need revision later; overall health); support during recovery (3 items: length of recovery; doctors’ recommendations; availability of resources); and others’ opinions (3 items: surgery as last resort; friends’/family’s recommendations; considerations about others). Controlling for age and education, results from the multiple linear regression model suggested that women rated risks/benefits (p=0.01), indications (p=0.02), and support during recovery (p=0.002) as more important in TJA decision making than did men, but rated ‘others’ opinions’ similarly (p=0.35).

Conclusions: Our results identified the importance of information about TJA in four distinct domains: indications for TJA, risks and benefits of surgery, support during recovery, and others’ opinions. Further, our findings indicate that, after controlling for age and level of education, gender differences exist in TJA information needs. These findings will be useful to inform TJA education and patient-physician decision making.

301 USE OF DRUG COMBINATIONS IN PATIENTS WITH OSTEOARTHRITIS: A POPULATION-BASED COHORT STUDY

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Purpose: Patients affected with osteoarthritis (OA) use different drugs in search for relief, with potential impact on patients’ safety and healthcare costs. However, the use of drug combinations in these patients has not been explored in detail.

We used a large database including primary care medical records and pharmacy invoice data to explore use of the following drugs in OA patients in the period 2006-2010: non-steroidal anti-inflammatory drugs (NSAIDs), Symptomatic Slow Acting Drugs for OA (SYSADOA), COX-2 inhibitors (COX2i), opioids, and other analgesics (paracetamol and metamizol).

Methods: - Study population and setting: We screened the SIDIAP Database (www.sidiap.org) to identify those aged 40 years or older with a new diagnosis of OA using ICD-10 codes. Among these, we ascertained prevalence of use of oral NSAIDs, COX2i, SYSADOA, opioids, and analgesics (all alone and in combination) in the period 2006-2011.

- Source of data: SIDIAP contains anonymised medical records and pharmacy invoice data of a representative >5 million people in Catalonia (North-East Spain).

- Statistical analyses: We estimated prevalence (and 99% Confidence Intervals) of use of these drugs and their combinations, and the proportion of occasional (MPR<25%) and regular (MPR>50%) users for each of them.

Results: We identified 281,356 patients with an incident clinical diagnosis of OA. Among these, 128,314 (45.6%) were treated with 3 or more drugs, and 57,835 (20.6%) with no subsidized drugs. The 3 most common combinations of drugs were: oral NSAID+analgesic (12.2%); 2.topical NSAID+analgesic (2.5%); and oral NSAID+SYSADOA (1.8%). Besides, 34,672 (12.3%) patients received only 1 drug, the 3 most common being, in descending order: oral NSAID, analgesic and SYSADOA. The proportions of occasional and regular users were highest for SYSADOA (24.5% occasional and 0.9% regular users), and lowest for opioids (7.3% occasional and 1.9% regular users). Proportions (%) of occasional and regular users for each drug of study are presented in Figure.

Conclusions: About 75% of OA patients are treated with at least 2 drugs, and more than half receive 3 or more. However, compliance with these drugs is very low, and hence consequences of polypharmacology on effectiveness and safety are difficult to predict as based on clinical trials results. These data are of interest for health care provision for patients with OA.

302 THE CONSULTATION PREVALENCE OF OSTEOARTHRITIS 2030 MAY INCREASE BY 50%: PROGNOSIS FOR SWEDEN

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Purpose: To project the future consultation prevalence of osteoarthritis (OA) in the knee, hip and hand.

Methods: The Skåne Health Care Register (SHCR) is a legislative, mandatory register in Skåne County, Sweden (total population 1.3 million), based on physicians’ International Classification of Diseases (ICD) 10 diagnostic codes. We used observational data on the consultation prevalence of the knee OA (M17), hip OA (M18) and hand/wrist OA (M15.1, M15.2, M18, M19.0D, M19.1D, M19.2D) by the 31st Dec 2011...
based on the SHCR data from years 1999-2011. We applied two scenarios to the age-specific (age 20-65 and >65 years) population structure prognosis for Skåne provided by Statistics Sweden. In scenario 1 (conservative) we assumed that the age-specific gender BMI remained constant. In scenario 2 we assumed that the age-specific prevalence of knee OA would increase relatively by 2.6% per year in the first 10 years and by 2% per year in the next 10 years for those aged <65 and by 1.6% per year in the first 10 years and by 1.2% per year in the next 10 years for the population >65. Initial values for that increase are based on the previously published changes in the prevalence of arthritis between 1994 and 2002 in Canada (Perrucio et al 2006). The reasons for this observed increase are not fully understood but the increase in obesity is the main plausible cause. For the OA in the hip or hand we used half of the increase for knee OA because the impact of the increase in body mass index on the consultation prevalence in those sites is probably lower.

Methods: In the conservative scenario, which solely depends on changes in age distribution of the population, the consultation prevalence of knee, hip and hand OA in adults (aged 20+) will increase from 9.0% in 2011 to 9.9% in 2030. In the conservative scenario, which solely depends on changes in body mass index on the consultation prevalence in those sites is probably lower.

Results: In the conservative scenario, which solely depends on changes in age distribution of the population, the consultation prevalence of knee OA would increase relatively by 2.6% per year in the first 10 years and by 2% per year in the next 10 years for those aged <65 and by 1.6% per year in the first 10 years and by 1.2% per year in the next 10 years for the population >65. Initial values for that increase are based on the previously published changes in the prevalence of arthritis between 1994 and 2002 in Canada (Perrucio et al 2006). The reasons for this observed increase are not fully understood but the increase in obesity is the main plausible cause. For the OA in the hip or hand we used half of the increase for knee OA because the impact of the increase in body mass index on the consultation prevalence in those sites is probably lower.

Conclusions: In this population-based study of symptomatic subjects with no radiographic OA, the ratio of uC2C/sCPII and older age were associated with an increased risk of cartilage damage, while lateral tibiofemoral tenderness was associated with a reduced risk of cartilage damage. Lateral tenderness likely relates to periarthritic pain syndromes and hence may be helpful in ruling out the presence of cartilage damage in those with knee pain. These findings may be useful for future studies aimed at identifying cohorts with early knee OA for epidemiologic research or clinical trials.

304 ADDING VALUE IN KNEE ARTHROPLASTY: ROLE OF SEX AND OBESITY ON PHYSICAL ACTIVITY POST SURGERY

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Purpose: Over 620,000 total knee arthroplasties (TKAs) are performed annually in the US. Approximately 80% of TKA recipients achieve the primary goal of relieving pain and improving functional status. Given the rich evidence documenting the benefits of physical activity (PA), TKA recipients could further improve their post-operative outcomes and quality of life by being more physically active. There has been little study of compliance with PA guidelines in persons who have had TKA, and factors influencing compliance with PA guidelines in this population.

Methods: We used data from a randomized controlled trial of the efficacy of post-TKA patient navigation conducted at a tertiary medical center. Consecutive subjects undergoing TKA for the primary diagnosis of knee OA were offered participation in the study, and those who agreed were followed with surveys preoperatively and at 3 and 6 months postoperatively. Preoperatively, we collected data on demographic and baseline clinical characteristics, including age, sex and obesity as well as self-efficacy and pain catastrophizing. At each assessment study participants reported pain and functional status (measured by WOMAC). At the 3 and 6 month survey we included the Yale Physical Activity Survey to ascertain patients' engagement in vigorous physical activity and leisure walking. We estimated the proportion of TKA recipients who achieved the level of PA specified by federal PA guidelines based upon their response to Yale PA Survey questions about vigorous activity. We examined associations between age, sex and obesity and the likelihood of non-compliance with PA guidelines. In addition we examined whether pain catastrophizing and self-efficacy influenced compliance with PA guidelines.

Results: The study sample consisted of 113 participants, 60% females, mean age 67.3 years (SD 8.5) and mean BMI 30.3 (SD 6.4). At 3 months post-TKA, about 20% of subjects reported amounts of vigorous PA consistent with PA guidelines, and at 6 months 35% of TKA recipients were compliant with PA guidelines, and at 6 months 35% of TKA recipients were compliant with PA guidelines. At six months, median time of vigorous PA was 30 min/week (IQR 10-120 min/week), and differed greatly between men (70 min/week) and women (30 min/week, p = 0.0117). The median time engaged in leisure walking was 70 minutes per week (IQR 22-120 min/week), which was similar for men and women. Results of multivariate analysis that included age, gender, obesity, pain status, pain catastrophizing and self-efficacy revealed that obesity was the only factor independently associated with greater likelihood of failure to achieve PA guidelines (OR 3.4, 95%CI: 1.37, 8.36).