Patient education was beneficial in primary care in improving self-reported health and reducing health service utilisation. No improvements were found for self efficacy. Improvements in pain and social outcomes were found for case management (GP and nurse). Primary outcome measures included quality of life (study 1 and study 3) and self reported disability (study 2). There were a range of different patient reported outcome measures across studies.

Conclusions: A systematic review identified three trials investigating multidisciplinary approaches to multisite or generalised OA. Trials each used core interventions endorsed by OA guidelines. All three trials targeted osteoarthritis of the hand, hip or knee. Despite each of the three studies having an educational intervention, the studies were very heterogeneous. There are currently very few studies that target multidisciplinary approaches to multisite osteoarthritis. A consistent approach to outcome measurement in future studies of multisite OA is needed.

381
DEMOGRAPHIC AND CLINICAL CHARACTERISTICS OF PRIMARY AND SECONDARY CARE PATIENTS WITH OSTEOARTHRITIS OF HIP AND KNEE ARE QUITE SIMILAR

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Purpose: As is stated in many guidelines for patients with osteoarthritis, it is advised to treat patients conservatively before patients are referred to secondary care. Therefore, it can be expected that secondary care patietns with osteoarthritis differ from primary care patients. The purpose of the current study is to compare demographic and clinical characteristics of patients with osteoarthritis who are referred to primary care physiotherapists and patients who are referred to secondary care.

Methods: In a cross-sectional study secondary analyses were performed on two cohorts of patients with knee or hip osteoarthritis: one primary care dataset ($n=200$) and one secondary care dataset ($n=279$). In both studies comparable measurements were performed at baseline in the same time period. Measurements included, among others, gender, age, location and duration of osteoarthritis, number of comorbidities, pain (VAS), physical function (WOMAC), muscle strength, range of motion, social support and quality of life.

Results: Both groups were similar in most characteristics, with some exceptions. The primary care group consisted of less patients with both hip and knee osteoarthritis and of younger patients compared to the secondary care group. Furthermore, secondary care patients reported more pain (4.0 versus 4.8), less muscle strength and more falls in the last six months.

Conclusions: There are differences between primary and secondary care populations of patients with osteoarthritis, but these differences are minimal. Looking at the results of this research, the question arises whether the health care of patients with osteoarthritis can be organised more efficient and less expensive. However, long-term prospective studies are needed to evaluate the cost effectiveness of both primary and secondary care of patients with osteoarthritis.

382
LONGITUDINAL CHANGES IN PRESCRIPTION USE IN THE OSTEOARTHRITIS INITIATIVE (OAI)

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Purpose: To investigate the longitudinal changes in prescription use in the OAI study

Methods: 48 month medication data were added to data collected for previous clinic visits of the OAI study. The data were sorted by drug classes with particular focus on NSAIDS, Statins and Bisphosphonates, chosen for their association with musculoskeletal diseases. Chi-squared statistics were used to compare groups at baseline and 48 months.

Results: There was an overall decrease in the number of prescriptions for both NSAIDs and Bisphosphonates from baseline to 48 months (by 48% (P<0.001) and 37 % (P=0.264) respectively, however the number of prescriptions for Statins increased by 58 % from baseline to 48 months (P<0.001) (Figure 1).

Analysis showed there were significant differences between prescribing patterns by sex. Statin prescriptions for men and women increased significantly between baseline and 48 months (P<0.001) but NSAID prescriptions decreased significantly only in women at 48 months compared with baseline for females (P<0.001). The decrease in Bisphosphonate prescriptions from baseline to 48 months were not significant in females (P=0.59) or males (P=0.062).

The differences between cohorts were analysed at each time point and each of the three drug classes showed significant differences (P<0.001). Subset analysis, however, found that both NSAIDs and Bisphosphonates were significantly lower in the progression than the incident cohort (both P0.05).

Conclusions: Over the duration of the OAI study the number of Statin prescriptions has significantly increased, whilst NSAID and Bisphosphonate prescriptions have decreased. The increase in Statin prescriptions is likely to be due to two factors, the increase in prescribing these drugs to a normal population for prevention of disease and an aging population. The decrease in the numbers of Bisphosphonate prescriptions may be attributable to patients having a drug holiday, although we do not know for how long the patients have been on Bisphosphonates prior to study entry. These temporal changes in prescription drug use should be borne in mind when analysing the OAI dataset.
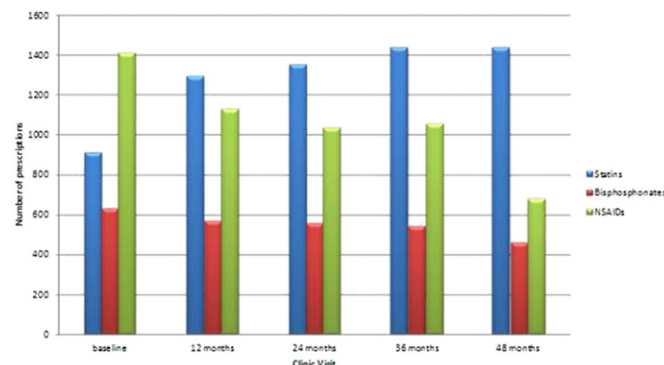
383
PSYCHOLOGICAL FACTORS ASSOCIATED WITH DAILY STEP COUNT IN KNEE OSTEOARTHRITIS

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Purpose: Despite strong evidence of the effectiveness of daily walking for alleviating self-reported pain and improving physical function for people with knee osteoarthritis (OA), daily physical activity levels remain below recommendations for this population. OA leads to psychological as well as physical dysfunction and while psychological factors are known to influence physical activity levels in other populations, little is known about the extent to which psychological factors influence walking levels among people with knee OA. This knowledge is important as greater understanding of modifiable factors that influence daily walking levels may enable interventions to increase walking behaviors to be better planned and targeted. Previous studies exploring associations between psychological factors and physical activity levels among people with knee OA, using a range of self-report and accelerometer-based physical activity measures, have reported that depression, anxiety and negative affect (encompassing depression, tension, fatigue and anger) are not associated with physical activity levels. These studies have not considered many other important psychological variables, which may be important modifiable mediators of physical activity for people with knee OA. In addition, none