

VDI Score increased from the time of diagnosis till the time of last follow-up and this rise was statistically significant ( $p \leq 0.002$ ) in all groups. The mean VDI Score for the APS group at diagnosis was 4.86 and was significantly higher than for the aPL positive (mean VDI Score=2.02,  $p=0.0001$ ) and negative (1.93,  $p=0.0001$ ) groups. At last time of follow-up the mean VDI Score for the APS patients was 6.27 and this value was higher than for the aPL positive (mean VDI Score=3.51,  $p=0.0001$ ) and negative (2.96,  $p=0.0001$ ) groups (see Figure1). 9 (4.9%) patients died, 4 of whom were assessed for aPL: 2 had APS and 2 positive aPL.

**Conclusions:** APS is a predictor of irreversible organ damage in vasculitides. We suggest that determination of aPL is warranted in the diagnostic work-up of vasculitis patients.

### BHPR – audit/service delivery

#### 371. DO ALL PATIENTS WITH CHRONIC INFLAMMATORY ARTHRITIS IN DISTRESS NEED A DOCTOR?



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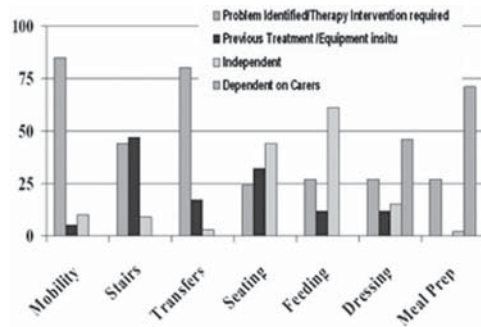
**Background:** The patient with chronic inflammatory arthritis can experience significant distress as their level of function declines and we struggle to manage their pain effectively. The burden of responsibility increases for carers as the patients independence is lost.

At clinic visits, the doctor is presented with a long complicated history, a distressed family, multifunctional problems and social care issues. Busy clinic settings often prevent detailed discussion of problems raised.

Our purpose as Clinical Specialists in Occupational therapy and Physiotherapy was to establish a rapid response therapy service to meet the needs of patients with chronic inflammatory arthritis in distress whilst they remain in their own home.

**Methods:** Referral criteria was formulated, patients were jointly assessed by a Specialist O.T. and P.T. favouring a social care model of practice within 4 weeks. A treatment plan was formulated, implemented and evaluated.

**Results:** 42 referrals received. F:M 36:6 aged 34-93, disease duration av 15.4 yrs 45% not on DMARDS. 0% employed 100% needed carer support 73% had accommodation that did not meet their needs. 34% required referrals to local agencies. 16.6% did need to see a doctor for review of medication. 17% needed a referral to other specialities but did not need to see a doctor. This graph displays functional problems identified and therapy intervention.



Summary of therapy intervention.

**Conclusions:** Predominantly patients with chronic inflammatory arthritis in distress did not present with medical problems. They focused on functional, social, emotional and housing issues. Our focus on treatment was to restore function, prevent falls, improve safety, gain pain control, liaise with community support networks and most importantly to address the patients/families concerns.

The service was cost effective in terms of reduced ambulance requests, clinic appointments, and hospital admissions.

94% patients were very satisfied and felt the service met their needs.

Common themes were identified enabling a guideline of therapy management of chronic inflammatory arthritis to emerge.

Evaluation of the rapid response therapy service has highlighted the diverse role specialist therapists can contribute. Limited time/resources make it crucial we identify the most appropriate professional to review the patient in the

most relevant setting. If these patients are to maintain maximum independence they do need a doctor but their need for highly skilled therapy staff is much greater.

#### 372. "I WANTED TO GIVE SOMETHING BACK": THE POSITIVE EFFECTS OF VOLUNTEERING AT A COMMUNITY-BASED ARTHRITIS RESOURCE CENTRE



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**Background:** Community-based arthritis resource centres provide information on a wide range of rheumatic conditions. Trained volunteers offer support, information and signposting to patients, their families and friends.

**Methods:** We sought to understand the impetus for volunteering and the perceived personal effects for the volunteers. Semi-structured interviews were conducted with four female trained volunteers, aged 45-77, at a community-based arthritis resource centre. All four volunteers have a rheumatic disease. Interviews were audio-recorded, transcribed verbatim and analysed using Interpretative Phenomenological Analysis.

**Results:** The impetus for volunteering came from a sense of strength gained from adversity and the desire to share experiences with others. The two major themes that emerged were *Sharing Experiences* and *Making Choices*. Participants' were very aware of the value of personal support and encouragement coupled with written information, due to their own experiences of uncertainty and isolation. Talking to another person with actual experience of rheumatic disease was perceived as very valuable as "it only takes one qualified volunteer you know". Re-establishing feelings of control and choice can take some time for people with rheumatic disease. Volunteering facilitates this process for both client and volunteer. Awareness of the new "changed" body is used as a positive example of accomplishment, reframing that which could be perceived negatively. Sharing knowledge and giving support re-establishes feelings of self-worth and being needed for the volunteers. The volunteers acknowledged that their work enabled them to focus on others rather than themselves, although they seized the opportunity to portray themselves in a positive way. This enabled the volunteers to become "visible" again within society and less isolated. Helping someone to leave "much lighter in step" than when they came in made the volunteers' feel needed and their role worthwhile.

**Conclusions:** Trained volunteers at community-based arthritis support centres can offer confidential support, information and signposting to clients (patients, their families and friends) without time constraints, in a non-threatening atmosphere. Volunteers with personal experience of rheumatic disease act as positive role models and gain personal benefit by enhancing their own feelings of self-worth.

#### 373. "JOINING THE DOTS": ISOLATION, UNDERSTANDING AND INTEGRATED HEALTHCARE FOR PATIENTS WITH LUPUS



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**Background:** Systemic lupus erythematosus (SLE) is a multisystem disease requiring multidisciplinary health and psychosocial care.

**Methods:** We examined the impact of external (social) and internal (psychological) features on SLE patients' perceptions of healthcare provision. Semistructured interviews conducted with ten women, aged 32-68 with SLE for 1-12 years, were audio-recorded, transcribed verbatim and analysed using Interpretative Phenomenological Analysis.

**Results:** Three themes emerged: *Isolation, Understanding and Communication*. Participants described how medical advice produced physical and subsequent social *Isolation* and felt that healthcare professionals did not appreciate its consequences. The body became physically isolated as it was concealed with clothing to protect from photosensitivity and with makeup to cover rashes. This theme was connected to feelings of "difference" to others, due to appearance and energy changes, and lack of *Understanding*. Participants expressed the opinion that no-one really understood what it was like to have lupus. Socially, they found that family and employers could not un-

understand the fluctuating nature of the disease. There was great concern to appear "legitimately" ill and to have a label for their condition. For some this had entailed a lengthy search within healthcare services, which highlighted *Communication* issues. They felt that only specialists had some understanding of their condition but even they did not understand psychosocial concerns. GPs and non-specialist doctors were felt to be poorly informed about lupus, undermining confidence in treatments and healthcare providers. Participants often saw several specialists and did not know whom to approach to talk about their concerns. Lack of communication at an interdisciplinary level left them feeling that "nobody is joining the dots".

**Conclusions:** The effects of SLE and measures that minimise the effects of photosensitivity have implications not fully understood by healthcare providers. Lack of communication left patients with concerns that could be remedied. Integrated clinics and the presence of trained volunteers with lupus, such as those available at the lupus open-access group in Dudley, ensure more adequate information from "someone who really understands". This may help minimise feelings of isolation.

#### 374. THE NATIONAL LIBRARY FOR HEALTH - TRAUMA, ORTHOPAEDICS AND MUSCULOSKELETAL SPECIALIST LIBRARIES



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**Background:** The National electronic Library for Health comes under the umbrella of the National Library for Health, a development of existing library services for the NHS and higher education, and itself part of the Department of Health's National Program for IT.

There are 19 specialist libraries covering medical specialities from cancer through respiratory care, to women's health, and including dedicated specialist libraries for Trauma, Orthopaedics and Musculoskeletal care. There are additional generic portals for 11 professional groups including most of the AHPs.

**Methods:** A team of associate editors and reviewers source, review and summarise information for relevance, quality and accessibility before producing a short summary of its merit and providing a link to the resource.

**Results:** The NeLH is used by around 200,000 people every month and has developed a strong identity as a source of authoritative evidence and best practice to support health care.

The NeLH provides direct access to important health care resources such as the National Service Frameworks, NICE guidelines, and protocols and care pathways as well as on-line access to the Cochrane database of systematic reviews, PubMed/Medline and 1000 full text journals.

**Conclusions:** This paper will outline the main features of the NeLH Trauma, Orthopaedics Musculoskeletal Specialist Libraries, highlighting services available and advising clinicians on how to get the most from the library. The tabbed features stratifying information according to the hierarchy of evidence will be introduced, along with advanced features such as searching for information using index terms. Finally, the SL's future role in linking to the electronic care record will be outlined, describing how the system will develop in time to suggest evidence, and to support prompts and reminders in the electronic care pathway.

#### 375. A RETROSPECTIVE AUDIT OF SECONDARY HEALTH CARE UTILISATION OF PATIENTS WITH FIBROMYALGIA



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**Background:** Fibromyalgia is the third commonest reason for a rheumatological referral. Fibromyalgia has a negative effect on the individual in terms of reduced physical, psychological and social function and on society with increased use of health care utilisation and sickness benefits. In 2000 a Nurse Consultant was appointed to develop a Chronic Musculoskeletal Pain Service. One of the aims of this service was to reduce the fragmentation of the existing service, which resulted in patients attending numerous specialists and receiving conflicting advice regarding care management. The objective of this audit was to assess secondary health care utilisation following attendance at a Consultant Nurse-led pain clinic.

**Methods:** 60 consecutive new patients who had been reviewed in the Consultant Nurse-led pain clinic were selected from the fibromyalgia database by a research nurse not involved in the patients' clinical care. The hospital computerised information system was utilised to obtain information regarding which secondary health care services had been accessed five years prior to the pain clinic appointment and which secondary care services were being

utilised 12-36 months following attendance at the pain clinic. Demographic data and the number of attendance at each secondary care appointment was also recorded.

**Results:** The sample consisted of 57 women and 3 men, mean age of 41 years (age range 29-71 years). 42 patients were married and 22 were in employment. In the 5 years prior to attending the Consultant Nurse-led clinic patients were accessing between 1-16 different hospital specialities (median 5). The number of different hospital specialities being accessed 12-36 months following attendance at the pain clinic ranged from 1-11 with a median of 1. Fifty-three patients reduced the number of specialities they were seeing, 3 patients increased the number and 4 patients continued to see the same number of specialists. Services patients were no longer accessing included Rheumatology (n=39), Imaging (n=33), Orthopaedics (n=30), Accident and Emergency (n=27) and Gynaecology (n=15). The total number of secondary care appointments in all specialities fell from a median of 12 (range 1-76) to 2 (range 1-30).

**Conclusions:** Having a designated Consultant Nurse-led service for the management of patients with Fibromyalgia may reduce the utilisation of secondary care specialities.

#### 376. BENCHMARKING THE NURSE CONSULTANT ROLE IN RHEUMATOLOGY



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**Background:** The Nurse Consultant role was introduced in 1998 to expand the clinical career pathway and retain experienced nurses in clinical care. These roles are essential to strengthen professional leadership whilst providing a framework to develop research and educational initiatives. Core standards for Nurse Consultants in rheumatology have been devised to support role development.

**Methods:** Rheumatology Nurse Consultants (n=6) have devised a forum for quarterly meetings with the aim of providing peer supervision and collaboration on role developments. The first outcome was the creation of core standards using national criteria as a benchmark which were developed using a mapping exercise achieving majority consensus. The resulting criteria focused on role function including expert clinical practice, education, research, leadership.

**Results:** Specific core standards for rheumatology Nurse Consultants have been developed. Fifty per cent of the role will involve clinical care e.g. nurse-led initiatives addressing patient focused outcomes with the remaining time divided between service improvements, developing education and research opportunities. The standards are adaptable and will be influenced by the needs of the local population, resources, knowledge and skills of the Nurse Consultant and team members. The standards also include the support mechanisms required to perform the role including supervision, secretarial and information technology. A future objective of the group will be to conduct peer review visits to benchmark the implementation of the standards.

**Conclusions:** The core standards are relevant to rheumatology Nurse Consultant role development. It is envisaged that all Nurse Consultants will structure their role around the standards, personalised to their area of work or interests and that they will provide a framework for new or aspiring Nurse Consultants.

#### 377. TELEPHONE FOLLOW UP OF PATIENTS COMMENCING ORAL BISPHOSPHONATES



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**Background:** Bisphosphonates are widely used in the management of osteoporosis. Non compliance may, however, limit the effectiveness of therapy. The aim of this study was to determine whether telephone follow up can be used as a tool to detect non compliance and side effects amongst osteoporotic patients who have recently commenced bisphosphonate therapy.

**Methods:** Men and women with osteoporosis attending the metabolic bone clinic at Hope hospital, Salford and who were recommended bisphosphonate therapy, were registered for telephone follow up. At the hospital, patients are given a hand-written note to take to their GP with a view to prescribing therapy, followed by a dictated clinic letter. Patients were contacted 6 weeks following their clinic visit and information obtained about whether or not they were currently taking therapy, and, if not, the reasons for this. If they were taking therapy, they were asked whether they were taking it appropriately

(based on manufacturers recommendations) and if they were experiencing side effects.

**Results:** In total 63 patients with osteoporosis were registered for telephone follow up. Their median age was 70 years and 54 (86%) were female. Of those registered, 56 were contacted (after an average of 2 telephone calls) with the remaining patients unable to be contacted. Of the 56 who were contacted 17 (30%) were not currently taking therapy. The reasons for this were because they had developed side effects (2), were apprehensive about taking the medication they had received (5), had not yet received it from their GP (4), were not clear why they had been prescribed it (3) and other reasons (3). Of the 39 who were currently taking therapy, almost all were taking it according to manufacturers recommendations, though a significant number (15) were experiencing some side effects. As a result of the telephone follow up, 22 patients were referred back either to the clinic for assessment or to their general practitioner with recommendations about therapy. One patient required a home visit.

**Conclusions:** In conclusion telephone follow up is a useful tool in the early detection of non-compliance and side effects associated with bisphosphonate therapy in patients with osteoporosis.

**378. EVALUATION OF AN EVIDENCE-BASED PHYSIOTHERAPY PROGRAMME FOR THE MANAGEMENT OF PATIENTS WITH OSTEOARTHRITIS OF THE KNEE**



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**Background:** The aim of this study was to determine the outcome of a physiotherapy programme for patients with osteoarthritis (OA) of the knee which was based on published studies, and to compare this to the outcomes of research based programmes. The purpose was to evaluate whether improvements in pain and function demonstrated following research trials actually translate to the clinical setting.

**Methods:** Based on a review of published studies a Physiotherapy OA Knee Programme of group education and exercise, was set up to be delivered for one hour per week over six weeks. Prior to commencing the programme all clients were assessed by a Chartered Physiotherapist and any individual treatment was completed.

Education covered anatomy of the knee, pathology of OA, benefits of exercise, use of heat and cold, indications for walking aids and the importance of footwear. Exercise comprised of a five minute warm up followed by a circuit of eleven stations. Each of the stations had 3 exercise options: "easy", "moderate" and "difficult". Patients performed the "easy" option at each station for 2 minutes on Week One of the programme and progressed to the "moderate" and "difficult" options as they were able during the course of the programme. Outcomes were measured using the WOMAC questionnaire and a visual analogue scale (VAS) for pain which were completed by all patients prior to Session 1 and immediately following the final session. Further analysis was performed using confidence intervals and a paired t-test. The outcomes from this Bristol OA Knee Programme were then compared with results from four papers using similar interventions and evaluation tools.

**Results:** 103 patients completed the programme. For WOMAC scores and pain VAS see Table 1. The results demonstrated statistically significant ( $p < 0.05$ ) reductions in pain, stiffness and disability. The greatest improvement was in reduction in pain (43% in VAS) which was a larger effect size than that reported following similar OA Knee Programmes, which showed a mean reduction of 16% in VAS. Other changes were similar to those reported in clinical trials.

WOMAC scores pre and post OA Knee Programme

Outcome	Pre-group Mean score	Post-group Mean score	Percentage improvement
WOMAC pain	9.5	8.1	15
WOMAC stiffness	4.3	3.8	11
WOMAC disability	32.8	28.4	14
WOMAC overall	46.4	40.2	14
VAS pain	66.9	38.2	43

$p < 0.05$  for all mean change scores

**Conclusions:** This study is representative of a true clinical service aimed at managing patients with OA of the knee. Despite research trials generally having greater levels intervention, this programme has demonstrated a higher reduction in VAS pain scores and has also shown a significant improvement in overall WOMAC which is comparable with the results from research trials.

**379. SETTING UP A PATIENT REFERENCE GROUP TO INFORM SERVICE DELIVERY IN A RHEUMATOLOGY UNIT**



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**Background:** There has been a move to give patients a real say in the way the NHS works. This has been highlighted recently in the BSR standards of care for patients with RA. In 2003 we set up a Rheumatology patient reference group (PRG). The aim of the presentation is to outline the process of setting up the PRG and identify the impact it has had on our Rheumatology Unit.

**Methods:** To become a member of the PRG a defined recruitment process has been developed, including an application pack for prospective patients/carers. An elected Chairman and Secretary run the group. Terms of reference have been drawn up by the group.

Objectives of the group are to enable service users to comment on the service provided and to contribute to planning, delivery and evaluation of the Unit.

The PRG meets regularly to action comments collected from other services users, discuss proposed service developments and review prospective patient information.

**Results:** The group devised a system whereby they canvass the views of Rheumatology Out-patients on a 6 weekly basis. To date approximately 500 patients have had the opportunity to comment on the service. 114 comments sheets have been completed, providing 194 comments/suggestions. Of the themes emerging, 74% of the comments show satisfaction with Unit staff and service/care received, and 26% of comments highlight concerns which have been reviewed by the PRG. All patient comments are acted on by the group, which involves corresponding with Trust Management including the Chief Executive, the Rheumatology multi-disciplinary team and reporting back to the patient/carer if requested.

To date, changes brought about by the PRG include access to the Rheumatology Department being improved with increased disabled car parking, strategically placed seating and review of unsuitable doors (all funded by the Trust). Reopening of in-patient beds when the Rheumatology ward was temporarily closed was influenced by the group. Changes to the service include a manned nurse led Helpline service being available for an hour each day in addition to 3 telephone Helplines using answer machines, and blood monitoring clinics are moving to an appointment system.

In addition, 20 patient information leaflets have been reviewed to ensure appropriate written communication, and reports provided. The PRG has also served as a model for other specialities setting up their own groups.

**Conclusions:** The PRG has been instrumental in evaluating, monitoring and developing St Helens and Knowsley Trust Rheumatology Unit. With surprising speed the PRG has already canvassed and improved the quality of the service provided.

**380. CAN PIINP HELP IN MONITORING RHEUMATOID ARTHRITIS PATIENTS ON METHOTREXATE?**



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**Background:** A 67 yr old rheumatoid arthritis (RA) patient of ours was admitted with acute liver failure and died shortly afterwards. He had been on methotrexate (MTX) for the previous 5 years and had had normal liver function tests (LFTs) until just before admission. Liver ultrasound (US) on admission suggested early fibrosis and portal hypertension. This prompted us to look at serum type III procollagen aminopeptide (PIINP) in our RA patients on MTX. Standard LFTs are a relatively insensitive test for liver fibrosis and several reports have suggested that PIINP, particularly when used sequentially, may be a better test.<sup>1</sup> This issue is particularly relevant in view of recent national patient safety advice.<sup>2</sup>

**Methods:** PIINP tests have been requested when thought to be clinically indicated in 36 patients with RA. Tests were identified via biochemistry database and notes pulled. Notes were available on 25 patients. Data were analysed using Formic software.

**Results:** 25 patients had a total of 31 tests. Female:male ratio was 17:8.

Characteristics of patients with normal and raised PIINP

	Normal PIINP (n=9)	Raised PIINP (n=16)
Age (yrs)	56	65
RA duration (yrs)	6	13
MTX duration (yrs)	3	4.5
Total MTX dose (mg)	2050	2308

Mean age: 62 yrs (range 43-75yrs). Average duration of RA: 10.5 yrs (2-25yrs), mean duration of MTX treatment: 4 yrs (1-10yrs). 7 patients were taking regular folic acid. To our knowledge, none took excess alcohol. Reasons for testing PIIINP were: raised ALT (20 patients), raised alkaline phosphatase (8), raised MCV (1) and long duration of treatment (1). Liver US was requested in 14 patients. 5 scans were abnormal, all suggesting fatty infiltration. All 5 patients had high PIIINP. Conversely, 5 patients with normal liver US had raised PIIINP. MTX was stopped in 7 patients. 2 of these had raised PIIINP alone; 2 had raised PIIINP and abnormal US.

**Conclusions:** This is a small but on-going study, intended to stimulate discussion. A "new generation" of MTX treated RA patients may be emerging who are at potential risk of undiagnosed liver damage. These are patients who have been on the drug for many years, may accumulate co-medication and may slip into excess alcohol intake. Our data are limited by the absence of liver biopsy as a "gold standard" but the reality is that biopsies are now very rarely used in rheumatology. We are starting to use PIIINP, in conjunction with liver US<sup>3</sup>, to inform our decisions about MTX continuation.

#### References

- [1] Br J Dermatol 1996;135:538-544
- [2] www.npsa.nhs.uk/advice
- [3] Br J Dermatol 1987;116:491-495

### 381. AUDIT: BONE SCINTIGRAPHY USE IN THE INVESTIGATION OF FOOT PAIN IN THE OUT PATIENT CLINIC OVER A 5 YEAR PERIOD



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**Background:** This audit had a dual purpose: Firstly, to define the indications for bone scintigraphy in the investigation of foot pain and create from the current literature a "Gold Standard" with which to compare our own department's practice; secondly to analyse whether those requests compliant with the gold standard had a greater yield of useful clinical information compared with non-compliant requests.

**Methods:** 35 patients were identified having searched radiology requests for "foot pain" and "bone scintigraphy" from the period April 1998 to April 2003. The notes and reports from the scans were reviewed retrospectively by one clinician (EJ). The following data were collected: name and age at the time of bone scan; the specific clinical problem necessitating the bone scan, for example "heel pain", any relevant past medical history and the reason given for requesting the scan, for example "Possible plantar fasciitis". The findings of the scan, any intervention and the subsequent clinical course of each patient were looked at. The reasons for requesting a scan were then compared with 10 "Goldstandard" indications defined following a review of current literature.<sup>1,2,3</sup> (see Appendix) The scan report of those adherent to the "Gold standard" were then analysed and defined as being either helpful or unhelpful in the patient's management. The same analysis was performed on non-adherent scans.

In this way we hoped to test the robustness of the "Gold standards" in order to create departmental Guidelines for the use of Bone Scintigraphy.

**Results:** Demographics: Mean age 50.6 years, Range of ages 14-72 years, 12 male, 23 female.

24/35 Scans ordered according to "Gold standard" (27 accounts given for 24 patients)

Of the "appropriately" ordered scans, what proportion were helpful in aiding/changing the diagnosis and management:

Helpful: 18/24 (75%)

Unhelpful: 2/24 (8.3%)

Normal scan 4/24 (16.6%)

11/35 scans ordered inappropriately:

6/11 helpful (54.5%)

3 of which lead to an alternative diagnosis and 3 of which were normal.

Normal Bone Scans:

In total 7/35 had normal scans

At follow up 2/7 had no symptoms and none had any long term problems

**Conclusions:** 68.5% scans were ordered according to literature-derived "Gold standards" Yield of useful information is higher in those ordered according to Guidelines: 75% v 54.5%

Higher rate of negative scans in the group of "inappropriately ordered" scans: 27% v 16%

A negative scan can be reassuring as there were no long term sequelae in our group.

### 382. RHEUMATOID ARTHRITIS PATIENT EDUCATION IN THE UK – WHAT IS ON OFFER AND HOW IS IT DELIVERED?



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**Background:** Many UK Rheumatology Centres aim to provide RA Patient Education/Self Management programs. Whilst these are assumed to be similar in nature and content, there is no standardised format. This abstract describes 11 such programs delivered in the UK.

**Methods:** Eleven UK patient education programs were described as part of the RA Self-Efficacy RASE Study. A structured questionnaire explored course content, organisation and participants. Responses were either by self-report (6/11) or by interview (5/11).

**Results:** The size of education "group" ranged from 1 to 12 patients (mean 7), with two centres offering education on a one-to-one basis. The total number of sessions in a program ranged from 1-6 (mean 4), with two offering a single session and four offering 6 sessions. Session lengths ranged from 1.5-3 hours (mode 2hrs), with the total number of hours over the entire program ranging from 2.5 to 12 hours (mean 8.1hrs). Most programs (6/11) were run during the daytime only, two ran only in the evenings and three centres offered both daytime and evening programs.

Most programs (10/11) were offered to patients with a range of inflammatory arthropathies, one program being currently limited to RA patients only. Four of the 11 programs were provided primarily for newly diagnosed patients.

The most frequent contributors to programs were nurses (9/11 programs), physiotherapists (10/11) and occupational therapists (10/11). Other contributors included podiatrists (4/11), doctors (4/11) and psychologists (2/11).

Topics covered by all eleven centres included; the disease process and the nature of flares, rheumatology services available, joint protection, relaxation, pacing and pain management through medication and other means (eg hot and cold). Topics covered by several, but not all, centres were; footwear (9/11), mood and stress management (8/11), employment issues (8/11), and complementary therapies (8/11). Several centres also addressed "making the most of consultations" (7/11), goal setting (6/11) and sexual advice (6/11).

**Conclusions:** The programs offered in these 11 centres varied greatly in terms of the size of patient group and the hours of education offered. Despite these differences there were many core themes covered in the content of programs, and all programs were limited to RA or inflammatory arthropathies. These similarities suggest broad agreement on a specific set of needs in this group, which differs from the needs of those with non-inflammatory arthritis. There is scope for program coordinators to exchange information and evaluations of less commonly covered topics.

### 383. MANAGEMENT OF KNEE OSTEOARTHRITIS IN PHYSIOTHERAPY OUTPATIENT DEPARTMENTS IN THE UNITED KINGDOM AND NORTHERN IRELAND



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**Background:** For patients with knee osteoarthritis (OA) evidence-based guidelines endorse early referral to physiotherapy to encourage regular exercise and patient education strategies, assisting in long-term self-management. Adherence to the guidelines however is unknown as there is no available data about current management of these patients in physiotherapy outpatient departments. Due to the prevalence of knee OA, application of other physiotherapeutic modalities that have a poor evidence base may be ineffective and a waste of limited available resources.

**Methods:** A descriptive questionnaire developed to obtain data regarding referral patterns and service provision for patients with knee OA was distributed to physiotherapy departments. Respondents were asked about treatment aims; physiotherapy modalities employed; average treatment times; and measures they used to assess treatment outcomes. Three hundred questionnaires were distributed through a regular mailing list of the Chartered Society of Physiotherapy, as such we were unable to specifically target outpatient departments. As a result many questionnaires may have been distributed to inappropriate departments, but it enhanced the random, non-selective distribution to a wide variety of recipients.

**Results:** Responses were received from 27.7% departments/physiotherapists, predominantly working in the NHS. Treatment aims were to encourage self-management; improve/increase strength, joint range of movement and function; and decrease pain. Exercise was utilised by all respondents, but often supplemented with electrotherapy, acupuncture and manual therapy, despite poor research evidence supporting their efficacy. Group therapy was less utilised than individual contacts, but meant that patients received increased contact time – most individuals were seen for a total of 1-2 hours,

whilst most group patients had 5-6 hours contact. Almost half of treatments were delivered without knowing whether they helped since only 54.2% reported using outcome measures to determine treatment efficacy.

**Conclusions:** Encouragingly all respondents realised the benefits of exercise for knee OA. Increasing contact time by delivering exercise in groups may increase clinical effectiveness further without substantially increasing costs. Delivery of other poorly researched modalities that lack evidence of efficacy and encourage reliance on physiotherapists may be a waste of time and resources. Whether any of the treatments are helpful is indeterminable since many physiotherapists are delivering treatments without evaluating their success. Until physiotherapists use validated outcome measures to determine treatment efficacy, the success of physiotherapy management for patients with knee OA remains largely unknown.

**384. AUDIT OF AN EXERCISE PROGRAMME DESIGNED BY PATIENTS FOR PATIENTS WITH INFLAMMATORY ARTHRITIS**



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**Background:** Involving users in service design empowers patients and moulds a service responsive to their needs. Our rheumatoid support group meet monthly in a local church hall. Patients are kept updated on service and treatment developments. Time is allowed for patients to express concerns or ideas for service development. A simple dynamic exercise programme was developed at the request of patients. Following this the patients opted to design their own audit on the effectiveness of the programme and the other forms of exercise available to them.

**Methods:** The clinical audit department worked with the patients to develop a questionnaire designed to determine the level of satisfaction with the programme and suggestions for further development. The questionnaire was distributed at the monthly support group.

**Results:** 27 patients completed the questionnaire. All patients reported they had the opportunity to participate in the exercise programme and that they had sufficient guidance and resources to carry out the exercises at home. 92% preferred to perform the exercises in a group setting. Exercises performed in the morning provided the most benefit to 39% of the respondents but 53% preferred to perform the exercises at varied times. All patients were keen that further health service personnel as opposed to service users should be trained to deliver the programme. It was felt by 89% that future service developments should include an aerobic exercise programme and 34% wanted hydrotherapy services available on site. The results were presented by the users at both the monthly support group and at the trust clinical governance day. As a result of this patient representatives now sit on the clinical audit committee.

**Conclusions:** Health care staff and commissioners may have different priorities for health service development than the patient population they serve. Our RA support group contains a number of highly motivated individuals but despite this they were keen that their exercise programme should continue to be led by health care professionals and not patients which would be against current health care philosophy. Due to the audit an aerobic exercise programme is now delivered to the patients by physiotherapy. In the future patients who are not attending the monthly support group should be involved so that any audit adequately reflects the views of all users. Encouraging patients to develop their own audit programme at a local level encourages users to influence service developments and provides the wider team with insight into the issues which matter most to their patient population.

**385. A RETROSPECTIVE ASSESSMENT OF THE VALUE OF EDUCATING NEW PATIENTS WITH INFLAMMATORY JOINT DISEASE, BY NURSE SPECIALISTS, IN A GROUP SETTING**



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**Background:** Inflammatory joint disease (IJD) usually has a major impact on a patients quality of life. Early effective intervention makes a difference and education and support improves patient comprehension and compliance. Education also improves patient choice and adaptation to their condition. We invite all new patients with IJD to attend a program of education from the multidisciplinary team. The object of this survey was to audit the effect of the course on physical, psychological and social disability.

**Methods:** All patients with IJD who had entered the course 3 years previously were assessed, together with sex matched controls who had declined to attend. Each patient was sent an information sheet, consent form, questionnaire and SAE. We explored demographic factors, employment, transport and educational level. Each patient completed HAQ and HAD questionnaires. Results were compared cross sectionally between groups using

unpaired t tests and longitudinally within groups between baseline and follow up values using paired t tests. Attenders were also asked to rate all aspects of the course on a visual analog scale, and non attenders were asked to select one statement from an options menu to best describe why they were unable to attend.

**Results:** The overall response rate was 60%. Significant differences between attenders and non-attenders were found in mean age (75 vs 54 years), employment status (25% vs 42%) and access to transport (67% vs 50%), p<0.05. No significant differences were detected between groups with regard to educational level and family commitments. No differences were found between groups for mean HAQ or HAD scores at baseline or at follow up. However, HAD scores did improve significantly during the course itself, although no significant differences were detected between baseline and 3 year follow up for either score in attenders. Patients rated all aspects of the course highly with mean values for "benefit", "relevance" and "novelty" being 86%, 91% and 79% respectively. Individual aspects of the course were rated much more variably. Among non-attenders, work commitments were quoted most often as the reason preventing attendance.

**Conclusions:** This exercise has taught us that younger employed patients often cannot attend the course during working hours and suggests that we need to provide an alternative schedule for this group. It also directs us towards appropriate selection of topics for education and allows more effective use of the multidisciplinary team. Although the course did not alter HAQ or HAD values significantly in the long term, patients perceived benefit from the course, especially with regard to allaying anxiety and sharing concerns.

**386. A PICTORIAL INSTRUCTION TO AID METHOTREXATE DOSING**



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**Background:** The prescribing of methotrexate causes considerable concern with regard to both dosing errors and monitoring, (July 29<sup>th</sup> 2004; National Patient Safety Agency). We felt that the highest risk period for patients with regard to dosing errors was at the introduction of therapy, and have devised a simple pictorial leaflet in an attempt to aid understanding and compliance.

**Methods:** The consultant staff agreed a uniform dose introduction regime for methotrexate, and policy with regard to folic acid supplementation for the department, following which a colour leaflet showing the tablets and regime was produced and piloted in the clinics. To further assess patient response we then mailed the leaflet to 100 patients on Methotrexate with an SAE and a questionnaire asking for their opinion.

**Results:** 73% of patients replied to the questionnaire, of these 97% of patients felt the leaflet was clear and easy to read. 78% of patients had received previous information about Methotrexate, 39% of these patients felt this leaflet was more effective than others they had previously received, comments regarding requests for more detailed information

**You have been prescribed Methotrexate. This is a Once-A-Week medication.**

	Methotrexate Day <input type="text"/>	Folic acid Day <input type="text"/> <small>NOT the same day as Methotrexate</small>
<b>Week 1</b>	Methotrexate 7.5 mg (3 tablets)	Folic acid 10 mg (2 tablets)
<b>Week 2</b>	Methotrexate 10 mg (4 tablets)	Folic acid 10 mg (2 tablets)
<b>Week 3</b>	Methotrexate 12.5 mg (5 tablets)	Folic acid 10 mg (2 tablets)
<b>Week 4 Onwards</b>	Methotrexate 15 mg (6 tablets)	Folic acid 10 mg (2 tablets)
<small>Continue on Methotrexate 15mg and Folic Acid 10mg until your next appointment. Make sure you have a blood test during week 4.</small>		

- ◆ You will need to have a blood test every month
- ◆ It may take 3 - 4 months before you feel better
- ◆ Make sure that you are prescribed 2.5mg strength Methotrexate. The 10mg tablets look very similar. We only use the 2.5mg tablets to avoid confusion and allow flexibility in treatment dosage.

**If you have any queries please contact the Helpline number: 01793 604323**

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