254 NON-SURGICAL TREATMENT IN HIP OSTEOARTHRITIS – IS IT USED?

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Purpose: The purpose of the study was to examine the use of non-surgical treatment before total hip replacement (THR) in people undergoing THR due to primary hip osteoarthritis (OA).
Methods: A questionnaire was mailed to 1,237 such persons operated in 2004, living in Västra Götaland, Sweden (response rate 91%). The study group was obtained from the Swedish Hip Arthroplasty Register, together with outcome 1 year after surgery, pain relief, satisfaction-VAS and health-related quality of life (EQ-5D), variables included in the register database. The costs for the operations were obtained from the cost per patient database in Västra Götaland.
Results: Forty-five percent of the study group reported having received physiotherapy before surgery. Only 11% considered they had had totally non-surgical treatment, including prescribed physiotherapy and adequate information about OA, the importance of physical activity, exercise and the use of walking aids.
Persons, who had received totally non-surgical treatment preoperatively, reported significantly improved pain relief and greater improvement in health-related quality of life at a one year follow-up. A health-economic analysis showed lower cost per quality-adjusted life-years (QALY) gained for their surgical procedure.
Conclusions: Persons with hip disabilities, health care givers and politicians should be informed about the effects of non-surgical treatment, and all patients should be offered it. THR is in general a successful surgical intervention with proven good cost-utility, however non-surgical treatment before THR can further increase pain-relief and health-related quality of life and subsequently led to an improved cost-effectiveness. Future prospective studies to evaluate the effectiveness of non-surgical treatment in hip disability are proposed.

255 OSTEOARTHRITIS MEASUREMENT IN ROUTINE RHEUMATOLOGY OUTPATIENT PRACTICE (OMIRROP) IN AUSTRALIA: A SURVEY OF PRACTICE STYLE, INSTRUMENT USE, RESPONDER CRITERIA AND STATE-ATTAINMENT CRITERIA

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Purpose: The purpose of the 2007 OMIRROP survey was to describe practice styles, instrument usage, and perceptions of responder and state-attainment criteria in OA management in routine rheumatology practice in Australia.
Methods: A 16 item (65 sub-component) questionnaire was developed, pre-tested with five rheumatologists, then revised, formatted, and mailed by Australia Post, with the assistance of the Australian Rheumatology Association (ARA), to rheumatologists residing in Australia. Two hundred and thirty six eligible practising rheumatologists were sent questionnaires in 2007. Second and third reminders were sent to non-respondents.
Results: Responses were obtained from 136 rheumatologists (response rate 58%). Respondents were more likely to longitudinally follow patients with OA Knee (53%) and OA Hip (48%) than patients with hand OA (34%). Of note, 47%, 52% and 66% of rheumatologists did not follow their knee, hip and hand OA patients respectively over time. Seventy nine per cent ($n = 107$) of respondents did not use any of the major Health Status Instruments (HSI) evaluated, for longitudinally monitoring the efficacy of anti-rheumatic drug therapy in their adult patients with osteoarthritis. The most frequently used measures for the remaining 21% ($n = 29$) of respondents were, the HAQ ($n = 18$) and the WOMAC Index ($n = 15$). The KOOS Index and the HOOS Index were amongst 7 instruments which were never used and the remaining 6 instruments evaluated were used by $\leqslant 4$ respondents. Amongst those who do use HSI's in clinical practice, the majority (51%) reported never recording the actual scores provided by these measures. Simplicity, quick completion, easy scoring, reliability, validity, and responsiveness were regarded as important attributes of an HSI for use in routine clinical practice. Rheumatologists were asked their opinion as to what relative and/or absolute critical values for pain, stiffness, function and patient global assessment (PGA) they considered of clinical value to patients, when evaluating the importance of the clinical response achieved (MCII) and the clinical state attained (PASS). There was diversity of opinion as to what constituted a responder and an acceptable symptom state, and 16–29% of respondents' selected "Don't Know" options for MCII and PASS.
Conclusions: Patient Reported Outcomes are not yet routinely used in OA clinical practice (cf. clinical research). Some existing HSI's meet many, if not all, of the measurement attributes required by rheumatologists. There is diversity of opinion, and a moderate level of absence of opinion, regarding what constitutes a clinically important response (MCII) and acceptable state-attainment (PASS). Further investigation of data interpretation and data capture issues is recommended, as a prelude to evaluating the role of quantitative measurement in routine clinical practice in OA.

256 CHECK: COHORT HIP AND COHORT KNEE; SIMILARITIES AND DIFFERENCES WITH THE OA INITIATIVE

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Purpose: To determine and compare the radiographic OA status and the health status of the participants in the CHECK (Cohort Hip & Cohort Knee) cohort with a subgroup of the Osteoarthritis Initiative (OAI).
The prognosis of OA for the individual patient is uncertain. Besides, community-based studies have demonstrated that there is an inconsistent relationship between the radiographic change and severity of joint pain and accompanying disability. Whether these discrepancies depend on the stage of the disease is not known. If we want to understand these discrepancies, observations in the early stages of development of OA are necessary.
Methods: In the Netherlands a prospective 10-year follow-up study was started on the onset and progression of OA in participants with early complaints of hip and/or knee: CHECK. The objective of CHECK cohort is to study the course of complaints, the mechanisms that cause joint damage and to identify markers for diagnosis and course of joint damage, as well as to identify prognostic factors. Inclusion criteria were pain and/or stiffness of knee and/or hip, age 45–65 years, and had never or not longer than 6 months ago visited the general practitioner for these symptoms for the first time.
In the same period in the U.S. an observational 4-year follow-up study was started, the OAI, to create a public archive of data, biological samples and joint images to study the natural history of, and risk factors for, the onset and progression of knee OA. This study connoted two different sub cohorts, one with symptomatic knee OA at baseline followed to evaluate worsening of disease (the progression cohort) and another without symptomatic knee OA, but selected on the basis of having specific characteristics which give them an increased risk of developing incident symptomatic knee OA (the incidence cohort).
For comparison with CHECK a subgroup of the incidence OAI sub cohort was selected which was comparable with the CHECK cohort: participants with age 45–65 years, with frequent or infrequent knee symptoms and no surgery in either knee ($n = 1785$).
Results: In CHECK 1002 participants were included, a mean age of 56 years, mean BMI of 26 kg/m^2 and 79% are female. The subgroup of the OAI cohort consisted of 1785 participants, a mean age of 57 years, mean BMI of 28 kg/m^2 and 64% are female. Based on the definition of K&L grade $\geqslant 2$, only 7% of CHECK participants had radiographic knee OA and 6% had hip OA. The percentage of participants with at least definite OA (K&L score $\geqslant 2$) in the CHECK study was significant lower than in the subgroup of the OAI population ($p < 0.000$). Women in both cohorts reported on the WOMAC subscales more pain, more stiffness and more problems in physical function ($p < 0.05$) compared to men. The CHECK cohort reported higher scores on pain, stiffness and function subscale (worse health) compared to the subgroup of the OAI ($p < 0.000$). On the Physical Component Summary score of the SF-36/Sf-12 the CHECK participants scored significant lower (worse Health Related Quality of Life) than the subgroup of the OAI participants ($p < 0.000$). For the mental summary score the CHECK study and the subgroup of the OAI had similar mean scores.
Conclusions: In comparison with the OAI participants, the CHECK participants had less radiological OA, but more pain, more stiffness, more limitations in activities and a worse physical component of the health status. Based on the radiological findings, we suggest that CHECK is started in an earlier phase of the disease compared to the OAI. The fact that CHECK participants had more pain might indicate that when symptoms of OA start, pain dominates.