to 12 (4–27) mm after 1 month, after 1 year to 6 (2–20) mm and after 2 years VAS pain was 7 (2–23) mm; see figure for details. Mean (SD) SF-36 bodily pain at baseline was 40 (21), and increased after 12 months to 73 (23) and 24 months to 74 (24). At baseline less than 3% of the patients reported no pain, after 3/6/12/24 months this proportion increased to 27/32/41/41%, respectively. In the interval 12 to 24 months more than 87% of patients reported exclusively either no or mild pain.

Conclusions: In this cohort of early DMARD-naïve RA patients treated according to modern treatment strategies aiming for remission, there was a substantial and significant reduction of pain after 1 month. Pain levels decreased further during the first year, and this reduction was sustained during the first 2 years of follow-up. Early intervention and treating to target in this population fulfils the patients' prioritised goal of minimising pain, leading to a decreased burden of pain in RA.

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OP0194-HPR NURSING TRIAGE IN RHEUMATOLOGY: THREE MONTHS EXPERIENCE IN AN OUTPATIENT CLINIC OF THE UNIVERSITY OF FLORENCE (ITALY)

G. Piemonte[1], K. El Aoufi[2], F. Braschi[2], M. Poli[2], S. Guiducci[2], S. Bellando Randone[2], L. Rasero[1], M. Matucci Cerinic[2]. *[1]Clinical and Experimental Medicine; [2]Clinical and Experimental Medicine - Div. Rheumatology, University of Florence, Florence, Italy*

Background: At present patients with rheumatic diseases are mainly assisted in outpatient settings. In our centre more than 150 patients with SSc (Systemic Sclerosis) and more than 100 patients with SPA (Spondyloathritis) are treated monthly. Rheumatic diseases are chronic conditions associated with disability, reduced quality of life and emotional and social consequences. Nurses' role is crucial in improving rheumatic patients' global health providing educational support, promoting self-management and helping accessing appropriate services when needed.

Objectives: To describe nursing triage in rheumatology – A nurse led service focused in monitoring disease activity, symptoms and complications and providing educational and clinical support. Nursing triage takes place before rheumatologists' assessment. Period of observation: 1/12/2013 – 28/2/2014

Methods: All SSc and VEDOSS patients were evaluated for Raynaud Condition Score (RCS), sHAQ, SScQoL, HAMIS, Cochin, Borg, IIEF5. DUs and other skin lesions were assessed. All SPA patients were evaluated for MASES, BASMI, BASDAI, BASFI, swollen and tender joints, tender points and sacroiliac joint pain. BP, BMI were available for all patients. A severity index based on the previous tests' scorings was obtained both for SSc and SPA patients. Severity index for SSc/VEDOSS was based on DUs presence, sHAQ, HAMIS, Cochin, Borg, RCS and ranges between 0 and 7 (0=lowest severity; 7=highest severity). Severity index for SPA was based on all the previous evaluations and ranges between 0 and 10 (0= lowest severity; 10= highest severity).

Results: 264 patients were treated in SSc/VEDOSS outpatient clinic (51 VEDOSS, 71 SSc, 7 primary RP, 98 secondary RP whose diagnosis had to be confirmed). DUs occurred in 29,41% of SSc patients, in 4,08% of patients with secondary RP, no DUs were found in VEDOSS patients. DUs were significatively associated with global and hand impairment and with reduced QoL ($p<0,05$). In SSc patients severity index, RP severity, overall and hand disability were more severe than VEDOSS patients ($p<0,05$). SPA patients had a mean severity index of 3,85; ds 2,67. The overall disability was low (BASFI mean value 2,32; ds 2,56), the disease activity was high (BASDAI mean value=4,09; ds 2,62).

Conclusions: SSc and VEDOSS patients with severity index=0 and SPA patients with severity index$\leq$1 may be followed mainly by nursing staff with interventions based on lifestyle modifications and non-pharmaceutical therapies. Adequate protocols must be approved by rheumatologists staff. In this context a nurse led helpline may be effective to select the most appropriate site and level of care for acute conditions in rheumatic diseases.

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OP0195-HPR COMPARISON OF EDUCATIONAL MODELS FOR MAINTAINING OPTIMAL SAFETY IN THE SELF-MANAGEMENT OF BIOTHERAPY AMONGST RHEUMATOID ARTHRITIS AND SPONDYLOARTHRITIS PATIENTS

F. Fayet[1], M. Rodere[1], C. Savel[1], B. Pereira[2], M. Soubrier[1], M. Couderc[1]. *[1]Rheumatology; [2]Biostatistic Unit, Clermont Ferrand Universitary Hospital, Clermont-Ferrand, France*

Background: Biotherapies prescribed in patients with rheumatoid arthritis (RA) and spondyloarthritis (SpA) are associated with risks that patients must be aware of. Patient education offers them to learn how to manage such treatments on a day-to-day basis. In our department, patients can benefit from 3 different educational models: individual informational consultation (Model 1), individual consultations including the 4 recommended steps (educational diagnosis, objectives, education and assessment) (Model 2) and individual consultations with group workshops (Model 3).

Objectives: To assess which educational model appears the most appropriate for maintaining optimal safety in the self-management of biotherapy.

Methods: This is an observational, monocentric, retrospective study on routine care. All patients on biotherapy with at least one educational consultation between 2009 and 2013 were subsequently divided up according to the undergone educational model (Models 1, 2, or 3). During normal management, patients filled out the BIOSECURE questionnaire, meant to assess their theoretical and practical knowledge (clinical cases), prior to consultation with an education nurse. The overall BIOSECURE score, its theoretical and practical subsections, the different dimensions of the questionnaire and the behaviors in risk situations were compared based on the 3 models.

Results: In total, 222 patients were included (67% women, age 53.9 years, disease duration: 10 years, RA n=137, SpA n=77 and uncategorized rheumatism n=8, anti-TNF 89.6%, rituximab 3.2%, abatacept 3.6%, and tocilizumab 3.6%. As regards the educational model, 106 patients (47.8%) benefited from Model 1, 88 (39.6%) from Model 2, and 28 (12.6%) from Model 3.

The overall BIOSECURE score was 76.6/100 without any significant difference depending upon the educational model (Model 1: 75.1, Model 2: 76.7, Model 3: 81.8; p=0.07). The BIOSECURE score was significantly higher amongst women (p=0.007), young people ($p<0.001$), working patients (p=0.005), higher education degree holders ($p<0.001$), patients whose diagnosis was most recent (p=0.008), as well as patients on etanercept (p=0.04) and those on intravenous biotherapies (p=0.004). Model 3 patients displayed a significantly higher practical score (clinical cases) than Model 1 ($p<0.001$) and 2 (p=0.003) patients. There was also a significant difference in BIOSECURE score in favor of Model 3 in certain skill areas, such as "Patient behavior in case of fever" (p=0.03) and "Behavior when faced with injuries, prevention of infectious complications and vaccination" (p=0.03). In terms of the implementation of acquired knowledge in risk situations, 64.5% of patients displayed appropriate behavior in the event of signs of infection, 68% in the case of surgical intervention, and 65% in the event of dental avulsion, without anydifference depending upon the model.

Conclusions: The educational model involving group workshops showed no significant variation from the overall BIOSECURE score amongst patients treated with a biotherapy for RA or SpA when compared to the models based solely on individual consultations. However, patients having participated in group workshops exhibited improvement in practical scores and certain skill areas.

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OP0196-HPR DOSE REDUCTION OF BIOLOGIC DRUGS IN AXIAL SPONDYLOARTHRITIS IN CLINICAL PRACTICE

L. Van Rossen[1], C. Harris[2], R. Withrington[1], A. Keat[2]. *[1]East Kent Hospitals University Foundation Trust, Canterbury; [2]Northwick Park Hospital, Harrow, United Kingdom*

Background: The practice of reducing the dose of anti-TNF agents during the treatment of patients with axial spondyloarthritis (axSpA) is often applied in clinical practice; it is not unusual for patients with axSpA to reduce the dose of anti-TNF agents despite the lack of supporting evidence from clinical trials or real-world investigations. Reasons for dose reduction include patient preference (fewer injections or infusions when the patient feels well) and cost reduction. The 2010 update of the ASAS recommendations for the use of anti-TNF agents in patients with axSpA does not consider dose reduction, nor do the 2015 draft BSR guidelines on the topic of biologics in axSpA. However, limited studies have indicated positive results.[1–3] Real-life data regarding dose reduction are therefore valuable and may inform further studies, potentially enabling a rational approach to dosing in clinical practice to be adopted in the future.

Objectives: To report the results of anti-TNF dose reduction in axSpA patients attending rheumatology practices in the UK.

Methods: In this retrospective study in SpA clinics at two UK hospitals, patients with axSpA who met NICE response criteria after 12 weeks of anti-TNF treatment,[4] and remained stable for at least 6 months, were considered for dose reduction. Dose reduction could have been suggested by either patient or practitioner. Dose reduction decisions were made on an individual basis and implemented by extending the interval between anti-TNF administration, reducing the dose of