Conclusion: Our data suggests that a MDC for RD-ILD results in a more thorough investigation and treatment, and this will likely lead to improvements in patient outcomes. Based on these findings, our rheumatology group is seeking internal funding for a pilot clinic evaluating prospectively the benefits of an ILD MDC.

REFERENCES:

Disclosure of Interests: None declared

AB1560-HPR NURSE-DRIVEN DIAGNOSTIC PROCESS OF PATIENTS WITH SJÖGREN’S SYNDROME (SS) A CLINICAL DEVELOPMENT PROJECT
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Background: Sjögren’s Syndrome (SS) is a chronic autoimmune disease that affects the body’s glandular functions, especially the lacrimal and salivary glands, causing the mucous membranes to dry out. There are no diagnostics criteria, and classification criteria are often used to support the diagnosis.

Methods: We identified a need to unify and consolidate the diagnostic process of patients with SS in the Capital Region of Denmark. A medical working group supervised the nurse-driven diagnostic process at Rigshospitalet, Glostrup. Here an interdisciplinary working group with physicians, nurses, and specialists developed a diagnostic process and logistic based on the American-European Consensus Group Classification Criteria 2002 (3). The nurse’s took medical history and performed sicca tests and made sure that the patient received adequate guidance. With input from three patients, the nurses at the outpatient clinic developed - written material on eye and mouth dryness. We developed a “smart phrase” for our documentation platform in the nurses at the outpatient clinic developed - written material on eye and mouth dryness. We developed a “smart phrase” for our documentation platform in the nurses at the outpatient clinic developed - written material on eye and mouth dryness. Also, the nurse had the opportunity to guide in oral hygiene, fatigue, and lifestyle factors.

The next step in our development project is to evaluate our revised nurse-led diagnostic process. In addition, the working group is currently working on material for a course in SS, where 4-6 patients and relatives can have the opportunity to participate.

REFERENCES:

Acknowledgements: I would like to thank the patients for the contribution to this project.

Disclosure of Interests: None declared

AB1561-HPR PHYSIOTHERAPY FOR RHEUMATOID ARTHRITIS (RA) – PAST, PRESENT AND A POSSIBLE FUTURE?
M. Mengshoel,1 University of Oslo, Department of Interdisciplinary Health Sciences, Oslo, Norway

Background: Physiotherapy has a long tradition providing services to patients with RA. The main aim of physiotherapy is to improve patients’ abilities to perform movements and physical activities through exercises and educating patients in self-management skills. For physiotherapy to proceed into future, it seems relevant to examine what shifts occurred in physiotherapy over time and why did they happen.

Objectives: Is to unpack the shifts in physiotherapy for patients with RA from 1980 until today.

Methods: Norwegian physiotherapy in rheumatology is used as case. The shifts are identified with help of literature about history of medicine and physiotherapy in rheumatology and empirical physiotherapy research since the 1980s. The author draws on own experiences first as a clinician and practice teacher for physiotherapy students in rheumatology, and later as a scientist and advisor for a multidisciplinary team in rheumatology.

Results: Physiotherapy focuses on movement and function, which over time have consistently been understood in relationship to disease-induced alterations and biomechanics. Shifts in physiotherapists’ remedial exercises have occurred over time as better disease control occurred and evidence showed that physical exercises and exercise programmes had disease modifying effects and improved patients’ functional capacity. In the 1980s, a move from earlier passive, joint protective movements with little weight load to cautious weight-bearing movements occurred, mostly as a response to improved disease-modifying drugs and joint surgery. In the 1990s, physiotherapy shifted from cautious weight-bearing movements to safely performed physical activity as a response to scientific findings showing beneficial effects on radiological, immunological, and physical function measures. In the 21st century, RA is identified earlier and increasing number of patients reach disease remission before irreversible occurs in the musculoskeletal system. Presently, a new shift in Norwegian physiotherapy is on the way. Adherence to EULAR guidelines 2018 on physical activity is moving physiotherapy from promoting exercises through engagement in self-determined physical activities into educating patients in performing structured intensive physical fitness training programmes for preventing future comorbidities.

Conclusion: At the moment, it is a dilemma that the raising rate of patients successfully treated to disease remission is not accompanied with more patients remaining in volitional work in Norway. Thus, there is a need in physiotherapy to critically scrutinize the meaning and significance of movements and functioning for the individual patient’s own life purpose and the society’s wish that people stay in paid work.

REFERENCES:

Disclosure of Interests: None declared

AB1562-HPR COMPARING THE PROVISION OF SUBCUTANEOUS METHOTREXATE BETWEEN HOMECARE AND OUTPATIENT PHARMACY: WHAT DO PATIENTS PREFER AND IS ONE ROUTE QUICKER?
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Using a mail-out questionnaire, 236 patients were identified from a database of patients who had received SC MTX between homecare and outpatient pharmacy. Patients were asked which route they preferred and how quickly they received their medication. The next step was to enrol patients to randomise them to either homecare or outpatient pharmacy.
Background: The provision of subcutaneous methotrexate has historically been through homecare who provide injection training and delivery. In July 2018, subcutaneous methotrexate was accepted for shared care in the Trust’s locality to reduce medication costs but to also improve safety, reducing the risk of concomitant trimethoprim prescribing. When suitable for shared care, initial injection training is provided by outpatient pharmacists and prescribing and monitoring during the stabilisation period is the responsibility of the rheumatology pharmacy team.

Objectives: The primary aim of this audit was to compare patient satisfaction between these two different routes of injection training and prescription provision. Additionally, the time it took for a patient to receive their first dose following a decision to start treatment, was also compared.

Methods: Patients were identified from databases held within the department, contacted retrospectively via telephone and asked to complete a short questionnaire. Clinic letters and the homecare company provided dates of treatment decision and initiation. Results: 40 patients were contacted, 20 had received treatment via outpatient pharmacy and 20 via homecare.

Table 1. Patient reported satisfaction following receipt of injection training and prescription provision via outpatient pharmacy and homecare

<table>
<thead>
<tr>
<th></th>
<th>Not satisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
<th>Not satisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time taken to start treatment</td>
<td>2</td>
<td>5</td>
<td>13</td>
<td>2</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Injection training</td>
<td>0</td>
<td>4</td>
<td>16</td>
<td>3</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Method for delivery of injection training and initial prescription</td>
<td>1</td>
<td>8</td>
<td>11</td>
<td>3</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Process of receiving repeat prescriptions</td>
<td>1</td>
<td>4</td>
<td>15</td>
<td>1</td>
<td>3</td>
<td>16</td>
</tr>
</tbody>
</table>

The mean time taken to start treatment was 30 days in the homecare group and 13 days in the outpatient group. 7 patients (35%) within the outpatient group started treatment within 7 days. The shortest time within the homecare group was 15 days (3 patients).

Conclusion: Reported patient satisfaction between the two routes of treatment provision was similar. Patients commenced treatment significantly quicker via outpatient pharmacy, reporting a high degree of satisfaction with the injection training provided by outpatient pharmacists. This audit has confirmed that shared care provision of methotrexate initially via outpatient pharmacy is a safe, efficient and viable option.


HPR Professional education, training and competencies

AB1563-HPR TRAINING AND ASSESSMENT OF MUSCULOSKELETAL ULTRASOUND AND INJECTION SKILLS - A SYSTEMATIC REVIEW

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Background: The importance of international harmonization regarding education of rheumatologists in musculoskeletal ultrasound (MSUS) and injection skills have been highlighted in several studies, including the need for standardized training programs containing competency-based education using validated assessment tools [1-2].

Objectives: To examine how residents are trained and assessed in MSUS, MSUS-guided and landmark-guided joint aspiration and injection. Additionally, to present the available assessment tools and examine their supporting validity evidence.

Methods: A systematic search of PubMed, Cochrane Library, and Embase was conducted in accordance with the PRISMA guidelines and studies published from January 1, 2000 to May 31, 2021 were included. Two independent reviewers performed the search and data extraction. The studies were evaluated using the Medical Education Research Quality Instrument (MERSQI).

Results: 9,884 articles were screened and 43 were included; 3 randomized studies, 21 pre- and post-test studies, 16 descriptive studies (Table 1), and 3 studies developing assessment tools. The studies used various theoretical training modalities e.g. lectures, anatomical quizzes, and e-learning. The practical training models varied from mannequins and cadavers to healthy volunteers and patients. Most studies used subjective “comfort level” as assessment, others used practical examination and/or theoretical examination. All training programs increased trainees’ self-confidence, theoretical knowledge, and/or practical performance, however few used validated assessment tools to measure the effect. Only one study met the MERSQI high methodical quality cut-off score of 14.

Table 1. Description of included studies examining training of MSUS, MSUS-guided or landmark-guided joint aspiration and injection skills.

<table>
<thead>
<tr>
<th>Study characteristics</th>
<th>MSUS</th>
<th>MSUS-guided</th>
<th>Landmark-guided</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of studies6</td>
<td>14</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Study design</td>
<td>0</td>
<td>0</td>
<td>3</td>
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<td>Randomized</td>
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<td>2</td>
<td>17</td>
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<tr>
<td>Pre- and post-test Descriptive</td>
<td>12</td>
<td>1</td>
<td>3</td>
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<tr>
<td>Participants6</td>
<td>408</td>
<td>38</td>
<td>1388</td>
</tr>
<tr>
<td>Residents</td>
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<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Experts</td>
<td>-</td>
<td>149</td>
<td>149</td>
</tr>
<tr>
<td>Medical students</td>
<td>-</td>
<td>-</td>
<td>149</td>
</tr>
<tr>
<td>Others</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Assessment6</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Objective</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Practical</td>
<td>2</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Theoretical</td>
<td>5</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Subjective Questionnaire Mixed</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>MERSQI6</td>
<td>9.2</td>
<td>7.5</td>
<td>8.9</td>
</tr>
</tbody>
</table>

Legend: 5 Studies developing assessment tools are not included in this table. 6 Accumulated number of participants enrolled in the studies. 7 Number of studies. 8 Mean score using the Medical Education Research Study Quality Instrument, maximum score =78.

Conclusion: The included studies were heterogeneous, and most were of poor methodological quality and not based on contemporary educational theories. This review highlights the need for educational studies using validated theoretical and practical assessment tools to ensure optimal MSUS training and assessment in rheumatology.

REFERENCES:


Acknowledgements: We thank Tove Margit Svendsen, research librarian at the Medical library at Rigshospitalet Denmark, for her assistance with developing the search string for the systematic review.

Disclosure of Interests: None declared


AB1564-HPR ULTRASOUND EXAMINATION AND INTRA-ARTICULAR INJECTIONS BY A RHEUMATOLOGY NURSE SPECIALIST.

A. Brink Walling1, A University Hospital Svendborg Hospital, Rheumatology, Svendborg, Denmark

Background: At The Department of Medicine, section of Rheumatology, Odense University Hospital (OUH) Svendborg, we consult patients with rheumatoid arthritis, psoriatic arthritis and gout. The patients can have joint inflammation. Therefor need joint assessment by ultrasound, arthrocentesis and / or IA injection. Ultrasound examination, arthrocentesis and administration of intra-articular (IA) injections for rheumatic disease represent an expansion of the nurse’s role.