# 2018 EULAR recommendations for physical activity in people with inflammatory arthritis and osteoarthritis

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ABSTRACT (246 words)

**Objective:** Regular physical activity (PA) is increasingly promoted for people with rheumatic and musculoskeletal diseases as well as the general population. We evaluated if the public health recommendations for PA are applicable for people with inflammatory arthritis (iA; Rheumatoid Arthritis and Spondyloarthritis) and osteoarthritis (hip/knee OA) in order to develop evidence-based recommendations for advice and guidance on PA in clinical practice.

**Methods:** The EULAR standardised operating procedures for the development of recommendations were followed. A task force (TF) (including rheumatologists, other medical specialists and physicians, health professionals, patient-representatives, methodologists) from 16 countries met twice. In the first TF meeting, 13 research questions to support a systematic literature review (SLR) were identified and defined. In the second meeting, the SLR evidence was presented and discussed before the recommendations, research agenda and education agenda were formulated.

**Results:** The TF developed and agreed on four overarching principles and ten recommendations for PA in people with iA and OA. The mean level of agreement between the TF members ranged between 9.8 to 8.8. Given the evidence for its effectiveness, feasibility and safety, PA is advocated as integral part of standard care throughout the course of these diseases. Finally, the TF agreed on related research and education agendas.   
**Conclusion:** Evidence and expert opinion inform these recommendations to provide guidance in the development, conduct and evaluation of PA-interventions and promotion in people with iA and OA. It is advised that these recommendations should be implemented considering individual needs and national health systems.

**Keywords**: Rehabilitation, Rheumatoid Arthritis, Spondyloarthritis, Hip Osteoarthritis, Knee Osteoarthritis

INTRODUCTION (word count 2999)

Physical activity (PA) is defined as ‘‘any bodily movement produced by skeletal muscles that results in energy expenditure above resting (basal) levels. PA broadly encompasses exercise, sports and physical activities done as part of daily living, occupation, leisure, and active transportation”1 2. Exercise is a subcategory of PA “that is planned, structured, and repetitive and [that] has, as a final or intermediate objective, the improvement or maintenance of one or more dimensions of physical fitness”1 2. PA-interventions can be provided or performed individually or in groups, supervised or non-supervised, in acute or chronic health states, but should always include behavioural change techniques (BCT) to promote long-term adherence3 4.

To promote the health benefits of PA in the general population, the World Health Organisation (WHO)5 and American College of Sports Medicine (ACSM)2 have provided internationally accepted recommendations for PA (Table 1). In this manuscript, the term PA always includes both physical activity and exercise according to the definitions above.

Inflammatory arthritis (iA, in this manuscript encompassing rheumatoid arthritis (RA) and spondyloarthritis (SpA)) and osteoarthritis (OA) (in this manuscript encompassing hip/knee OA (HOA/KOA)) are major causes of pain and disability worldwide6. There is strong evidence for the benefits of PA on improvements on disease activity7, activities and participation, however, people with rheumatic and musculoskeletal diseases (RMDs) are in general less active compared to healthy controls8-10. Possible underlying reasons could be that health care providers (HCP, including rheumatology health professionals (e.g. physiotherapist (PT), occupational therapist (OT), nurse, podiatrist, psychologist), physical education professions and medical doctors (rheumatologists and other specialists)) and people with iA and OA may be reluctant towards engaging in PA, fearing flare-up or joint damage by exercising11. Furthermore, current clinical management recommendations such as the European League Against Rheumatism (EULAR) recommendations on the management of RA12, SpA13 or HOA/KOA14 and the ACSM guidelines for exercise testing and prescription15 recommend exercise and/or PA, but none of these is specific regarding the required type and dosage. Therefore, it is not clear how these recommendations should be used in routine clinical care. In particular, the evidence on the effectiveness and safety of exercise and PA to a level that meets public health (PH) recommendations has not yet been clearly examined and defined in people with RMDs. A EULAR task force (TF) was therefore set up, (1) to evaluate if the PH recommendations for PA are applicable for people with iA and OA; (2) to develop evidence-based recommendations on PA-promotion and -delivery in the management of people with iA and OA; and (3) formulate an educational and research agenda.

These EULAR recommendations for PA in people with iA and OA are for HCPs, patient organisations and policy makers.

METHODS

The EULAR standardized operating procedures (SOP) for the development of recommendations were followed16. The AGREE II-instrument17 was used to structure this manuscript.

The multidisciplinary TF consisted of a selection of 22 European PA-experts (six medical doctors, including three rheumatologists, one of them specialized in cardiovascular diseases, one GP, one orthopaedic surgeon; nine PTs, a psychologist, an OT, a nurse, and a human movement scientist) and three patient representatives. A steering group managed the process (convenor KN, methodologist TVV, expert JB, fellow AR).

During the first TF meeting, definitions of exercise and PA were clarified and the TF agreed to follow the ACSM position stand2. The TF agreed that RA and SpA as predominant iA conditions, and HOA/KOA as most relevant for PA recommendations would represent the field of iA and OA respectively.Clinically relevant questions on the provision of advice and guidance regarding exercise and PA, from which 13 research questions were defined by consensus to guide the subsequent detailed systematic literature review (SLR) (online-supplementary-Table\_S1).

Two SLRs were performed by AR with the support of two librarians and under the supervision of the convenor and methodologists. The questions were written according to the Population, Intervention, Comparison, Outcome (PICO) format18, resulting in two PICOs: 1) on effectiveness, safety and feasibility of PA and 2) on facilitators and barriers towards PA (online-supplementary-Table\_S2). For the first PICO, the fellow searched for key meta-analyses (MAs) or systematic reviews (SRs) including randomized controlled trials (RCTs) that investigated the effectiveness of PA-interventions in adults with RA/SpA/HOA/KOA. The SLR was performed in PubMed/Medline, Cochrane Library, Embase, Web of Science, Emcare, and PsycInfo, using both MeSH terms and freetext,covering the time frame until 4/2017. For the second PICO, a SLR, covering the time frame until 7/2017, was performed in PubMed/Medline and Cochrane Library including qualitative studies if they described facilitators and barriers regarding PA (including exercise) in people with RA/SpA/HOA/KOA. Experts in the field of RA (EH), SpA (HD), OA (CJ) and behaviour change (KK) respectively checked if all relevant titles and abstracts were included.

Based on the PICOs, the same author (AR) screened the titles and abstracts according to inclusion and exclusion criteria. Potentially relevant articles were identified and full text versions evaluated. Studies including adults (>18 years) with RA/SpA/HOA/KOA that included PA interventions that met the PH recommendations according to the ACSM principles2 regarding frequency, intensity and duration for effective interventions were eligible for inclusion. All data extractions were checked by experts from the TF.

Studies measuring the effectiveness of PA-interventions were meta-analysed. These results and detailed descriptions of the methods are reported elsewhere 19. Studies were used for answering more than one research question if appropriate. For clinical studies evaluating the effectiveness of PA the Cochrane Risk of Bias Assessment Tool was used to assess selection bias, performance bias, detection bias, attrition bias and reporting bias20 by two independent assessors (AR, CH). An additional person (KN) helped to resolve any differences in rating between the assessors. The research evidence was categorized according to the Oxford levels of evidence21.

During the second TF meeting, the results from the SLR were presented, and the experts developed ‘overarching principles’ (background statements to preface recommendations) and drafted 10 recommendations through an iterative process of discussion and consensus. After the meeting, the recommendations were collated and sent to the TF members by e-mail, to rate the level of agreement (LoA) independently and anonymously on a 0-10 point scale (0 =totally disagree, 10 =totally agree). Mean LoA >8 would be considered a “high” LoA. Furthermore, the TF formulated a research agenda and education agenda based on identified gaps in the evidence.

RESULTS

The search yielded 3471 references, 96 of which were included in the SLR: Four MA/SR7 22-24 and 66 RCTs25-93 investigated the effects of exercise interventions, 11 RCTs94-106 investigated the effects of a PA-promotion-intervention, 11 qualitative studies and literature reviews3 11 107-115 described barriers and facilitators regarding PA (Figures 1a,b). The included RCTs were published between 1985 and 2017. Most information is from studies with low (48%) or unclear (39%) risk of bias (online-supplementary-Figure\_S1).

The TF agreed on four overarching principles and ten recommendations for PA in people with RA/SpA/HOA/KOA based on SLR and expert opinion. High loA was achieved for nine out of ten recommendations and two recommendations were graded as strength level A. Table 2 summarizes the overarching principles and recommendations with their associated level of evidence, strength of recommendation and LoA.

**Recommendation 1: PA as integral part of standard care**

Given the evidence for effectiveness, feasibility and safety, the PH recommendations for PA are applicable, and thus, PA should be an integral part of standard care for people with RA/SpA/HOA/KOA. PA according to PH recommendations2 is effective on PA level, physical fitness as well as disease-specific and general outcomes in people with RA/SpA/HOA/KOA (category l evidence16). Our MA including eleven RCTs26 35 36 42 43 50 54 56 57 61 70 showed that cardiovascular exercises have a moderate beneficial effect on cardiovascular fitness (evaluated in VO2 max) in all three conditions. Our MA including 25 RCTs28 31 38 39 47 49 50 62-66 72 75-78 81-83 85 86 88 90 91 showed that muscle strength exercises have a moderate beneficial effect for muscle strength in people with RA and HOA/KOA. Our MA including seven RCTs52 55 58 78 88 90 116 showed that combined exercises (aerobic or strength exercises plus flexibility exercises) had no effect on flexibility in people with SpA or HOA/KOA. However, exercise conditions, assessments and outcome measures varied greatly. There is no study comparing the effect of flexibility exercises alone versus no exercises. In one RCT48 the effect of a neuromotor-exercise program on neuromotor performance was investigated in people with RA showing a positive effect. Eleven RCTs described the promotion of daily PA. Our MA including six RCTs95 98 101 102 104 117 applying BCTs for the counselling intervention showed a small beneficial effect.

Feasibility of interventions can be captured by adherence to the intervention or the study protocol118. Adherence to interventions (number of sessions attended/total number of sessions) has been reported in 26 RCTs (35%) and the mean adherence was 69% in people with SpA, 71% in people with RA and 79% in people with HOA/KOA. However, the (self-) reported adherence to intervention might be over-estimated due to recall bias or social desirability. In 68 RCTs (94%) protocol violations were reported, with approximately 10% of these being disease- or intervention-related.

PH recommendations for PA can be considered safe. No detrimental effects were reported, rather beneficial effects on disease activity and symptoms in inflammatory arthritis7. Forty-four percent of all included RCTs reported on adverse events (AE), of those 62% described no AE and 38% describe minor AE such as transitional exercise related joint or muscle pain.

**Recommendation 2: Responsibility for PA promotion**

All HCPs should have a responsibility for PA promotion and collaborative working that facilitate a close cooperation between different professions to support appropriate disease management. This statement was based on the finding that sixty-six percent of the included studies reported the profession of the HCP providing the intervention, of which 75% were physiotherapists25 31 36 40 44 45 48 50 53 55 58 61 64-66 70 73-79 81 84 87 88 91 94 96 101-105 119 120. However, the functions and responsibilities of HCPs vary across Europe121 122. Therefore, the TF agreed that PA advice should be provided by all HCPs.

**Recommendation 3: Delivery of PA**

The delivery of interventions should be performed by HCPs competent in the field of PA principles and rheumatic conditions. The reporting of training on PA guidelines was rare. One study59 described a “4-hours education session on cardiovascular training”, others described the instructing person as “trained”25 50 69 70 84 88 123 or “experienced”31 49 76 77 88. Some studies with focus on the promotion of daily PA described training sessions on behaviour change skills like Motivational Interviewing94 96 104.

**Recommendation 4: Evaluation of PA**

The PA level (active or non-active) and the exercise domains (cardiorespiratory, muscle strength, flexibility and neuromotor) should be routinely assessed. Of 11 trials investigating the effect of PA promotion interventions, three RCTs 94 96 105 described baseline screening to distinguish between active and non-active persons before starting the tailored PA-intervention. Specific tools are needed to assess each domain 15,p 68.

**Recommendation 5: General and disease-specific contra-indications**

Tools for specific contra-indications (CIs) were found 94 15 124 , however available general or national guidelines defining absolute or relative CIs should be followed as a priority.

**Recommendation 6: Personalized aims and evaluation**

The PA-interventions should be based on individual aims, which should be regularly evaluated. This can be done by PA assessments and any other assessments related to the individual aims. As PA assessments, performance–based tests, patient reported outcome-measures (e.g. SQUASH104, PASE94) and self-monitoring tools (e.g. wearables such as Fitbit100, pedometer99 or accelerometer101) were identified. However, we did not evaluate the validity and reliability of the assessments applied.

**Recommendation 7: General and disease-specific barriers and facilitators**

General and disease-specific barriers (that are not CI per se) and facilitators should be addressed as described in eleven studies11 107-115 125. Disease-specific barriers included lack of knowledge about the disease, lack of knowledge about safe exercising (both in people with iA/OA and HCPs), and symptoms like pain, fatigue, stiffness, reduced mobility, fear of flare-ups or causing damage. Disease-specific facilitators included positive impact of exercise in symptoms or disease control, information about disease and correct exercising, the use medication for pain prior to exercising, using self-regulation techniques, supportive, but not controlling encouragement from HCPs and a supportive social background.

**Recommendation 8: Individual adaptations to PA following individualised assessment**

Adaptations to PA should be made on a comprehensive individual assessment. However, no evidence on the necessity of general adaptations in people with RA/SpA/HOA/KOA was found. In some RA studies the “24 hour-rule” was applied, i.e. the exercise intensity was reduced when the increased pain persisted for more than 24 hours 23 40 50. ACSM provides adaptations to exercise testing in people with arthritis, (e.g. no high-intensity testing if acute inflammation) and training such as exercising when pain is typically least severe or to train carefully in order to reduce risk of associated injuries; although no clear evidence that high-impact activities cannot be engaged during active inflammation15, pp 298-301. Individual disease-related barriers (e.g. symptoms) may determine these adaptations.

**Recommendation 9: Behaviour change techniques**

BCTs should be an integral component of PA-interventions. Several behaviour change theories were used in PA promotion interventions in the field of RA and HOA/KOA4 126, but the reporting was poor. Future research based on theories in design, evaluation and interpretation of findings is needed.

A meta-analysis of six RCTs94 95 98 101 102 104 investigating the effects of a PA promotion intervention according to general PA recommendations2 and based on counselling interventions that apply BCTs showed a small beneficial effect on PA level19. Counselling interventions show a small beneficial effect if BCTs are applied19.

**Recommendation 10: Modes of delivery**

HCPs should consider the whole range of modes to deliver interventions. No evidence on the superiority of specific delivery modes was found. The delivery modes of PA-interventions vary considerably and are mostly described as ‘land- and/or water-based’ and ‘supervised and individualized’, the latter usually applied to group settings. As booster strategies phone calls36 96 98 105, devices (e.g. pedometer98 99, wearable100 101), home visits63 70, log book36 51 76 98, web-based instructions127, written material51 54 103, visual instructions (e.g. video103) were reported.

**Research and Education Agendas**

Based on the gaps identified in the literature, the TF discussed and proposed a research agenda (Box 1) with the prioritised research topics and an education agenda (Box 2) with topics for education and training in PA promotion for HCPs. Evidence on impact of (reducing) sedentary behaviour emerged as an important future research topic.

DISCUSSION

The TF agreed on four overarching principles and ten recommendations for PA in people with RA/SpA/HOA/KOA, which integrated the perspectives of the TF members from different professional, cultural and personal backgrounds. This led to a broad consensus on the principles and recommendations within the group and ought to foster its feasibility and practicability in the diverging health systems across Europe.

The LoA on the recommendations among the TF members was very high. The only exception was about the competency of HCP, which may be due to country specific differences in the availability of HCP competent in PA promotion.

Although the PH recommendations for PA are well established, the feasibility and applicability of these for people with iA and OA has not been assessed so far. Accordingly, the development of the recommendations was needed. Expectedly, they emphasise the importance of PA and will guide future PA-interventions in people with chronic rheumatic conditions.

PA promotion is a behavioural intervention and therefore BCT are central components in PA-interventions. Identifying effective and cost effective BCT within PA promotion intervention in people with chronic conditions is currently a hot topic in research and for example a research priority of the National Institute for Health and Care Excellence, United Kingdom128.

We decided a priori to include only studies fulfilling the PH recommendations for PA according to ACSM principles2. This was a far-reaching decision, which allowed drawing stronger conclusions on the effectiveness and especially the safety of correctly dosed PA-interventions. We followed a pragmatic search strategy with the plan to answer all RQs related to PICO 1 with findings of available SR/MA. However, there were no SR/MA on all exercise dimensions and all conditions available; this lead to extracting single RCTs from high quality SR/ MA. This however excluded high—quality reviews (e.g. Cochrane reviews) and RCTs that did not fulfil the ACSM principles and affected the potential to report 1A evidence according to Oxford levels of evidence21. Furthermore, only one reviewer screened the abstracts and decided on unclear abstracts together with a second reviewer, which is not fully in line with standard procedures of a SR129. However we applied a double-check by experts to ensure that no relevant studies were missed.

A major problem for data extraction and interpretation was that the reporting of interventions in most studies was incomplete. Manuscripts that applied TIDieR130 (Template for Intervention Description and Replication) guidelines reported more precisely the PA-interventions and substantially improved the objective evaluation of the PA-interventions.

For the research questions related to the effectiveness and safety of PA-interventions and BCT the PICO scheme was applied, resulting in 1A level of evidence. All other research questions we had to answer in a descriptive way limiting the level of evidence to 3 to 4. However, this limitation is due to the nature of the research questions. Nevertheless, the qualitative studies may provide valuable insight into important PA-related fields, such as assessments, barriers and facilitators, PA promotion strategies.

The recommendations focused on the conditions RA/SpA/HOA/KOA, the most prevalent RMD conditions to increase the generalisability and applicability of the recommendations. However, large heterogeneity between these conditions may limit the precision of the recommendations. Therefore, additional disease-specific recommendations are desirable. In addition, not all sub-conditions were considered and represented (e.g. juvenile arthritis).

The research agenda highlights several areas where scientific evidence is lacking. It is a clear ambition to implement these recommendations into daily clinical routine. Due to the different health systems across Europe, development and evaluation of target group and culture-specific implementation strategies is needed and should involve all stakeholders.

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Contributions

AR and KN contributed equally. AR was the research fellow for the project, undertaking the SLR. The fellow was supervised by the steering group consisting of KN (convenor), TVV (methodologist), JB (expert). KN and TVV supervised the process of the SLR. KN organized and chaired the TF meetings. AR and KN drafted the manuscript with advice from TVV and JB. All authors have contributed to the recommendations by participating in the TF meetings; during discussion and agreement on the recommendations; revising and approving the manuscript for publication.

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Competing interests

None.

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| **Table 1 Public Health recommendations for PA** | |
| **The ACSM-AHA primary physical activity recommendations\*** | |
| * All healthy adults aged 18-65yr should participate in moderate intensity aerobic PA for a minimum of 30min on 5 d · wk-1 or vigorous intensity aerobic activity for a minimum of 20min on 3 d · wk-1. * Combinations of moderate and vigorous intensity exercise can be performed to meet this recommendation. * Moderate intensity aerobic activity can be accumulated to total the 30min minimum by performing bouts each lasting ≥10min. * Every adult should perform activities that maintain or increase muscular strength and endurance for a minimum of 2 d · wk-1. * Because of the dose-response relationship between PA and health, individuals who wish further improve their fitness, reduce their risk of chronic diseases and disabilities, and/or prevent unhealthy weight gain my benefit by exceeding the minimum recommended amounts of PA. | |
| Cardiorespiratory (‘‘aerobic’’) exercise\*\* | |
| Frequency  Intensity  Time  Type  Volume  Pattern  Progression | ≥5 d · wk-1 of moderate exercise, or ≥3 d · wk-1of vigorous exercise, or a combination of moderate and vigorous exercise on ≥3–5 d · wk-1 is recommended.  Moderate and/or vigorous intensity is recommended for most adults. Light to moderate intensity exercise may be beneficial in deconditioned persons.  30–60 min · d-1 - (150 min · wk-1) of purposeful moderate exercise, or 20–60 min · d-1  (75 min· wk-1) of vigorous exercise, or a combination of moderate and vigorous exercise per day is recommended for most adults. ≥20 min d-1 (150 min · wk-1) of exercise can be beneficial, especially in previously sedentary persons.  Regular, purposeful exercise that involves major muscle groups and is continuous and rhythmic in nature is recommended.  A target volume of ≥500–1000 MET min · wk-1 is recommended. Increasing pedometer step counts by ≥2000 steps per day to reach a daily step count ≥7000 steps per day is beneficial. Exercising below these volumes may still be beneficial for persons unable or unwilling to reach this amount of exercise.  Exercise may be performed in one (continuous) session per day or in multiple sessions of ≥10 min to accumulate the desired duration and volume of exercise per day. Exercise bouts of ≥10 min may yield favorable adaptations in very deconditioned individuals. Interval training can be effective in adults.  A gradual progression of exercise volume by adjusting exercise duration, frequency, and/or intensity is reasonable until the desired exercise goal (maintenance) is attained. This approach may enhance adherence and reduce risks of musculoskeletal injury and adverse CHD events. |
| resistance exercise\*\* | |
| Frequency  Intensity  Time  Type  Repetitions  Sets  Pattern  Progression | Each major muscle group should be trained on 2–3 d· wk-1  60%–70% of the 1RM (moderate to hard intensity) for novice to intermediate exercisers to improve strength.  ≥80% of the 1RM (hard to very hard intensity) for experienced strength trainers to improve strength.  40%–50% of the 1RM (very light to light intensity) for older persons beginning exercise to improve strength.  40%–50% of the 1RM (very light to light intensity) may be beneficial for improving strength in sedentary persons beginning a resistance training program.  ≤50% of the 1RM (light to moderate intensity) to improve muscular endurance.  20%–50% of the 1RM in older adults to improve power.  No specific duration of training has been identified for effectiveness.  Resistance exercises involving each major muscle group are recommended. A variety of exercise equipment and/or body weight can be used to perform these exercises.  8–12 repetitions is recommended to improve strength and power in most adults. 10–15 repetitions is effective in improving strength in middle aged and older persons starting exercise 15–20 repetitions are recommended to improve muscular endurance.  Two to four sets are the recommended for most adults to improve strength and power. A single set of resistance exercise can be effective especially among older and novice exercisers. ≤2 sets are effective in improving muscular endurance.  Rest intervals of 2–3 min between each set of repetitions are effective.  A rest of ≥48 h between sessions for any single muscle group is recommended.  A gradual progression of greater resistance, and/or more repetitions per set, and/or increasing frequency is recommended. |
| Flexibility exercise\*\* | |
| Frequency  Intensity  Time  Type  Volume  Pattern  Progression | ≥ 2–3 d· wk-1 is effective in improving joint range of motion, with the greatest gains occurring with daily exercise.  Stretch to the point of feeling tightness or slight discomfort.  Holding a static stretch for 10–30 s is recommended for most adults. In older persons, holding a stretch for 30–60 s may confer greater benefit. For PNF stretching, a 3- to 6-s contraction at 20%–75% maximum voluntary contraction followed by a 10- to 30-s assisted stretch is desirable.  A series of flexibility exercises for each of the major muscle–tendon units is recommended. Static flexibility (active or passive), dynamic flexibility, ballistic flexibility, and PNF are each effective.  A reasonable target is to perform 60 s of total stretching time for each flexibility exercise.  Repetition of each flexibility exercise two to four times is recommended. Flexibility exercise is most effective when the muscle is warmed through light to moderate aerobic activity or passively through external methods such as moist heat packs or hot baths.  Methods for optimal progression are unknown. |
| Neuromotor exercise training\*\* | |
| Frequency  Intensity  Time  Type  Volume  Pattern  Progression | ≥ 2–3 d· wk-1 is recommended.  An effective intensity of neuromotor exercise has not been determined.  ≥20-30 min · d-1 may be needed.  Exercises involving motor skills (e.g., balance, agility, coordination, and gait), proprioceptive exercise training, and multifaceted activities (e.g., tai ji and yoga) are recommended for older persons to improve and maintain physical function and reduce falls in those at risk for falling. The effectiveness of neuromuscular exercise training in younger and middle-aged persons has not been established, but there is probable benefit.  The optimal volume (e.g., number of repetitions, intensity) is not known.  The optimal pattern of performing neuromotor exercise is not known.  Methods for optimal progression are not known. |

\*ACSM : American College of Sports Medicine, AHA : American Heart Association, extracted from the ACSM Guidelines for Exercising Testing and Prescription, capter 1, p415 ; \*\*Extracted from ACSM position stand2, Table 2, p1336; d, days; wk, week; yr, years, min, minutes; h, hours; s, seconds; PA, physical activity, MET, metabolic equivalent of task; CHD, coronary heart disease;

**Figure 1a: Flow Chart of the literature search related to PICO\_1.**

**Figure 1b: Flow Chart of the literature search related to PICO\_2.**

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| Table 2 Recommendations for physical activity and exercise in people with inflammatory arthritis and osteoarthritis | | | |
| *Overarching Principles*   1. Physical activity is part of a general concept to optimize health related quality of life. 2. Physical activity has health benefits for people with RA/SpA/HOA/KOA. 3. General physical activity recommendations, including the four domains (cardiorespiratory fitness, muscle strength, flexibility and neuromotor performance) are applicable (feasible and safe) to people with RA/OA/SpA. 4. The planning of physical activity requires a shared decision between health care providers and people with RA/SpA/OA, which takes people’s preferences, capabilities, and resources into account. | | | |
| Recommendations | **Category of evidence** | **Strength of recommendation** | **Level of Agreement mean (SD)**  **Median (Range)** |
| 1. Promoting physical activity consistent with general PA recommendations should be an integral part of standard care throughout the course of disease in people with RA/SpA/HOA/KOA. | 1B | A | 9.81 (0.39)  10 (9-10) |
| 1. All health care providers involved in the management of people with RA/SpA/HOA/KOA should take responsibility for promoting PA, and should cooperate, including making necessary referrals, to ensure that people with RA/SpA/HOA/KOA receive appropriate PA-interventions. | 4 | D | 9.14 (0.98)  9 (7-10) |
| 1. Physical activity interventions should be delivered by health care providers competent in their delivery to people with RA/SpA/HOA/KOA. | 4 | D | 8.86 (1.48)  10 (5-10) |
| 1. Health care providers should evaluate the type, intensity, frequency, and duration of the people’s actual physical activity by means of standardized methods to identify which of the four domains of general physical activity recommendations can be targeted for improvement. | 3 | C | 9.05 (1.04)  9 (6-10) |
| 1. General and disease-specific contra-indications for physical activity should be identified and taken into account in the promotion of physical activity. | 4 | D | 9.10 (1.41)  10 (5-10) |
| 1. Physical activity interventions should have clear personalized aims, which should be evaluated over time, preferably by use of a combination of subjective and objective measures  (including self-monitoring when appropriate). | 4 | D | 9.05 (1.25)  9 (5-10) |
| 1. General and disease-specific barriers and facilitators related to performing physical activity, including knowledge, social support, symptom control, and self-regulation should be identified and addressed. | 3 | C | 9.19 (1.13)  10 (6-10) |
| 1. Where individual adaptations to general physical activity recommendations are needed, these should be based on a comprehensive assessment of physical, social and psychological factors including fatigue, pain, depression, and disease activity. | 4 | D | 9.24 (0.86)  9 (7-10) |
| 1. Health care providers should plan and deliver physical activity interventions that include the behavioural change techniques self-monitoring, goal setting, action planning, feedback and problem solving. | 1A | A | 9.48 (0.79)  10 (7-10) |
| 1. Health care providers should consider different modes of delivery of physical activity (e.g. supervised/not-supervised, individual/group, face-to-face/ online, booster strategies) in line with people’s preferences. | 4 | D | 9.00 (1.30)  9 (5-10) |

Abbreviation: RA, rheumatoid arthritis; SpA, Spondyloarthritis; HOA, hip osteoarthritis; KOA, knee osteoarthritis; SD, standard deviation; PA, physical activity

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| Box 1 Research agenda for physical activity in people with inflammatory arthritis and osteoarthritis |
| 1. To evaluate the long-term effectiveness of PA at different intensities and types, and monitoring of Adverse Events (AE). 2. To evaluate links between PA behaviour and disease-specific outcomes. 3. To evaluate the long-term effectiveness of sedentary behavior reduction, including the monitoring of AE. 4. To evaluate links between sedentary behavior and disease-specific outcomes. 5. To identify which PA-intervention strategies work best to increase PA level and adherence in various subgroups. 6. To identify markers of response and non-response to PA treatment. 7. To identify disease-specific contra-indications on different exercise domains (cardiovascular, strength, flexibility, neuromotor). 8. To further develop and evaluate strategies to reduce and monitor a change in sedentary behavior. 9. To develop PA-interventions targeting all exercise dimensions simultaneously with special focus on feasibility. 10. To evaluate and recommend valid PA assessments feasible for the use in clinical practice. 11. To study how to facilitate PA behavior change immediately from screening onwards and how to address facilitators and barriers. 12. To identify facilitators and barriers of health care providers towards applying the PA recommendations. 13. To perform long-term effectiveness trials on combined interventions including other health behaviours. |

Abbreviations: PA, physical activity

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| Box 2 Education agenda for physical activity in people with inflammatory arthritis and osteoarthritis |
| 1. Increase knowledge about PA among HPs, physicians and people with inflammatory arthritis and osteoarthritis. 2. Increase HPs’ and physicians’ skills in communicating the role of PA in managing general health and disease-specific issues. 3. Include knowledge and skills on PA promotion in all HPs’ and physicians’ undergraduate training curricula. 4. Develop a EULAR training module on PA for HPs and rheumatologists. 5. Propose a session on PA at every EULAR congress. 6. Develop education materials for people with inflammatory arthritis and osteoarthritis. |

Abbreviations: PA, physical activity; HP, health professionals