Results: Mean PASE score was 149.80 (SD 78.4) and heath factors (BMI and waist circumference) were assessed from two 20 meter walks, and covariables including demographics (age, sex, race, number of non-elective hospitalizations in the prior decade (a proxy for comorbidity), eligibility for Medicaid (a proxy for low income) and number of hip osteoarthritis were measured.

Methods: Cross-sectional accelerometer data from 969 adults aged 55 and above with radiographic knee OA (Kellgren-Lawrence ≥ 2 in one or both knees) participating in the Osteoarthritis Initiative accelerometer monitoring ancillary study was assessed for physical activity and function. Participants’ response to the PASE questionnaire was followed by 7 days of accelerometer monitoring. Accelerometer measures included average daily minutes in MVPA and average daily minutes in MVPA sessions of 10 minutes or more (MVPA bouts). Other subjective measures included WOMAC (Western Ontario MacMaster) function, SF12 (12-Item Short Form Health Survey) physical function, objective measure gait speed averaged from two 20 meter walks, and covariables including demographics (age, gender, and heath factors (BMI and waist circumference) were assessed.

Results: Mean PASE score was 149.80 (SD = 78.4) and mean accelerometer MVPA was 15.55 minutes/day (SD = 17.18). PASE scores were modestly correlated with average daily minutes in MVPA (r = 0.31) and MVPA bouts (r = 0.21). PASE scores correlated better with accelerometer measures of MVPA and MVPA bouts in participants who were particularly inactive (characterized by older age, higher BMI, and greater waist circumference). There were two significant gender effects. Accelerometer measures of MVPA and MVPA bouts compared to PASE scores had stronger correlation in WOMAC function (r = 0.14 - 0.12 versus -0.02), SF12 physical function (r = 0.22, 0.19, versus 0.07), and gait speed (r = 0.35, 0.29, versus 0.16).

Conclusions: In this population with radiographic knee OA, modest correlations of PASE with accelerometer MVPA assessments limit the ability to use this self-reported instrument to explore relationships of activity intensity and OA. Accelerometer data are complementary and help to better characterize the effects of physical activity on health outcomes. Accelerometer MVPA and MVPA bouts were more strongly associated with physical function than PASE, although that correlation was modest at best. The choice of PASE versus objective measurement for future epidemiologic studies must take into account the purpose for which physical activity is being measured.

Purpose: In France, the cost of an osteoarthritic patient has not been estimated for several years. The aim of the study was to evaluate the annual cost of the treatment given to osteoarthritic patients by GP.

Methods: The cohort was made up of patients who were diagnosed with osteoarthritis between April 2009 and March 2010 (IMS Disease Analyzer database) The cost includes all medical cost to the patients in the cohort, and coligated in the Disease Analyzer database (all consultations with GPs and all resulting drug prescriptions). The evaluated cost is therefore the annual cost of treatment given to an osteoarthritic patient.

Results: 18 976 patients suffering from osteoarthritis were followed. For these patients, who had an average age of 66, all consultations with GPs as well as all resulting drug prescriptions were valued both in terms of societal cost and cost to health insurance. The average annual cost of disease management by a GP of a patient suffering from osteoarthritis is therefore valued at €755 societal cost, of which around 60% (€447) is paid by health insurance. The annual cost of treatment by a GP of a patient suffering from hip osteoarthritis is significantly lower at the societal level (€715) than at the health insurance level (€425) compared to patients suffering from osteoarthritis in the knee or elsewhere, despite their higher age.

Conclusions: No literary data evaluating the cost of an osteoarthritic patient currently exists. The closest data is that produced by a COART® France study (Le Pen et coll, Revue du rhumatisme, December 2005). The prevalence of osteoarthritis has been estimated at around 4 million sufferers, even though this figure may be conservative, we can estimate that the cost of osteoarthritis treatment is around 3 billion euros. We are sure that further data will be added to existing ones.

OSTEOARTHRITIS IN FRANCE THE COST OF AMBULATORY CARE IN 2010

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Purpose: The relationship of PASE to moderate/vigorous physical activity measured by accelerometer in the Osteoarthritis Initiative.

Methods: MEASURED BY ACCELEROMETER IN THE OSTEOARTHRITIS INITIATIVE RELATIONSHIP OF PASE TO MODERATE/VIGOROUS PHYSICAL ACTIVITY


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INCIDENCE, RISK FACTORS AND CONSEQUENCES OF PERIPROSTHETIC AND FEMORAL FRACTURE AMONG THOSE WHO SURVIVED TOTAL HIP REPLACEMENT FOR MORE THAN A DECADE

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Purpose: To determine the incidence and risk factors for periprosthetic and non-periprosthetic femoral fractures, as well as the risk of subsequent hospitalization following these fractures, for a population–based cohort of patients who had a total hip replacement (THR) in 1995-1996 and were followed from 2006-2008.

Methods: We used Medicare claims data to assemble a cohort of Medicare beneficiaries who had elective primary THR from July, 1995 through June, 1996. We obtained Medicare hospital claims for these patients through 2008. The ICD-9-CM code for periprosthetic fracture (996.44) was introduced in October, 2005. We excluded periprosthetic fractures occurring in the knee or shoulder region. We used the incidence density method to calculate the annual incidence of each fracture. Time ‘at risk’ was defined from the beginning of observation (January 2006) to one of the three events, whichever occurred first: 1) death, 2) fracture or 3) end of the observation period (December 2008). We used multivariate Cox proportional hazards models to identify risk factors for periprosthetic fractures and for non-implant related femoral fractures, including sex, age, race, number of non-elective hospitalizations in the prior decade (a proxy for comorbidity), eligibility for Medicaid (a proxy for low income) and number of hip osteoarthritis.