limitation and 17% reported improvement on the transition question at 3 years. Changes in AUSCAN scores in the hand OA group were 0.0 (3.8) for Pain, 0.1 (1.0) for Stiffness and -0.6 (6.1) for Functional limitation with 14% reporting improvement on the transition question at 3 years. Baseline and 3-year AUSCAN scores were consistently higher in the hand OA group compared with the no OA group. 

Conclusions: Hand OA is thought to have a good prognosis. This study shows high levels of disabling pain at baseline, which do not improve over three years. Only a minority of participants with hand OA report improvement in the medium term. Longer-term follow up can help to determine the burden of hand OA and to assess the impact of this on pain and functional limitation.

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HIGH PREVALENCE OF VENOUS INSUFFICIENCY IN PATIENTS WITH KNEE OSTEOARTHRITIS


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Purpose: Patients with osteoarthritis (OA), due to age, walking functional impairment and/or a high prevalence of obesity may have a higher risk of lower limb venous insufficiency. However, the prevalence of this condition has been rarely addressed.

Objectives: To evaluate the frequency of lower limb venous insufficiency in patients with symptomatic OA of knee, hip or hands in a rheumatology consultation in a primary health setting.

Methods: Consecutive patients aged >50 y referred during a 6-month period to a rheumatology practice in a primary health setting because of OA of the knee, hip or hands. Diagnostic of lower limb venous insufficiency was obtained for each patient from the computerized data base (e-cap system) used by their family physicians. Patients with soft tissue disorders (e.g. shoulder tendinitis, plantar fasciitis, etc) adjusted for age were used as control group.

Results: 290 patients were included, 160 with OA and 130 with soft tissue disease, mean age 64.4±9.5 y, F/M 222/68 (77/23%). No differences were found between both groups regarding age or gender. The frequency of lower limb venous insufficiency was significantly higher in the OA group (12.5% vs 4.6% in the control group, p< 0.05); this difference was at the expense of patients with knee osteoarthritis (n= 97), which showed a prevalence of 13.4% (p< 0.05 vs. control group), whereas patients with hand or hip OA did not show significant differences compared to the control group. Obesity was present in 38.5% in patients with knee OA and osteoarthritis and 16.7% of patients with knee OA and obesity had also a diagnosis of venous insufficiency.

Conclusions: These data suggest that lower limb venous insufficiency is more prevalent in patients with knee OA. This fact could be related to reduced mobility and other factors such as obesity. Encouraging exercise and mobilization in patients with lower limb OA could also prevent and help in the management of venous insufficiency in this population.

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RACIAL DIFFERENCES IN KNEE OSTEOARTHRITIS PAIN: POTENTIAL ROLE OF OCCUPATIONAL TASKS

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Purpose: African Americans with osteoarthritis (OA) report greater pain severity than Caucasians. One potential explanatory factor is exposure to occupational tasks that involve substantial joint loading, since African Americans are more likely than Whites to have physically demanding occupations. The purpose of these analyses was to examine whether racial differences in pain, among people with knee OA, persisted when controlling for occupational task exposures.

Methods: This cross-sectional analysis included participants enrolled in the Johnston County Osteoarthritis Project from 1999-2004 who had radiographic knee OA (KL ≥2) and had worked outside the home for >1 year. Pain severity was assessed with the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) pain subscale. Participants reported the frequency of completing nine different occupational tasks involving lower extremity joint loading (walking, lifting/carrying/moving objects weighing more than 10 pounds, standing, bending/twisting/reaching, squatting, climbing stairs, crawling on knees, crouching or kneeling, and doing heavy work while standing) at their longest job (which had a mean duration of 23 years, SD=11) and their current job (if currently working). The total number of occupational tasks performed “often” or “always” were counted for the longest and current jobs, separately. Analyses of the longest job included N=322 African Americans and N=524 Caucasians; analyses of the current job included N=166 African Americans and N=160 Caucasians. Unadjusted linear regression models examined the association of race with pain. Multiple linear regression models examined the association of race with pain when controlling for the number of occupational tasks reported.

Results: Among participants who worked outside the home for >1 year, African American race was associated with significantly worse WOMAC pain scores in the unadjusted regression model (B=0.136, p<0.001). This estimate was slightly attenuated, but still statistically significant, when adjusting for the number of occupational tasks reported for the longest job (B=0.129, p<0.001). Among participants who were currently working, African Americans with osteoarthritis (OA) report greater pain severity than Caucasians. One potential explanatory factor is exposure to occupational tasks that involve substantial joint loading, since African Americans are more likely than Whites to have physically demanding occupations. The purpose of these analyses was to examine whether racial differences in pain, among people with knee OA, persisted when controlling for occupational task exposures.

Conclusions: Among people with radiographic knee OA, the number of physically demanding occupational tasks performed at the longest job did not account for racial differences in current pain severity. Longitudinal analyses will be required to validate these findings. However, the number of current physically demanding occupational tasks did account for the significant association between race and pain. Our study results suggest people with OA who have physically demanding jobs may be at risk for poorer clinical outcomes; better job accommodations and other effective interventions (i.e., exercise, self-management) may help to improve outcomes in this vulnerable group.