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MANAGEMENT OF SYMPTOMATIC HAND OA (HOA) PATIENTS IN AMBULATORY PRACTICE IN FRANCE: A CROSS-SECTIONAL SURVEY

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Purpose: Few clinical trials have been performed in HOA. Despite the recent presentation of the European Ligue Against Rheumatism recommendations, few is known with respect to the way doctors treat symptomatic HOA patients.

Aim of this study: To describe the therapeutic uses of French doctors in HOA according to the level of symptoms.

Methods: Prospective cross-sectional pharmacoepidemiologic survey. A sample of 100 French rheumatologists (Rh) and 100 general practitioners (GPs) had to describe 2 HOA patients presenting consecutively: either with a flare of symptoms, i.e. pain score ≥ 50 mm on a VAS and functional index for hand OA score (FIHOA) [2] ≥ 5, and or with quiescent symptoms (pain < 50 mm and FIHOA < 5).

Results: 169 doctors (aged 50 years, 69% men) described 316 patients of which 178 (56%) were in the "flare" and 44% in the non-flare group, 83% women (95% menopaused), mean age 66 years (10), mean BMI 25 (4), with a familial history of HOA in 60%.VAS Pain score rated 66 (9) mm in the flare group and 30 (11) mm in the non-flare group, and FIHOA averaged 12 (4) and 4 (1) respectively. Treatments received: 88% in the flare group vs 76% received level 1 or 2 analgesics (p = 0.004), 69% vs 30% received an NSAID (p < 0.001) of whom 66 and 50% were prescribed a gastroprotective drug respectively. 90% of the patients in the flare group were prescribed a symptomatic slow-acting drug in OA (SySADOA) vs 80% (p = 0.01). No difference was observed between the groups regarding the duration of treatments with the exception of level 1 analgesics (46 days in the non-flare group vs 27; p = 0.001). Topical NSAIDs were used in 60% of patients in both groups. Steroids intra-articular (IA) injections were performed in 16% of patients in the "flare" group vs 4% (p < 0.001). Surprisingly non pharmacological therapies were more often used in "flare" patients: 38% vs 27% (p = 0.03), and comprised physical therapy (10%), splints (22%) and Spa therapy (6%). GPs prescribed more analgesics (93% vs 73%), more NSAIDs (62% vs 43%) and more physical therapy (19% vs 3) than Rh. Conversely, Rh prescribed more splints (30% vs 13), and more IA steroids (16% vs 5). Mean costs of therapies were similar in both groups of patients (278 Euros, patient's perspective). Drugs accounted for 189 Euros in the "flare" group vs 206.

Conclusions: We observed some differences between Rh and GPs in their management of hand OA symptoms: more splints, IA steroids injections and SySADOA prescription by RH, while GPs use more analgesics/NSAIDs and surprisingly more physical therapy. Further studies in this field are required to confirm our results.

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THE SAFETY AND EFFICACY OF ROUTINE PERI-OPERATIVE NSAIDS PROPHYLAXIS FOR ECTOPIC BONE FORMATION AFTER HIP REPLACEMENT SURGERY (HIPAID), A RANDOMISED CLINICAL TRIAL

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Purpose: To determine the benefit and risk of NSAID-based prophylaxis for ectopic bone formation amongst patients undergoing total hip replacement (or revision) surgery.

Methods: A double-blind randomised placebo-controlled clinical trial, stratified by treatment site and surgery (primary or revision), was conducted in 20 orthopaedic surgery centres in Australia and New Zealand. 902 patients undergoing elective primary or revision total hip replacement surgery were randomly allocated to 14 days treatment with ibuprofen (1200mg daily) or matching placebo commenced within 24 hours of surgery. Patients were only excluded if there was, in the opinion of the responsible physician, a definite indication or contra-indication for treatment with an NSAID during the 14 day study treatment period. Outcomes were assessed 6 to 12 months after surgery and included changes in self-reported hip pain and physical function (WOMAC), physical performance measures and radiographic evidence of ectopic bone formation.

Results: There was only a 6% loss to follow-up for self-report measures and a 12% loss to follow-up for radiographs. Six to twelve months after surgery, there were no significant differences between the ibuprofen and placebo groups for improvements in hip pain (mean difference, 95% confidence interval: -0.1, -0.4 to 0.2, p = 0.6) or physical function (-0.1, -0.4 to 0.2, p = 0.5), despite a much reduced risk of ectopic bone formation (relative risk 0.69, 95% confidence interval 0.56 to 0.83) associated with ibuprofen. There was a significantly increased risk of major bleeding complications during the admission period (2.09, 1.00 to 4.39).

Conclusions: These data, from the largest-ever trial of prophylaxis against ectopic bone formation, do not support the use of routine NSAIDs-based prophylaxis for patients undergoing total hip replacement surgery.