I1. GOUT: SHOULD WE TREAT TO TARGET?

Pascal Richette

The aim of urate-lowering therapy (ULT) is to maintain the urate concentration below the saturation point for monosodium urate. This therapy allows for dissolving crystal deposits and curing gout, as long as it is maintained. The EULAR and the more recent ACR guidelines recommend that the plasma urate levels should be maintained below 360 μmol/l, and the British guidelines below 300 μmol/l. Lower levels can be advised for severe gout because the velocity of tophus disappearance is inversely correlated with uricaemia. The decision to start ULT for gout should be weighed with the potential adverse effects. Because gout is not always a progressive disease, ULT is not recommended after a single acute attack. Dietary changes, cessation of the use of alcohol, weight loss, and substitution of another class of antihypertensive drugs for patients with diuretics may lower uricaemia and control incipient gout. ULT is indicated for patients with recurrent gout attacks, chronic arthropathy, tophi and gout with uric acid stones. ULT should be started 1–2 weeks after inflammation has abated because of the risk of acute attack. Prevention of acute flares, which can be induced by the dissolution of IA crystal deposition, is advised during the first 6 months of ULT and can be achieved by use of colchicine, 0.5–1 mg/day, or small doses of NSAIDs.

Because the time for crystal disappearance in SF increases with the duration and severity of gout, preventive therapy should be pursued longer for patients with severe tophaceous gout. Flares should be treated without interrupting the ULT, which should be continued indefinitely, because gout usually recurs a few years after the treatment has been stopped.

Disclosures: P.R., Ipsen, Menarini, Savient, Sobi, Novartis—Consultation Fees.

I2. PATHOGENESIS AND TREATMENT OF PYROPHOSPHATE ARTHROPATHY

Geraldine McCarthy

Pyrophosphate arthropathy includes pseudogout and other calcium pyrophosphate dihydrate (CPPD)—crystal-related arthropathies. These are common conditions that present particular management problems in clinical practice as they often affect older patients with multiple medical comorbidities. In this talk, current understanding of the pathogenesis of pyrophosphate arthropathy is presented. Recent novel insights into the pathogenesis of crystal-induced joint inflammation and subsequent joint degeneration are discussed. The epidemiology, metabolic and endocrine disease associations, and routine investigations used in the diagnostic workup are briefly reviewed. Current treatment approaches that are mainly directed at relieving the symptoms of joint inflammation are outlined. Unlike gout, there are no agents available that have been shown to decrease crystal load in CPPD-related joint disease. The potential of colchicine as a prophylactic agent in managing recurrent attacks and the likely mechanisms of its effects on the NACHT, LRR and PYD domain-containing protein 3 (NALP-3) inflammasome of the innate immune system are highlighted. The use of agents that directly target the inflammasome, in particular drugs which inhibit the IL-1 pathway, in the treatment of severe, refractory pseudogout is discussed.

Disclosures: The author has declared no conflicts of interest.

I3. GENETIC AND ENVIRONMENTAL RISK FOR HYPERURICAEMIA AND GOUT

Michael Doherty

Gout is the most common chronic inflammatory arthritis and its incidence and prevalence continue to rise in many parts of the world. Gout is a common complex disorder with multiple genetic, constitutional and environmental risk factors, the majority of which lead to persistent elevation of uric acid above the saturation point for urate crystal formation. This presentation will review data relating to: the heritability of gout; individual genetic risk factors (which predominantly involve renal excretion of uric acid); constitutional risk factors (male gender, ageing, OA); metabolic syndrome—obesity, hypertension, hyperlipidaemia, insulin resistance (each of which independently elevate uric acid levels); nutritional risk factors; and risk factors relating to renal impairment, drugs and extrinsic toxins. Risk factors for provocation of acute attacks will also be considered.

Disclosures: M.D., Ipsen, Menarini, Savient, Ardea Biosciences, Novartis—Ad hoc Advisory Board.

I4. FAST-TRACK HIP AND KNEE ARTHROPLASTY: CURRENT STATUS AND FUTURE CHALLENGES

Henrik Husted

Fast-track THA and TKA is a dynamic process combining clinical and logistical enhancements to ensure the best outcome for all patients regarding faster early functional recovery and reduced morbidity. Focus is on reducing convalescence by ensuring a smooth pathway with the best available clinical treatment from admission to discharge—and beyond. Main focus areas include pain treatment, mobilization, organizational aspects, traditions, and care principles.

Outcome is typically evaluated as: (i) length of stay in hospital (LOS), patient satisfaction, and reduced convalescence in the form of earlier achievement of functional milestones; (ii) safety aspects (reduced morbidity and mortality in the form of complications and readmissions in general and dislocations/manipulations in specific); (iii) feasibility (can the track be applied to other subgroups of patients, i.e. bilaterals or revisions?); and (iv) economic savings. Favourable outcomes regarding all these parameters have been documented for fast-track THA and TKA. This presentation will highlight the current status of fast-track THA and TKA with a kaleidoscopic overview of the documented best available treatment on the main focus areas as well as address future challenges for improving even further—which includes a revision of traditions and answering of the question: Why is the patient in hospital today? LOS is now 1–2 days for unselected patients in leading departments with few readmissions, high patient satisfaction and economic savings. In Denmark, the nationwide median LOS is now 4 days and improved logistic features include homogeneous entities, regular staff, high level of continuity, preoperative information including intended LOS, admission on the day of surgery and functional discharge criteria. The improved clinical features include both intraoperative (spinal anaesthesia, local infiltration analgesia [LIA], plans for fluid therapy, small standard incisions, no drains, compres- sion bandages and cooling) and postoperative (deep venous thrombosis prophylaxis starting 6–8 h postoperatively, multimodal opioid-sparing analgesia, early mobilization and discharge when functional criteria are met) facilitating early rehabilitation and discharge.
Future challenges include identification of high-pain responders to improve multimodal pain treatment; identification of high-risk patients regarding complications in fast-track set-ups; how to reduce post-operative cognitive dysfunction; how to reduce orthostatic intolerance; and when how and to whom to initiate and give rehabilitation.

Disclosures: H.H., Biomet—Consultant, Rapid Recovery Consultation and when how and to whom to initiate and give rehabilitation.

15. LESSONS FROM THE NATIONAL JOINT REGISTRY AND PATIENT REPORTED OUTCOME MEASURES (PROMS)
Simon Jameson1,2
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Around 160,000 hip, and knee replacements are carried out annually in England and Wales. The National Joint Registry has collected information on joint replacement patients, the implants used, and the surgeons and hospitals performing these operations since 2003, and is currently the largest implant registry. There are many implant options available and national implant expenditure is vast. Revising implants that have failed carries the risk of higher morbidity and poorer function compared with primary procedures, and is costly to healthcare providers. Thus, performing the most appropriate primary procedure to reduce this revision burden is of paramount importance. Registry analyses allow long-term comparisons across large numbers of implants, and between patient groups, hospitals and surgeons where randomized trials are not feasible. More emphasis is now placed on these large non-randomized observational studies as evidence for best practice. The key areas that required examination were: the most appropriate implant in younger patients (including the role of unicondylar knee replacements and hip resurfacing), the justification for costly implant technology in older patients and the use of patient-reported outcome measures following joint replacement. The lessons learned from these analyses will be discussed.

Disclosures: The author has declared no conflicts of interest.

16. INSIGHTS INTO ARTICULAR RESURFACING AND WHAT HAPPENED WITH METAL ON METAL IMPLANTS
Mike Reed1
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The reasons for the rise and fall of hip resurfacing are explained, with a description of what went wrong, when we knew and where we are now. Metal on metal hip replacement is far more prevalent and emerging problems may involve far more patients. Is there still a place for the metal on metal hip joint?

Disclosures: The author has declared no conflicts of interest.

AN EMBARRASSMENT OF RICHES: CLINICAL RESEARCH IN RHEUMATOID ARTHRITIS

17. HOW CLINICAL RESEARCH IMPROVES PATIENT OUTCOMES
A. Murray Brunt1
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I will use my experience of over 20 years as an oncologist to show how a clinical trial culture can be developed in a busy department. The developments in oncology over those 20 years have been significant and analogous to the situation that rheumatology is in as a specialty. The trial culture has many benefits, and the most important is the patient outcome which I will illustrate with examples from my own practice.

It is 30 years since Tamoxifen was shown to be of benefit to breast cancer patients, but even recently trials such as ATLAS have revealed an additional 3% mortality benefit which will save over 1200 lives per year in the UK. Involvement in the initial trials of the monoclonal antibody trastuzumab have led to large mortality benefits and the patients being discharged now at 10 years follow-up for an aggressive breast cancer can be told with a high degree of confidence about their chances of cure.

There are indirect benefits with trial involvement, an example being the external quality assurance programme and team that comes with the national radiotherapy trials where technical advances are put into place. Our department welcomes this external input and helps drive forward our desire to improve the service we provide for our patients; it breeds excellence.

Patients derive not only better outcomes from involvement with treatments that may become standard of care in the future but also security from being managed by a team that is perceived (and is) at the cutting edge of medicine.

Disclosures: The author has declared no conflicts of interest.

18. HOW RESEARCH CHANGED MY LIFE
Ailsa Bosworth1
1National Rheumatoid Arthritis Society, Maidenhead, Berkshire, UK

Taking part in a trial at Guys in 2000 for a new anti-TNF drug that was unlicensed in the UK at the time, changed my life in more ways than one. It got my disease under control for the first time after 18 years of pretty aggressive disease and led me to start the National Rheumatoid Arthritis Society, a job which I have found more challenging, yet immensely fulfilling than any other job I have ever had.

Being invited to speak at this session has caused me to look at the experience of being on a trial for 4 months and what that meant to me personally, and to examine why people seem to respond well to intensive vs routine care in RA and to consider the importance of the availability of research to all rather than the few from a patient perspective.

Disclosures: The author has declared no conflicts of interest.

19. SHOULD IT BE STANDARD OF CARE TO OFFER ENTRY TO RESEARCH TRIALS AT EACH THERAPEUTIC DECISION STAGE OF THE PATIENT JOURNEY?
Maya Buch1
1University of Leeds, Leeds, UK

The management paradigm and therapeutic landscape of rheumatoid arthritis (RA) has advanced greatly over the last decade. Whilst patients have benefitted markedly with more targeted strategies and the availability of highly effective therapies, our goals of treatment continue to evolve. There therefore remains a continued need to evaluate new treatment approaches as well as new therapies under development. Clinical trials remain the cornerstone for effective evaluation of treatments. Current and future ambitions on the management of RA include the identification of the right treatment for the right patient at the right time. For such a treatment goal to be realized, it is crucial that at every decision-making time point, patients are considered for clinical research studies. This talk will argue the case that to ensure the successful delivery of clinical studies, needed for optimal evidence-based management, clinical research should become a standard of care in a patient’s journey.

Disclosures: M.B., Abbott, BMS, Roche—Honoraria, Pfizer—Grant, Honoraria.

10. RESEARCH OPPORTUNITIES FOR RA PATIENTS, THEIR RHEUMATOLOGISTS AND THEIR AHPS, INCLUDING ECONOMIC ASPECTS
Deborah Symmons1,2
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The government views clinical research as being of benefit to both the health and wealth of the nation. Research benefits the health of the nation in many ways, including illuminating the cause of disease (and thus offering prospects for prevention), by developing and testing new medicines and treatments, and by refining the use of existing therapies. It improves the wealth of the nation by attracting pharmaceutical companies and the manufacturers of medical devices to base themselves and conduct their work in this country. In addition testing new drugs (which are provided free of charge by the manufacturing company) may free up resources for the NHS to target elsewhere.

The government established the National Institute of Health Research (NIHR) in England 2009. One of its goals is to double the...
number of patients in clinical studies and trials. We should aspire for every RA patient to be offered the opportunity to participate in a clinical study, as there are many questions left to address. The NIHR funds a self-management domain and encourage and effective collaboration with patients and encourage self-management.

However, multimorbidity is increasingly common, especially in older patients and those living in deprived areas. The presence of more than one long-term condition potentially has impacts on the delivery of health care, and on the ability of patients to manage their care outside the context of routine services. However, research is only beginning to identify the challenges posed by multimorbidity. We present data from a cohort of patients with arthritis and other conditions to explore their experience of care, and their reports of self-management.

Methods: We surveyed respondents with a range of long-term conditions in general practices in two areas of the UK. We conducted a comprehensive assessment of their demographic and clinical characteristics, their experience of the delivery and organisation of care (through the PACIC measure) and their self-reported self-management.

Results: In the cohort of 2439 patients with long-term conditions, 33% self-reported arthritis. The number of comorbidity conditions reported by these patients ranged from 1 to 12, with a mean of 4, and 29% of patients reported clinically significant levels of depression symptoms.

In terms of their experience of care for their long-term conditions, only around half of patients reported being given choices about treatment, being asked about problems with medicines or their effects, being asked about their goals for treatment, or being given a copy of a treatment plan. Few reported being asked about how their treatment, being asked about problems with medicines or their effects, being asked about their goals for treatment, or being given a copy of a treatment plan. Few patients have been asked about problems with medicines or their effects, being asked about their goals for treatment, or being given a copy.
BSR/BHPR: FACILITATING ADHERENCE TO TREATMENT IN RHEUMATOLOGY

I15. PATIENT NON-ADHERENCE TO TREATMENT: WHAT CAUSES IT AND WHAT CAN BE DONE ABOUT IT
John Weinman

Non-adherence to medical treatment is widespread in patients with rheumatological conditions and across all major health problems. Although a wide range of interventions have been developed to target different aspects of non-adherence, they have not been very successful in providing sustained improvements. This presentation will mainly focus on the extent to which patients’ beliefs about their illness and treatment explain why they frequently fail to adhere. It will begin with a more general overview of the nature and causes of adherence failure and, using the distinction between unintentional and intentional types of non-adherence, a range of psychological determinants will be examined. The main focus of the talk will be on the role of illness and treatment beliefs as key determinants of intentional non-adherence, and Leventhal’s self-regulation model will provide the theoretical framework for this. In the final part of the talk, examples will be provided of successful intervention studies together with a discussion of key issues for future research.

Disclosures: The authors have declared no conflicts of interest.

I16. ADHERENCE AND ADAPTATION: TARGETING BELIEFS AND BEHAVIOUR TO OPTIMIZE SELF-MANAGEMENT
Lis Cordingley

In their 2004 editorial Kravitz and Melnikow described patient adherence to physicians’ treatment recommendations as “the key mediator between medical practice and patient outcomes” (p197). Patient adherence to medication, psychotherapy and lifestyle advice is recognized as low with some leaders in the field suggesting that a degree of non-adherence should be viewed as the norm for most long-term conditions. Non-adherence covers a range of behaviours including incorrect dosage, incorrect timing, non-attendance at clinic, not undertaking recommended exercises and not following health behaviour advice such as smoking cessation. Recent studies of patients with rheumatoid arthritis have reported rates of medication non-adherence of around a third, although estimates vary according to the measure of adherence used.

Provision of information alone rarely leads to changes in behaviour and interventions based upon increasing knowledge have had little impact upon adherence rates. In line with the development of patient-centred practice use of the term adherence has overtaken compliance, and communication skills have been cited as key to improving medication self-management. However, this talk will present evidence indicating that theory-based approaches to consultations that target patient beliefs and behaviour are more likely to improve patient motivation and outcome than communication skills alone.

The introduction of new therapies including anti-TNF therapies for inflammatory arthritis are seen as a significant advance in treatment, however, they may also bring additional challenges to patients such as adapting to new modes of delivery or new concerns about the nature of the medication itself. Moreover, a decision to step-up treatment with more powerful therapies may also act as an unwelcome reminder to the patient of the severity of their condition or an indication that prior treatments have failed. Studies are needed to identify the challenges faced by patients using new therapies. Some new findings from a prospective study investigating the influence of demographic and psychological factors on adherence to anti-TNF medication by patients newly started on treatment will be presented.

Adoptive challenges to living with long-term inflammatory conditions and these can have an impact on self-management, particularly in the area of treatment adherence. Attending to broader patient perspectives and viewing non-adherence as an anticipated and understandable behavioural response enables health professionals to open up discussions about factors that influence medication use and to devise effective systems to optimize patient self-management.

Disclosures: The author has declared no conflicts of interest.

I17. THE CLINICAL APPLICATION OF BEHAVIOUR CHANGE STRATEGIES TO FACILITATE ADHERENCE TO TREATMENT
Sarah Dean

Adhering to a recommended treatment or to advice for self-managing a chronic condition usually requires the person to alter their behaviour in some way, e.g. to take a new tablet or to do some exercise that they have not previously done.

Michie and colleagues (2011) have collated a list of evidence-based techniques that can be used by health professionals to promote this behaviour change. Their behaviour change technique (BCT) taxonomy lists 93 strategies. The taxonomy is used to identify and describe in a standardized way, the active behaviour change components of interventions designed for treating a wide range of health conditions.

These BCTs can be used to help design interventions but also have utility for direct clinical application.
OSTEOPOROSIS: AN UPDATE

I18. INVESTIGATION AND MANAGEMENT OF RENAL BONE DISEASE

David J. Hosking¹
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The skeleton and the kidney deteriorate with age and many patients with osteoporosis have some degree of chronic kidney disease (CKD). For example, 61% of elderly women in the US have CKD stage 3 (eGFR 30–60 ml/min/1.73 m²) while 23% of women with CKD 3–4 have osteoporosis. Treatment algorithms such as FRAX are probably reasonably appropriate at modest reductions in GFR (~45 ml/min/1.73 m²) but become less useful as evidence of renal bone disease develops. In the later stages of renal failure osteoporosis is often accompanied by secondary hyperparathyroidism and various forms of renal bone disease (CKD-MBD: chronic kidney disease-mineral and bone disorder).

In mild to moderate CKD (Stage 3) treatment centres around ascorbic acid, which can be given with care with bisphosphonates as GFR falls below 40 ml/min. In mild hyperparathyroidism such as is found in early CKD there is preservation of cancellous bone but loss of cortical bone due to increased endosteal resorption. This cortical thinning has an adverse effect on bone strength but may be obscured by preserved trabecular bone and may explain why fracture risk is increased in these patients despite minimal reduction in BMD assessed by DXA. At this stage of CKD high resolution peripheral quantitative computed tomography (HRpQCT) tends to show evidence of early trabecular loss with a reduction in trabecular number and an increase in trabecular separation but no change in thickness.

As end stage renal disease approaches (CKD 4–5D) it becomes increasingly important, but difficult, to differentiate osteoporosis from renal bone disease. Densitometry (DXA) is unable to separate these components and although many patients will experience a progressive decline in both lumbar spine and femoral neck BMD these changes do not correlate with the major changes in PTH, FGF 23 or calcitriol. For these reasons it is often impossible to predict the type of underlying bone disease and other techniques such as HRpQCT have been used either to evaluate ex-vivo bone biopsies or to study bone in vivo.

In end stage renal disease there are few studies of the relationship between BMD, fracture risk and the response to treatment so that the strength of clinical evidence is weak and the quality of studies is low. Renal transplant bone disease has a multifactorial aetiology where there is a high risk of fractures but no data relating BMD to fracture risk. At a clinical level it is difficult to identify those patients who may benefit from treatment and there are no randomized trials of bone specific treatment. Extrapolation from non-renal transplant patients may not be valid and the situation is confounded by the use of immunosuppression and glucocorticoids.

Disclosures: The author has declared no conflicts of interest.

I20. BISPHOSPHONATE THERAPY: WHAT IS THE OPTIMAL DURATION?

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Bisphosphonates are the most widely used pharmacological intervention to reduce fracture risk in postmenopausal women and older men at increased risk of fracture. Because of the unique pharmacokinetics of bisphosphonates and, in particular, their long retention time in bone, it is possible that beneficial effects on fracture risk may persist for some time after treatment is stopped. The possible association between bisphosphonate therapy and two rare but serious conditions, namely osteonecrosis of the jaw (ONJ) and atypical femoral fractures, coupled with the prolonged action of bisphosphonates, has raised questions about the optimal duration of therapy. In particular, the issue arises of whether some patients should be given a drug holiday, followed after a period of time by resumption of treatment.

In deciding the optimal duration of therapy, the benefits and risks of both continuation and discontinuation must be considered. Long-term treatment is associated with fracture reduction but may increase the risk of rare adverse effects such as ONJ and atypical fractures. Discontinuation might reduce the risk of ONJ and atypical fractures but may also be associated with reduced protection against fracture. Following withdrawal of bisphosphonate therapy the rate of offset of efficacy varies, being most rapid with risendronate, intermediate for alendronate and longest for zoledronic acid. Post-hoc analysis of Phase 3 trials suggests that women with a low femoral BMD and/or a vertebral fracture at baseline may be at increased risk of fracture if therapy is discontinued.

For alendronate and risendronate, an initial 5-year period of treatment can be advised, with assessment of the need for further treatment at the end of that time based on fracture history, age and BMD. If treatment is stopped, reassessment of risk should be performed after 2–3 years for alendronate, but at 1 year for risendronate. In patients treated with zoledronic acid, an initial treatment period of 3 years appears to be sufficient, with reassessment of the need for further treatment after 3 years. Nevertheless, the strength of evidence for fracture reduction in high-risk patients treated with bisphosphonates and the rarity of long-term adverse effects emphasise the importance of continuing therapy long-term in individuals who remain at high risk of fracture.

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vasculitides (AAV) are a group of conditions which predominantly affect small and medium sized vessels. They are now termed granulomatosis with polyangiitis (GPA), microscopic polyangiitis (MPA) and eosinophilic granulomatosis with polyangiitis (EGPA). The untreated prognosis of these conditions is poor and the median survival of untreated GPA in one series has been 5 months. Pulsed or continuous cyclophosphamide induces remission in 90% of patients with AAV, but with the risk of treatment associated morbidity and damage. Since the first case report of the use of rituximab in a patient with relapsing GPA in 2001, there have been several case reports, open label studies, two randomized controlled trials and at least two sets of published recommendations advocating the use of rituximab in a subset of patients with AAV. The two RCTs (RAVE and RITUXVAS) demonstrated non-inferiority of rituximab to pulsed cyclophosphamide in inducing remission in patients with AAV. In RAVE, 197 patients with GPA or MPA were randomized to rituximab or cyclophosphamide. 64% of patients in the rituximab arm vs 53% of patients in the control group achieved the primary end-point of remission without steroids at 6 months (P = 0.001). In RITUXVAS, 44 patients with renal AAV were randomized to rituximab or cyclophosphamide arms. 76% in the rituximab arm vs 82% in the cyclophosphamide arm achieved the primary end-point of sustained remission at 12 months (P = 0.68). Post-hoc analysis of 101 patients with relapsing disease in RAVE, 67% of rituximab treated patients vs 42% of cyclophosphamide treated patients achieved the primary end-point (P = 0.01) suggesting that rituximab may be superior to cyclophosphamide for treating relapsing GPA or MPA. Both trials hoped to demonstrate non-inferiority with the presumption that a better adverse event profile will make rituximab a better option for remission induction therapy. But there were no differences in the side effect profile between the control and the experimental arms in both RCTs.

There remain several questions about the position of rituximab in treating AAV. The initial treatment regimen in the clinical trials has been 375 mg/m2 x 4 weekly pulses, but the conventional treatment regimen in most rheumatology units has been 1 g x 2 fortnightly pulses. Rituximab has been used with concurrent cyclophosphamide infusions and without it. The role of serial monitoring of ANCA, immunoglobulins, and CD20 cells has not been defined. Pre-emptive treatment with rituximab has been used, but with increasing reports of non-infectious pulmonary toxicity and the risk of hypogammaglobulinaemia, this may not be as safe as initially perceived.

Rituximab has partially fulfilled the aspiration of targeted therapy in AAV, but its positioning in the treatment algorithm needs further definition.

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122. CURRENT AND EMERGING BIOLOGICS IN SLE
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In recent years there has been increasing interest in new biologic therapies for SLE. Open-label studies have emphasized the efficacy of rituximab in refractory SLE patients and there is also emerging evidence that use in early disease may hold promise for tailored steroid-free regimes. A number of clinical trials using biologic agents, including rituximab, have not however achieved their primary end-point. Aspects of trial design including choice of disease activity instrument, use of concomitant medications and inadequate power may have contributed to these perceived ‘failures’ nevertheless many valuable lessons have been learned from such trials.

Recently belimumab has been successful in two pivotal Phase III trials and has been licensed by the EMEA. These trials employed a novel SLE Responder Index (SRI) derived from a secondary analysis of previous Phase II data. Patients with serologically active disease appear to respond best to this agent and use of belimumab within this subset appears to provide long-term stability of disease. Newer agents in development include drugs that target B-cell depletion or modulation in other ways as well as drugs targeting the IFN pathway.

In the UK two major initiatives are under way that will help improve our understanding and use of these agents. The first is a prospective biologics register for SLE patients, which is already established and seeks to study long-term safety of these agents in SLE. Secondly, two trials of B-cell depletion have been supported by Arthritis Research UK, one examining B-cell depletion in refractory non-renal SLE and the other studying early use of B-cell depletion in LN.

Conclusions: Biologic therapy holds much promise in SLE and as we learn more about the disease and apply the lessons learned from recent trials, we will be in a strong position to further accelerate drug development in SLE. UK rheumatologists can lead the way in this through recruitment to national initiatives such as recently funded clinical trials as well as the ongoing UK-wide safety register.

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123. NOVEL BIOLOGICS IN SEVERE HAEMATOLOGICAL MANIFESTATIONS OF CONNECTIVE TISSUE DISORDERS
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Haematological complications are not uncommon in CTDs. These can vary from easily manageable problems like mild to moderate anaemia and leukopenia to difficult cases of severe thrombocytopenia and multi-vessel thrombosis. Treatment of the severe complications involves multidisciplinary approach. In this regard, the arrival of new biologic agents is very much welcome.

Anti-CD20 therapy with rituximab has been shown to particularly effective in thrombocytopenia associated with rheumatological diseases and may be helpful as an agent with ‘multi-system’ benefits. Anti-complement therapy with eculizumab has found its way into being a useful modality in refractory catastrophic antiphospholipid syndrome. Since increased tissue factor expression is one of the mechanisms for thrombosis in CTDs, newer agents like diazep (adenosine uptake inhibitor) and defibrotide (adenosine receptor agonist), in addition to the well-known angiotensin converting enzyme inhibitors, are potential therapies due to their effects on monocyte tissue factor expression. Other attractive approaches in this setting include anti-cytokine therapies with ability to inhibit TNF, interleukin-6 and mitogen-activated protein kinases.

In this context, it is also useful to bear in mind the growing number of reports of the paradoxical induction of autoimmune processes, especially with anti-TNF agents.

Disclosures: J.T., Alexion—Honoraria.

BHPR: INTERACTIVE PANEL DISCUSSION AND PROBLEM SOLVING TO OPTIMIZE WORK PARTICIPATION

I24. WORK AND MUSCULOSKELETAL CONDITIONS: THE KEY ISSUES
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This presentation will provide the background to the topic of work and musculoskeletal conditions. It will outline the challenges (i.e. size of the problem and reasons for work restriction) and opportunities to reduce the burden of musculoskeletal conditions on work, underlining the importance of a biopsychosocial and inter-disciplinary approach involving interaction between those with a musculoskeletal condition, clinicians, employers and policy makers.

Disclosures: The author has declared no conflicts of interest.

I25. INTERACTIVE PANEL DISCUSSION AND PROBLEM SOLVING TO OPTIMIZE WORK PARTICIPATION
Dame Carol Black1, Bill Gunnyeon2, David Walker3 and Adele Higginbottom4
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Downloaded from https://academic.oup.com/rheumatology/article-abstract/52/suppl_1/i1/1928867 by guest on 16 December 2018
The topic of work continues to develop quickly and demands increasing interest from all stakeholders involved in the care of working age patients with musculoskeletal conditions. Work is important for both individuals and society for economic, social and personal reasons. People with arthritis should have the opportunity to remain in employment or change employment appropriately. Some can continue without help; some require adaptation; some could do different jobs and some can’t or even shouldn’t work. Patients should have choice in this and not feel stigmatized by not working. Once work is lost it ceases to be an ambition. This session aims to (i) facilitate the provision of direction for delegates to improve work participation for people with musculoskeletal conditions and (ii) act as a mechanism to provide feedback to the Department of Work and Pensions on practice and policy issues. First of all, an overview of the challenges and opportunities to manage work participation for people with musculoskeletal conditions will be provided. This will include a summary of the key issues around assessment of work disability, and multi-disciplinary approaches to enhancing work participation. The second part of the session will focus on assessment. Most rheumatologists have noticed an increase in requests for support for DWP assessments and appeals. Some case histories will be presented. The Work Capability Assessment (WCA) is based on generic abilities as discussed in the previous presentation. The particular problems related to arthritis are: Pain stiffness and fatigue; effects of malfunction of individual joints and often huge variability with time. Could relating the assessment to more work based abilities perhaps directly relating to the impacts of arthritis produce a better assessment for arthritic patients? Could such an assessment have a role in the routine assessment of patients and help keep them in work? What would this look like say for hand function? The final component will allow delegates to participate in an open discussion on points raised within the presentations, or issues from practice. This session follows on from the 2011 BHPHR conference symposium ‘Improving opportunities to manage work participation for people with musculoskeletal conditions will be provided. This will include a summary of the key issues around assessment of work disability, and multi-disciplinary approaches to enhancing work participation. The second part of the session will focus on assessment. Most rheumatologists have noticed an increase in requests for support for DWP assessments and appeals. Some case histories will be presented. The Work Capability Assessment (WCA) is based on generic abilities as discussed in the previous presentation. The particular problems related to arthritis are: Pain stiffness and fatigue; effects of malfunction of individual joints and often huge variability with time. Could relating the assessment to more work based abilities perhaps directly relating to the impacts of arthritis produce a better assessment for arthritic patients? Could such an assessment have a role in the routine assessment of patients and help keep them in work? What would this look like say for hand function? The final component will allow delegates to participate in an open discussion on points raised within the presentations, or issues from practice. This session follows on from the 2011 BHPHR conference symposium ‘Improving

Disclosures: The authors have declared no conflicts of interest.

JEWELS IN THE CROWN

I27. THE NEW COMMISSIONING LANDSCAPE: OPPORTUNITIES AND CHALLENGES
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Abstract not provided

I28. UNMASKING LUPUS: CHANGING PERCEPTIONS OF THE DISEASE AND ITS TREATMENT
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SLE has been a challenge to physicians and patients for over 100 years. The disease is more common than many people realize, especially in those of African descent, and can be difficult to diagnose due to its varied presentations. Although now recognized as a condition that affects about 1 in 2000 women in the UK, it is rarer in men and may appear to be a more severe disease in men than in women, as milder cases may go undetected. Involvement of the kidneys is more common in those of African origin. This is asymptomatic and will be missed if not actively sought. Although LN used to have a poor prognosis, with early detection and appropriate treatment the outcome is now much better, particularly with improvements in the management of comorbidities and an increasing number of drugs available for the treatment of refractory cases. Much work has been done on developing better methods for the classification of lupus, the assessment of disease activity in all systems including neurological, gastrointestinal, ophthalmic and renal, as well as identifying and reducing the risk of chronic damage due to the disease and its treatment. In addition, the multitude of effects of the disease on the lives of patients have been documented using quality of life instruments and on line surveys, to supplement comments made by patients in the clinic. As a result of these activities there is better methodology for assessing the benefits of new therapies than were available 25 years ago. However optimal outcome measures for clinical trials in lupus have yet to be confirmed and it is likely that multiple methods of ascertainment will continue to be necessary for demonstrating efficacy and safety in this complex disease, as are required to identify patients with the disease in epidemiological surveys. Meanwhile a number of exciting clinical trials are in progress for renal and non-renal lupus. With better disease control, an increasing number of women with lupus are keen to undertake pregnancy although this was considered too dangerous to recommend. Fortunately we have analysed long term data on the outcome of children born to mothers with lupus, as it is critical that they receive pre-pregnancy counselling about the possible risks and likely outcomes of pregnancy due to the disease and its treatment in their individual case. It is important that lupus patients are on optimal therapy and that they are managed by a multidisciplinary team before and during pregnancy.

Disclosures: The authors have declared no conflicts of interest.

HEBERDEN ROUND

I26. BHPHR/BSR POSTGRADUATE RESEARCH STUDENT NETWORK: AN INTERACTIVE SESSION TO BUILD LINKS WITH DOCTORAL, POSTDOCTORAL AND SENIOR RESEARCHERS
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To provide a coordinated network for early career researchers that facilitates peer group discussion and support from a range of leading academics. This interactive speed-dating session will enable you to meet other researchers with common interests and methods, and begin to build networks for post-doctoral collaborations. The facilitators will give you brief guidance on how to effectively communicate your research to others. A networking database will be constructed after the event to facilitate communication among the delegates that attended.

Disclosures: The authors have declared no conflicts of interest.