

is one of the most disabling. According to an epidemiological study conducted in France [1], the prevalence of symptomatic knee arthritis is estimated as 7.6%, which in relation to the French population aged between 40 and 75 years (INED 2008 data) corresponds to a total population of about 2 million patients. To evaluate everyday disability (in the broad sense of the term) due to knee arthritis in a population whose diagnosis has recently been confirmed.

**Methods:** The disability generated was evaluated by means of the BONE'S questionnaire. The BONE'S (Burden Osteoarthritis New Scale) questionnaire has been recently validated. It consists of 20 items, structured around 5 dimensions: "Autonomy", "Relationships and leisure", "Hygiene and beauty", "Psychology" and "Budget". Prospective, non-interventional evaluation. 100 French doctors (rheumatologists and general practitioners) recruited patients who had consulted them spontaneously and for whom knee arthritis was diagnosed.

**Results:** 456 subjects were deemed eligible for evaluation. The sex ratio favoured women (65% against 35%). The average age of the population was  $65.16 \pm 10.9$  years. 35% declared that they were active. The average BMI of the population was  $27.75 \pm 4.9$ ; the proportions for men and women were respectively: 27% and 34% < 25, 46% and 34% between 25 and 30, 21% and 32% > 30. The mean score of the burden was found to be  $30.04 \pm 17.8$ . The score differed according to sex:  $31.33 \pm 16.9$  against  $28.34 \pm 18.9$  ( $p < 0.05$ ). The score also differed according to BMI:  $26.1 \pm 17.4$  if <25,  $30.8 \pm 18.1$  between 25 and 30 and  $33.6 \pm 17$  if >30 ( $p < 0.01$ ). The most affected dimensions were autonomy, leisure and psychology. The effect on the budget dimension was 6 times greater for active patients compared to inactive patients. The monthly expenses to be paid by the patient differed depending on the sex: €31.09 for women and €23 for men (not significant).

**Conclusions:** This evaluation confirms the impact of knee arthritis in the everyday life of subjects who suffer from it. 35% of subjects are active, and the negative impact on work is liable to grow in view of the ageing of the population and the longer working lives in developed countries.

#### 400 COMPARATIVE STUDY OF PATIENTS KNOWLEDGE ON OSTEOARTHRITIS TREATMENT OPTIONS TO ACR GUIDELINES

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**Purpose:** Portuguese population is growing older, according to national data in 2011 the aging index was 129. The number of elderly population is higher than the younger; average life expectancy is 79.2 years (1). Because knee Osteoarthritis increases with age, and according to WHO 80% of these subjects will have some degree of impairment and 25% will not be able to do their daily living activities (2), OA has a big impact on the sustainability of both health and social care as populations grow older. Our goal was to compare current guidelines of managing knee OA, to the degree of information each patient has about their treatment options.

**Methods:** 94 subjects (72.3% female; 27.7% male), of four different general physicians of the region of Algarve were studied. All subjects had knee Osteoarthritis according to American College of Rheumatology clinical and radiological criteria. Subjects were accessed randomly after visiting their GP, and the Osteoarthritis Quality Indicator (OA-QI) Questionnaire (3), was applied.

**Results:** The education level of Portuguese elderly population is very low, what is reflected in this sample, 66% only have 4 years of formal education (primary school) and 19.9% have less than 4 years or has never learned how to read or write. The prevalence of OA increases, in subjects who are overweighted (OW) or obese. In this random sample 69 in 94 were OW or obese (mean BMI was  $29 (\pm 5 \text{ sd})$ ), 37.9% of OW, 77.8% of obese I (OI), 88.9% of obese II (OII) and 100% of obese III(OIII) were advised to lose weight but only 3.4% OW; 29.6%OI; 22.2% OII and 50% OIII say they have been referred for a specific diet consultation. When asked about exercise only 92 subject answer, of these 79.3% admit have been told of the benefits of exercise, but only 33.8% admit during exercise regularly. Regarding pharmacological treatment options, only 61.7% say that Paracetamol is their first option to treat pain, 93.5% admit to take anti-inflammatory drugs and 20% of these say

they have never been informed of the effects or possible side effects of this medicine. Because of the deterioration of their symptoms 26.6% of the subjects say that a corticosteroid injection has been considered and 33% has been referred for operation (joint replacement).

**Conclusions:** Comparing to the American College of Rheumatology recommendations, we expected to find higher number of subjects mentioning to have been informed of non-pharmacological treatment options such as weight lose and exercise. We also did not expect that the impact of this knowledge on patients, namely by the low percentage of subject doing regular exercise, even after admitting to have been informed of the beneficial effect of exercise. We also did not expect to find that the number of subjects that say have been referred for operation to be higher than the number that say have been referred to a dietician. Subjects taking paracetamol for first medication to treat pain was lower than the number actually taking anti-inflammatory drugs. The sample of this study is preliminary study will have to be increased, but results seem to confirm the necessity to reinforce information on treatment guidelines to GP's and education and life style programs targeted to OA patients. In our opinion, the very low education level of the population should be taken into account for these programs.

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#### SERVICE PROVISION FOR PATIENTS WITH CHRONIC POST-SURGICAL PAIN AFTER TOTAL KNEE REPLACEMENT: A QUALITATIVE STUDY OF HEALTHCARE PROVIDER PERSPECTIVES

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**Background:** Total knee replacement is one of the most commonly performed elective surgical procedures. The operation is often considered an effective intervention for pain, but recent studies indicate that up to 20% of patients experience chronic post-surgical pain (CPSP) after total knee replacement; this equates to around 16,000 new cases of CPSP in the UK each year. Despite the high number of patients with CPSP after knee replacement, ongoing work within our Unit suggests that there is little standardisation in service provision, with a lack of clear clinical pathways for the identification, assessment and management of patients with CPSP. The aim of this qualitative study was to explore healthcare professionals' views about service provision for patients with CPSP after total knee replacement to identify ways in which improvements could be designed.

**Methods:** Healthcare professionals in a major acute care UK NHS Trust with clinical experience of working with patients experiencing CPSP after total knee replacement were eligible to participate in the study. Study information was disseminated to potential participants through direct e-mails, a local professional organisation and at clinical meetings. Four focus groups with a total of 18 healthcare professionals were held. Participants included seven physiotherapists, three surgical registrars, two consultant orthopaedic surgeons, two nurses, one occupational therapist, one orthotist, one consultant pain specialist and one clinical psychologist. The focus groups were facilitated by an experienced qualitative researcher and a topic guide was used to help elicit participants' views and experiences. Focus groups explored referral pathways and service provision for patients with CPSP after total knee replacement. With written consent from participants, focus groups were audio recorded and transcribed. Anonymised transcripts were managed using QSR NVivo 10 and analysed using thematic analysis.

**Results:** Analysis found that a key narrative was healthcare professionals' view that service provision should reflect the complex and individual nature of CPSP, but that current provision was not well joined-up. Current access to services was dependent on patients taking a proactive approach and there were no clear entry points to post-surgical pain services. Treatment options were based partly on individual judgements of patients' context and need, but also influenced by the healthcare professional's specific specialism or service, and knowledge of available services and treatments. Participants saw