Conclusions: The immediate effects of neck stabilisation exercises on proprioceptive function of neck may reflect that these exercises, may enhance postural awareness and control while in motion.

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THU0725-HPR   **EULAR POINTS TO CONSIDER/RECOMMENDATIONS FOR THE HEALTH PROFESSIONALS' PREVENTION AND MANAGEMENT OF OSTEOPOROTIC FRACTURES**

E. Hurkmans[1], N. Wilson[2], T. Stamm[3], J. Adams[2], on behalf of Task force group HP management osteoporotic fractures. *[1]Social Affairs and Health, Ecorys, Rotterdam, Netherlands; [2]Faculty of Health Sciences, University of Southampton, Southampton, UK; [3]Section for Outcomes Research, Center for Medical Statistics, Informatics, and Intelligent Systems, Medical University of Vienna, Vienna, Austria*

Background: Interventions delivered by non-physician health professionals, such as physiotherapists, occupational therapists and nurses play an important role in effective management of patients with osteopenia or osteoporosis.
Objectives: To establish EULAR Points to Consider/Recommendations for the prevention and management of osteoporotic fractures by non-physician health professionals.
Methods: Points to consider/recommendations were developed according to EULAR standard procedures[1] using six stages: i) establishment of an international expert panel/task force including patients, rheumatologists, orthopaedic surgeons and health professionals; ii) a first Delphi-round to set up clinical questions; iii) a literature review; iv) a task force meeting to review the results of the literature search and to formulate points to consider/recommendations; v) development of consensus and assessment of the level of agreement with the points to consider/recommendations using second Delphi round; vi) a field test.
Results: Eight clinical questions and two overarching principles were formulated, subject to the literature search (the clinical questions only) and discussed and refined during the task force meeting. The two overarching principles focused on the importance of shared decision making between patients and professionals and the involvement of different health professionals. Two clinical questions were merged and the task force finally agreed on seven recommendations/points to consider: 1) Health professionals should start with fall risk evaluation in patients at risk of primary or secondary fracture. Patients with high risk should be evaluated by a health professional using multi-component screening, or referred to another health professional competent in multi-component screening. 2) Health professionals should ensure that after osteoporotic fracture, patients are given opportunities to participate in adequate exercise and are supported in adequate nutritional intake. Calcium and vitamin D intake should be discussed with the patients. 3) Smoking and overuse of alcohol should be discouraged. 4) Tailored multicomponent interventions including, for example: exercises, environmental adaptations, nutrition, life-style and education, should be offered to patients at high risk of primary osteoporotic fracture and/or high risk of falls. 5) Health professionals should be included in Fracture Liaison Services (FLS) and/or a coordinated, multidisciplinary post-fracture prevention program. Patients with fragility fractures should be referred to a FLS or an adequate, coordinated, multidisciplinary post-fracture prevention program. 6) Health professionals should address, monitor and support medication adherence in a structured follow up. 7) Health professionals should identify patients at risk of bone fragility, ensure they are offered opportunities for adequate treatment, and address bone fragility through patient education.
Conclusions: These points to consider/recommendations should be applied by health professionals in the prevention and management of osteoporotic fracture to ensure high quality care.

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THU0726-HPR   **ADHERENCE TO BIOLOGICAL THERAPY IN CHRONIC INFLAMMATORY RHEUMATISM: RESULTS OF A RETROSPECTIVE STUDY IN AUVERGNE, FRANCE**

F. Fayet, M.R. Rodere, C. Savel, B. Pereira, M. Soubrier, M. Couderc. *Hospital Gabriel Montpied, Clermont-ferrand, France*

Background: The arsenal of treatment options for Chronic inflammatory rheumatism (CIR) has considerably grown over recent years with the biological therapies. Poor patient adherence to treatment is a major barrier to proper disease management. Patient education enhances drug adherence by improving the knowledge and skills needed to manage the disease and treatments.
Objectives: This study aimed to assess adherence to subcutaneous biological therapy using the Morisky Medication Adherence Scales (MMAS-4) in patients with CIR: rheumatoid arthritis (RA), ankylosing spondylitis (SA) and psoriatic arthritis (PsA), who received education in our department.
Methods: This was a retrospective single-centre observational study of routine care. All patients on subcutaneous biological therapy who received at least one education interview between 2009 and 2013 were included. Adherence was assessed using the Morisky questionnaire (MMAS-4). A comparison of adherence was made based on the BIOSECURE questionnaire (knowledge and skills relating to biological therapy) and type of educational model received by patient (model 1: providing information; model 2: performing one-on-one education; model 3: performing head to head and group-based education). Adherence was also compared based on population characteristics, type of care (mixed or solely hospital), type of CIR, number of education interviews, injection frequency and type of biological therapy.
Results: A total of 193 patients were included in the study, 124 of whom were women. The population's mean age was 53.3±14.8 years. Patients had had CIR for 10 years,[5–18] with 113 patients suffering from RA, 73 from SA, and 7 from PsA. Of the 193 patients, 192 (99.5%) were on TNF inhibitors (of whom 107 [55.4%] were on etanercept, 58 [30.1%] on adalimumab, 10 [5.2%] on certolizumab and 17 [8.8%] on golimumab) while 1 (0.5%) was on abatacept. About 75.7% (n=146) of the patients reported good adherence (Morisky=0), 17.6% (n=34) moderate adherence (Morisky=1 or 2), and 6.7% (n=13) poor adherence (Morisky=3 or 4). No significant association was observed between knowledge and skill levels as evaluated by the BIOSECURE questionnaire and adherence as evaluated by the Morisky questionnaire (respectively, 76±13, 77±11, 76±18, p=0.91). A total of 92 patients received model 1, 80 received model 2, and 21 received model 3. Adherence was poorer in the group that received model 3 compared with the other two models (79% Morisky score of 0 for model 1, 76% for model 2 *versus* 57% for model 3; p=0.04) and poorer in young patients (p=0.005). No difference existed based on gender, education level, marital status, type of care (mixed or solely hospital), type of CIR, number of education interviews, frequency (1, 2 or 4 weeks) of biological injections.
Conclusions: : Adherence to biological therapy was quite good in this study. No link existed between adherence and knowledge levels. Combining head to head and group-based patient education did not improve adherence compared with simply providing information or performing head to head patient education alone.
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