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Background: Although most of the patients after total knee replacement (TKA) report very satisfied outcome scores, there is still a significant proportion of patients that experience persistent knee pain, functional disability or dissatisfaction after TKA because of osteoarthritis (OA). It is difficult to quantify the proportion of patients with poor response to TKA, as different definitions on failure are being used (1). Additionally, patients and surgeons only agree in 36% on failure of total joint replacement (TJR) (2). This may be caused by different perceptions about concepts underlying poor response to TKA.

Objectives: To explore if patients and knee specialists have different views about relevant concepts reflecting poor response to primary TKA.

Methods: A qualitative, multicentre study was performed using semi-structured interviews in Belgium and in the Netherlands. Purposive sampling was used to enrich data variation. Twenty-five patients with knee OA without surgical indications (N=2), pre- and postoperative patients (N=11 and N=12, respectively) and fifteen knee specialists (orthopedic surgeons (N=9), physician assistants (N=1), nurse practitioners (N=1) and specialized physiotherapists (N=4)) were interviewed individually. Conversations were audiotaped, transcribed verbatim, and analysed using a thematic analysis.

Results: Concepts underlying poor response to TKA were: persistent pain, limited knee function, limitations in physical functioning, complications, unmet expectations, unexpected sequelae and dissatisfaction (Figure 1). The concepts persistent pain, limited knee functioning, complications and limited physical functioning were found to underlie expectations and/or unexpected sequelae after TKA. Dissatisfaction was considered a overarching concept resulting from unmet expectations and/or unexpected sequelae after TKA (e.g. long-term use of pain medication, continuous awareness of the prosthesis). All seven concepts were identified by both patients and knee specialists although poor knee function was more often described by patients in terms of prosthesis awareness, whereas knee specialists described poor knee function in terms of instability.

Conclusion: Patients and knee specialists identified similar concepts as relevant concepts reflecting poor response to TKA. These results will be used to formulate a uniform definition of poor response to TKA.

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Figure 1. Relevant concepts reflecting poor response to TKA according to the patients' and knee specialists perspectives. Concepts in solid gray were relevant to both, prosthesis awareness was relevant to patients and instability was identified as important outcome by knee specialists.

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POS0273-HPR PHARMACIST'S IMPACT ON SELF-MANAGEMENT FOR PATIENTS WITH CHRONIC INFLAMMATORY ARTHRITIS TREATED WITH BIOLOGICAL DMARDS

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Background: Knowledge about chronic inflammatory rheumatic diseases and skills to administer and manage subcutaneous (subcut) biological DMARDs (bDMARDs) are key aspects to optimize patient's self-management. Intervention of several successive health professionals (e.g. comprehensive multidisciplinary team) has proven to be an effective method to improve patient's self-management of their disease and treatment.

Objectives: To assess the pharmacist's impact on patient's knowledge and skills during a multidisciplinary annual review. The secondary objectives were to assess this impact on therapeutic adherence and patient's satisfaction as well as to determine the factors associated with the level of knowledge at baseline.

Methods: Study type: prospective, monocentric, 6 months-follow-up, non-controlled study approved by Local Ethical Committee. Inclusion criteria: patient with either rheumatoid arthritis (RA) or spondyloarthritis (SpA), and treated with subcut bDMARDs. Intervention: The visit with a pharmacist evaluating and discussing patient's knowledge and treatment adherence. At baseline (M0): date of the visit and, 3 (M3) and 6 months (M6) later, knowledge and adherence were assessed using self-administered questionnaires: Biosecure and CQR-5 respectively. A questionnaire was sent at M3 in order to evaluate the patient satisfaction. Endpoints: Primary: Changes in Biosecure score Secondary: Percentage of patients with high level of knowledge (score > 84) and percentage of patients with high adherence at M3 and M6; patient's satisfaction; identification of patient's factors (socio-demographics, rheumatic disease treatments) associated with different levels of knowledge at baseline.

Statistical analysis: repeated measures ANOVA, Bonferroni and Generalized Estimating Equation, univariate and multivariate linear regression.

Results: The study was conducted from October 2019 to July 2020; 79 patients were included (age (years) = 50±15; sex ratio = 1.1; RA=25, SpA=54). The Biosecure scores changed from 71±18 to 82±15 (M3) and to 84±14 (M6) (p<0.001). At M0, M3 and M6, the rate of patients with a high level of knowledge was 24.1%, 59.5% and 63.3% respectively (p<0.001). No difference was observed for the change in the 92% of patients considered as high adherent (92% versus 95% at M0 and M6 respectively; p=0.077). Patient's satisfaction regarding the pharmaceutical intervention was 25±3 (max = 28).

Factors associated with a better Biosecure score in the multivariate analysis were the following, lifestyle as a couple (p<0.001), information given by a nurse (p=0.033), information searched for on patient associations (p=0.013) and a low Charlson score (p=0.001)

Conclusion: Pharmacist's intervention in the comprehensive multidisciplinary annual review resulted in a beneficial impact on patients' knowledge and skills to manage their bDMARDs with a high level of satisfaction from a patient perspective.

Disclosure of Interests: None declared

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POS0274-HPR BARRIERS TO PHYSICAL ACTIVITY COLLECTED BY THE IFAB QUESTIONNAIRE CORRELATE WITH LEVELS OF PHYSICAL ACTIVITY IN PATIENTS WITH RHEUMATOID ARTHRITIS OR SPONDYLOARTHRITIS: A CROSS-SECTIONAL STUDY OF 150 PATIENTS

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Background: Physical activity is important for patients with inflammatory arthritis (IA), such as spondyloarthritis (axSpA), rheumatoid arthritis (RA) or psoriatic arthritis (PsA). They are more prone to physical inactivity but derive specific benefits from regular physical activity (1,2). It is not easy to modify physical activity level (3). Barriers and facilitators to physical activity can be assessed through questionnaires (4), however, it is important to demonstrate a link between these explanatory elements and physical activity levels.

Objectives: To measure the correlation between barriers and facilitators to physical activity, assessed through a simple questionnaire, and self-reported physical activity levels.

Methods: This was an international, multicentric, cross-sectional study performed between October 2019 and June 2020 (ClinicalTrials NCT04426747). Consecutive patients were included if they had definite axSpA, RA or PsA, were aged above 18 and able to walk. Barriers and facilitators to physical activity were measured using the 10-item Inflammatory arthritis Facilitators and barriers questionnaire (IFAB) (5). The IFAB ranges -70 to 70 with lower scores indicating more barriers; scores below -5 correspond to significant barriers. Physical activity was measured by the IPAQ-S questionnaire (6). Exploratory analyses used steps per day collected by smart-phone, and psychological readiness to change by stages of behavior change. Statistical analysis used Spearman correlation (ρ , $p < 0.05$), Student T test or multivariate analysis using R version 3.5.1. There was no imputation of missing data.

Results: Of 245 patients included, 150 had analysable data (69 (46%) axSpA, 63 (42%) RA, 18 (12%) PsA). Mean age was 48.6 years (SD 17.1), mean disease duration 11.7 (10.1) years and 60% were women. The mean score of barriers and facilitators to physical activity was 6.0 (SD 19.2, median 4) (Figure 1). A total of 39 (26%) patients scored less than -5, which could justify a targeted intervention. The mean physical activity was 2837 (SD 2668, median 1784) Metabolic Equivalent of Task min per week. Physical activity was correlated with score of barriers and facilitators to physical activity in linear regression (ρ 0.28, $p < 0.001$), as well as the stage of behavior change regarding active lifestyle (ρ 0.35, $p < 0.001$). No correlation was observed with steps per day (Table 1)

Conclusion: Perceived barriers and facilitators to physical activity are correlated with physical activity. Targeting patients with high barriers and low facilitators to physical activity could be an effective option to improve physical activity levels.

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Table 1 for abstract: correlation between IFAB questionnaire, each items and level of physical activity with or without extreme values

Item	Correlation with IPAQ-S min/met/week, ρ	Correlation with stage of behavior change, ρ	Correlation with mean steps per day, ρ
Total IFAB score	0.28 ***	0.35 ***	0.08
Item 1	0.29 ***	0.16 *	0.16 *
Item 2	0.06	0.02	0.05
Item 3	0.08	0.16 *	0.01
Item 4	0.13	0.09	-0.07
Item 5	-0.09	0.10	0.07
Item 6	0.22 **	0.25 ***	-0.05
Item 7	0.22 **	0.20 **	0.12
Item 8	0.16 *	0.26 ***	0.11
Item 9	0.15	0.33 ***	0.11
Item 10	0.09	0.17 *	0.02
Social support questions	0.14	0.27 ***	-0.03
Psychological and knowledge status questions	0.22 **	0.16 *	0.09

*= $P < 0.05$, **= $p < 0.01$, ***= $p < 0.001$

Figure 1. Distribution of the IFAB scoreFootnote: Y axis: effectifs, X axis: IFAB score (possible values from -70 to 70)

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POS0275-HPR CONCORDANCE BETWEEN THE PHYSICIAN'S AND THE NURSE'S ASSESSMENT OF DISEASE ACTIVITY IN RHEUMATOID ARTHRITIS USING DAS-28, CDAI AND SDAI IN SEVEN MIDDLE EASTERN ARAB COUNTRIES

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Background: Managing patients with chronic rheumatic diseases is increasingly relying on the collaboration of a multidisciplinary team, including the rheumatology nurse who can aid assessment of disease activity among other healthcare tasks.

However, this practice, although common in Europe and North America, is still poorly implemented in the Middle eastern Arab countries (MEAC).

Objectives: To evaluate the concordance between the physician's and the nurse's assessment of disease activity in patients with rheumatoid arthritis (RA) in the MEAC.

Methods: During a routine patient visit to one of 9 rheumatology clinics located in 7 Middle Eastern Arab countries, the physician and the rheumatology nurse (who was already working in the clinic) performed the disease activity score 28 (DAS), Clinical Disease Activity Index (CDAI) and Simple Disease Activity Index (SDAI) in a blinded manner. The concordance regarding the 3 continuous scores was calculated using paired t-test. The agreement between physician- and nurse-DAS categories (remission, low, moderate and high disease activity) was calculated using weighted kappa for category comparison. Predictive factors of positive concordance between physician- and nurse-DAS were identified using binary logistic regression.

Results: The study included 373 patients' measurements over a period of two years (2018 to 2019). The mean age of the patients was 49.6 years (± 28.2), 82.6% were females, and the mean disease duration was 11.3 years (± 7.5).

The mean physician-DAS was slightly higher (3.97 (± 1.52)) than the nurse-DAS (3.90 (± 1.54)) ($p = 0.002$), with a mean difference of +0.08 [95%CI 0.03; 0.12] (Table 1). The difference in the DAS individual items, the CDAI and the SDAI were not statistically significant.

When analyzing DAS as a categorical 4-items variable, the agreement between the physician and the nurse was present in 79.36% of the cases (weighted kappa was 0.77 [95%CI 0.73; 0.83] which is considered as excellent, and was higher in patients with high disease activity (Figure 1).

A positive concordance between the physician- and the nurse-DAS was associated with the country (higher in Egypt, $p < 0.001$) and the status of higher disease activity ($p < 0.001$).

Conclusion: The agreement between the DAS-28 performed by the physician and by the nurse was excellent and was associated with the country and a higher disease activity. The present study confirms that the support of a trained nurse for evaluating disease activity in RA is feasible in the Arab countries and may save some valuable time in the clinic, whilst maintaining the quality of care for patients with RA.