strictly defined concept of the OA, which is often used to refer to OA involving the knee, hip, and other joints of the body. OA is the most common chronic joint disease and the leading cause of disability in adults. The severity of OA is often characterized by pain, stiffness, and limita
Study. Source population: Canadian Association of Retired Persons. Lifetime Physical Activity Questionnaire: Lifetime activity in three domains — sport, occupation and domestic — was self-reported retrospectively via a validated online computer-adaptive survey. For each specific activity type (e.g., each individual sport, each occupation held) detailed questions were asked regarding frequency, duration and intensity. Activities were further deconstructed by time spent in major body movement type (e.g., walk, run, squat).

Exposures: Energy Expenditure: estimated by multiplying number of hours spent in an activity by the average intensity of that activity, as signed using standardized metabolic equivalents and reported in MET-hours/week.

Hip and knee (tibio-femoral) joint force was estimated as the product of lifetime bodyweight, typical hip and knee force for specific activities and time spent in specific activities, and reported in kg-hours/week. A lifetime bodyweight trajectory was derived using current weight, weight at age 20, maximum weight, and interpolated using a lowess (non parametric smooth) curve. The typical hip and knee joint force assigned to each of the body movements was based on a comprehensive review of the biomechanical literature and a survey of expert opinion. Relative Joint Loading Index: the ratio of cumulative joint force to total metabolic equivalent (done separately for hip and knee).

For each physical activity exposure, mean values for 5-year intervals over a person’s lifetime, averaged over all subjects, were calculated. Results: Complete baseline data was collected on 4,269 subjects. The sample included 33% female with a mean age of 61.5 years and BMI of 27.5. Overall, women had higher lifetime energy expenditure than men (126 vs 107 MET-hours/wk), and slightly higher hip (47.9 vs 43.3 kgs-hrs/wk, x 100) and knee force (54.2 vs 44.1 kg-hrs/wk, x 100). On balance of the activity across domains, mean energy and joint force for ‘female household’ and ‘male occupation’ were similar. The higher overall scores among women were attributable to significantly higher energy expenditure and joint forces from occupational activities compared to household activities among men. Males expended approximately 2 times the mean energy and 3 times the mean hip and knee force in sport as women; however for both genders, sport had a much smaller contribution to joint force and energy expenditure than the occupation and domestic domains. For both hip and knee forces, the highest joint loading index score (most joint force relative to energy expenditure) was for the male sport, while the lowest score was for female occupation.

Conclusions: Joint force trajectories for the hip and knee were constructed from survey data, and followed expected trends by gender and physical activity domain. These measures may help provide information on the tolerance of the hip and knee joint to long term load. Comparing energy expenditure trajectories to joint force trajectories revealed variation in different population strata, indicating these measures may be useful for separately analyzing the effects of energy expenditure and joint load on health outcomes.

**353 DISSEMINATION OF THE EULAR RECOMMENDATIONS FOR THE MANAGEMENT OF KNEE OSTEOARTHRITIS (OA) IN FRANCE: WHAT SAY AND WHAT DO RHEUMATOLOGISTS? THE DRAGON STUDY**

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Purpose: EULAR recommendations for the management of knee OA (KOA) have been published in 2000, then 2003 and widely disseminated in France. However, no study focused on the level of adhesion of rheumatologists (RH) to these recommendations and their application in daily clinical practice.

Objective: To compare self-declared level of adhesion of French rheumatologists to the EULAR recommendations for the management of KOA and the way they effectively manage patients in 2007.

Methods: This was a prospective observational cross-sectional study. RH randomly selected within a representative panel of French RH were asked to answer a questionnaire assessing their level of knowledge of the EULAR recommendations for knee OA and to rate their adhesion to each. They had then to describe 2 successive patients visiting for symptomatic knee OA, and their treatments. Patients were given by their RH a questionnaire they had to answer at home on their level of satisfaction or their expectations.

Objective: To evaluate the level of satisfaction and expectations of knee OA patients treated by French rheumatologists (RH) in 2007.

Methods: This was a prospective observational cross-sectional study. RH randomly selected within a representative panel of French RH were asked to answer a questionnaire assessing their level of knowledge of the EULAR recommendations for knee OA and to rate their adhesion to each. They had then to write down and rate their patients’ visits for symptomatic knee OA, and their treatments. Patients were given by their RH a questionnaire they had to answer at home on their level of satisfaction and expectations with respect to the management of their knee OA. Data collected: Demographics, knee OA history and level of symptoms at visit, non pharmacologic and pharmacologic treatments prescribed on day of visit. Statistics: descriptive: mean, median, standard deviation (sd).

Results: 346 patients out of 374 (92.5%) included by 214 RH returned their answers: mean age 69.1±9.8 years, 67% women, BMI 28.5±5.7, pain on VAS = 49±22.2 under treatment, presence of knee effusion in 116 patients (34%); 38% at a Kellgren-Lawrence (KL) radiological grade 2, 43% at a KL 3, 9% at a KL 4. Knee OA symptoms were present for 6.2±6.2 years; patients were followed by a practitioner for 4.5±4.6 years (mean number of GP visited 1.3, mean number of orthopaedic surgeons visited 0.5, mean number of RH visited 1.2).

Conclusions: In general, EULAR recommendations for knee OA seem to be both agreed and followed by French RH. However, the percentage of patients receiving paracetamol is low and the number of patients having IA steroids under the number of patients presenting with knee effusion and/or night pain. Pain level rated by these treated patients remains over the “patient acceptable symptom state”.

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