activity promotes recruitment through normalising the experience of research participation.
Objectives: To evaluate a programme promoting local research through a poster campaign in musculoskeletal clinic waiting areas. To measure differences in awareness of local research before and after the poster campaign.
Methods: 8 posters were developed collaboratively by clinical staff, research staff and patient representatives for display in musculoskeletal clinic waiting areas in a large UK teaching hospital. Each poster briefly describes the findings and potential impact of a study carried out locally. A questionnaire measuring awareness of local research was given to consecutive patients and relatives/friends/carers (aged 16+) entering the clinics on 6 dates and times before and 6 months after introduction of the posters. Responses were analysed adjusting for age and gender using ordinal logistic regression, with the SAS JMP Statistical Visualization System.
Results: The response rate was 92% (n=156/170). A majority of respondents were aged 50–69y (43%, n=56), with all other age groups (16–29, 30–49 and 70+) represented. 56% (n=88) of respondents were female and 74% (n=116) were patients. There were no significant differences in awareness of local research before and after the poster campaign ($p>0.20$ in all cases). 6 months after introduction of the posters, only 24% of people reported seeing the posters. There were, however, some differences in awareness of local research for those respondents who had seen the posters. This group were significantly more likely to agree with the statement 'Research is going on at this hospital to understand arthritis and develop new treatments' ($p<0.001$).
Conclusions: The poster campaign failed to increase awareness of local research amongst people using musculoskeletal clinic waiting areas. This was despite significant input to design and content by patient research partners and high approval of final drafts by this group. Few people reported seeing the posters, which may be due to the high volume of competing posters on display. This concurs with existing data that people fail to see and be influenced by posters in clinic waiting areas (1). Those people who had seen the posters were significantly more aware of local research, which may be due to the impact of the poster. Another explanation is that people already aware of local research disproportionately noticed and remembered the posters. To increase the success of a research awareness campaign, tools should be developed and tested with their target audience (i.e. patients not aware of or involved in research) in addition to patients already actively involved.
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AB1077-HPR FIBROMYALGIA SYNDROME: NURSE CASE MANAGEMENT FOR A STRUCTURED PATIENT PATHWAY

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Background: Fibromyalgia Syndrome (FMS) is a common, potentially disabling, chronic disorder that is defined by widespread pain, often accompanied by fatigue and sleep disturbance, cognitive and somatic symptoms. Fibromyalgia continues to present a challenge for healthcare professionals (HCPs) because of the lack of a clear patient pathway. Nurses' role need to be better defined.
Objectives: Our aim is to investigate the presence of correlations between clinical and clinimetric parameters and Fibromyalgia Scale (FS) assessed by 2011 ACR criteria, in order to define which parameters should have priority in the construction of a care plan for FMS patients, as well as outline a role for nurses specifically designed for FMS patients.
Methods: 168 patients (155 women and 13 men; age MEAN±DS 54.50 ± 12.32) were evaluated for clinical and demographic parameters: age, sex, disease duration, year of diagnosis and latency of the disease. They were assessed by FS, which is divided into Wide Pain Index and Symptoms Score, and gives a total score of severity (FS with range 0–31 and cut off $\geq$13). They were also assessed for pain and sleep (Numeric Rating Scale Pain and NRS Sleep), Regional Pain Scale (RPS), disability (Fibromyalgia Impact Questionnaire and Health Assessment Questionnaire), mood disorders (Hospital Anxiety and Depression Scale), sleep quality (Numeric Rating Scale Sleep), fatigue (Functional Assessment of Chronic Illness Therapy- Fatigue) and quality of life (Short Form-36).
Results: FS is significantly and positively correlated with HADS-D for depression, HADS-A anxiety, NRS for pain, FIQ, HAQ and FACIT-F ($p<0.01$) and Tender-Points ($p<0.05$), it is also significantly and negatively correlated with the NRS for sleep quality, SF 36 all subscales, and ISF (p: <0.05) and ISM (p: <0.01). At linear regression model, FS is significantly and independently associated with RPS, FACIT-F and with SF_36_RE, that together explain the variability of FS in 96% (88.7%; 5.4%;1.9% respectively).
Conclusions: It would be desirable, therefore, the use of FS scale in everyday clinical practice, thus allowing nurses to assess FMS patients and plan their clinical and therapeutic pathway, together with the rheumatologist. Our results confirm that important aspects to be treated in FMS patients are quality of life, pain and fatigue, they are considered as independent predictors for FS. Thus, they explain 96% of FS score variability. In this context nurses' role is crucial since FMS most common symptoms seem to be adequately treated with a multimodal and holistic approach and with interventions tailored to the individual. Thus, we propose a Case Manager Nurse (CMN) that should set up and coordinate a multidisciplinary approach aiming at improving FMS patients' QoL and self-perceived health status.
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AB1078-HPR TELEPHONE FOLLOW-UP, STANDARDIZED TO THE INITIATION OF BIOLOGIC THERAPY OF PATIENTS WITH RHEUMATOID ARTHRITIS (RA) IN A SPECIFIC UNIT OF BIOLOGIC THERAPY. PILOT STUDY

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Objectives: To know the usefulness of follow-up call legalized at the beginning of biologic therapy and patient contact with consultation of nursing after the start of treatment.
Methods: Observational study cross.Patients: We collected 120 patients who began treatment with biologic therapy, intravenous or subcutaneous from December 2013 to November 2015. Protocol: Protocol is education for self-management of subcutaneous biological therapy at the beginning of the treatment. This Protocol includes a follow-up call from the consultation of nursing that matches the first administration of the treatment at home or within 3–5 days after the first infusion. This call is made in the case of the biological subcutaneous as per guideline: etanercept (7 days), adalimumab (14 days), golimumab (28 days), tocilizumab (7days), certolizumab (14 days), abatacept (7days) either guideline prescribed in case of dose reduction. Offers the possibility of contact (telephone and e-mail) with the consultation of nurses in case of doubt or incidence during treatment and is analytical control to the month of the beginning of nurse telephone consultation. Statistical analysis: a descriptive analysis of the main variables.
Results: 120 patients with RA initiated treatments were: etanercept 33,3% (n40), adalimumab 8,3% (10), tocilizumab sc 20% (24), abatacept sc 12,5% (15), golimumab 13,3% (16), rituximab 6,7% (8), certolizumab pegol 3,3% (4), biosimilar 2,5% (3). In terms of the associated FAME: none 38,3% (46), methotrexate 49,2% (59), Leflunomide 8.3% (10), sulfasalazine 1,7% (2), hydroxychloroquine 2,5% (3).They were detected in the Protocol call patients with incidences 14,16% (17): local reaction3.3% (4), pruritus 5.8% (7), upset general 0.8% (1), diarrhea 0.8% (1), constipation 0.8% (1), headache 1.7% (2). The patients called the nursing consultation to communicate incidences 10.83% (13): anemia 0.8% (1), hypertransaminasemia 1,7% (2), implant dental 0.8% (1), bruising 0,8% (1), inefficiency 6.7% (8). Also communicated to the consultation of nursing infections during 16.6% (20): urinary tract infection 5,8% (7), upper respiratory tract infection 1,7% (2), upper respiratory tract infection+herpes simplex 0,8% (1), lower respiratory tract infection 3,3% (4), surgical wound infection 0.8% (1), dental infection 0,8% (1), herpes simplex 0,8% (1), gastroenteritis 0,8% (1), not frightening infection 1,7% (2).Patients who started biologic therapy in the period studied only 8.3% (10) changed treatment.The emergence of new comorbidities were detected during treatment with biologic therapy 4,16% (5): hypertension 0,8% (1), hypertension + diabetes mellitus II 1,7% (2), nonspecific Interstitial pneumonia 0,8% (1), psoriasis 0,8% (1).
Conclusions: The follow-up call is a useful tool for the control of security of the new beginnings of biological agents. It could foster adherence to treatment monitoring at home and offering the possibility to communicate with the nursing.
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