borough. Patients included in the study had prevalent moderate and severe VFFs (defined by Ghent criteria).

Results: 84 patients were included, of which there were 71 females and 13 males. Median age was 76 (IQR 67 – 82) and BMI was 25 (IQR 21 – 27), with 6% of patients noted to be underweight (BMI <18.5). 38% of patients had a family history of osteoporosis and 21% of patients reported a history of parental hip fracture. 21% of patients had experienced recurrent falls. Over half (56%) of cases were noted to have had 2 or more previous fragility fractures. Of the female cohort, 24% had early menopause, 13% were nulliparous and 1% had late menarche. Of the modifiable risk factors, alcohol (24%), sedentary lifestyle (21%) and smoking (13%) were the most common. Thyroid disease (18%) was the most common medical condition associated, followed by coeliac/malabsorption (7%), endocrinopathy (6%) and COPD (6%). Proton Pump Inhibitors (PPIs) and steroids were the most common medications associated with 16% and 14% of cases respectively. 73% of patients had good calcium intake and 62% had calcium supplements. Overall, 27 patients had 3 or fewer risk factors, 35 patients had 4 to 6 risk factors, 19 had 7 to 9 risk factors, and 3 had greater than 10 risk factors.

Conclusion: Our study identified several risk factors and their prevalence. The majority of patients were female, of which 24% had early menopause. Several modifiable risk factors such as low BMI, alcohol, smoking and sedentary lifestyle, were commonly seen, emphasizing the need to identify these risk factors in the initial consultation. Over half of patients (56%) had had 2 or more previous non-VFFs, suggesting the need to screen for VFFs in patients with multiple fragility fractures at baseline assessment. A number of co-existing medical conditions were also observed with thyroid disease being the most prevalent. PPIs and steroids were the most common medications associated with 16% and 14% of cases respectively. 73% of patients had good calcium intake and 62% had calcium supplements. Overall, 27 patients had 3 or fewer risk factors, 35 patients had 4 to 6 risk factors, 19 had 7 to 9 risk factors, and 3 had greater than 10 risk factors.

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References:
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AB0618 GLUCOCORTICOID INDUCED OSTEOPOROSIS PREVENTION IN THE OUTPATIENT RHEUMATOLOGY CLINIC

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Background: Patients with rheumatic disease are at risk of developing glucocorticoid induced osteoporosis (GIOP) as many are prescribed systemic oral glucocorticoids as an adjunct to their maintenance therapy. Based on the 2017 ACR Guideline for the Prevention and Treatment of Glucocorticoid-Induced Osteoporosis, a good practice recommendation exists that “initial clinical fracture risk assessment should be performed as soon as possible, but at least within six months of the initiation of long term glucocorticoid treatment.” Long-term glucocorticoid use is defined by duration of 3 months or greater. Fracture risk assessment should include dual energy-ray absorptiometry (DEXA) scan. Patients on greater than or equal to 2.5 mg of prednisone should be treated with an optimal dose of calcium and vitamin D and may benefit from oral bisphosphonate as primary prevention against GIOP if their fracture risk is moderate to high.

Objectives: The aim of this Quality Improvement Project is to assess the current status of provider implementation of GIOP recommendations in the rheumatology clinic. Ultimate goal is to improve osteoporosis prevention in the rheumatology clinic.

Methods: We conducted a retrospective chart review of 60 patients in two outpatient rheumatology clinics. Clinic 1 follows patients with lower socioeconomic status and Clinic 2 follows patients with higher socioeconomics. Inclusion criteria were patients on long-term glucocorticoid use, defined as at least 3 months of corticosteroid use in at least 2.5 mg prednisolone daily, as well as age less than 65. Females aged 65 or older were omitted to prevent overlap of the United States Preventative Taskforce recommendation for all women ≥ 65 years to be screened for osteoporosis with DEXA scans. DEXA scan orders, calcium and vitamin D prescriptions, and osteoporosis medication prescriptions were abstracted. After baseline data obtained, intervention of the educational program was performed in both clinics of 19.7% and 13.3% in Clinics 1 and 2 respectfully after the second audit cycle.

Results: Upon completion of second audit cycle, there was no change in percentage of DEXA scan orders at Clinic 1, however there was a 10% overall improvement in DEXA scan orders in the Clinic 2. In terms of Calcium and Vitamin D prescriptions, there was an overall improvement in both clinics of 19.7% and 13.3% in Clinics 1 and 2 respectively after the second audit cycle.

Additionally, there was a 3.4% increase in osteoporosis medication prescriptions overall subsequent to the second audit cycle in Clinic 1. However in Clinic 2 there was an overall decrease in osteoporosis medication prescriptions of 6.6%.

Conclusion: Overall, the results of the intervention were strongest for improvements in Vitamin D and Calcium orders in both clinics. Improvements in DEXA scan orders and osteoporosis medications were present in Clinic 2 and not present in Clinic 1. This reveals continued efforts and education of providers needed to be made for improvement in bone health monitoring.

References: