associated with low back pain and related disabilities (OR=1.53 and 1.98, 95%CI=1.06-2.21 and 1.46-2.69, respectively).

Conclusions: The present study showed that mild KL 3 lumbar spondylosis was not associated with symptomatic parameters; however, more than moderate radiographic lumbar spondylosis with multiple KL 2 intervertebral levels was associated with low back pain and related disabilities. This suggests that lumbar spondylosis with multi-level KL 3 might be appropriate as the diagnostic criterion of radiographic lumbar spondylosis in terms of the relation to the symptoms. Although this was a cross-sectional study, future longitudinal survey in the ROAD study will elucidate the relationship of changes between radiographic findings and the symptoms in more detail.

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PREVALENCE AND PREDICTION OF RECURRENT MUSCULOSKELETAL SYMPTOMS DURING A TEN-YEAR PERIOD AND THE SIGNIFICANCE OF PHYSICAL ACTIVITY AT WORK

K. Søgaard1, B. Juul-Kristensen1, G. Sjøgaard1, H. Hannetz2, H. Burt2
1 Univ. of Southern Denmark, Odense, Denmark; 2 The Natl. Res. Ctr. for the Working Environment, Copenhagen, Denmark

Purpose: Work-related musculoskeletal disorders (WMSD) are defined as latent disorders caused, provoked, or aggravated by several risk factors mainly existing at work. Several studies have found WMSD to take a fluctuating course and recurrent symptoms may over time develop into chronic conditions such as osteoarthritis. The Danish Work Environment Cohort (DWEC) with registrations every fifth year since 1990 offers a unique possibility to observe recurrent symptoms in specific body regions and within occupations with different exposure.

In this study it is hypothesized that low physical activity at work as well as high physical activity are associated with recurrent WMSD. Specifically the following hypotheses are tested: 1) Recurrent musculoskeletal symptoms in a given body region are to a large extent present in the working population in terms of repeated reports of symptoms over a ten-year period. 2) Employees with a low, as opposed to high amount of sitting during daily work have a higher frequency of recurrent musculoskeletal symptoms in the low back, an equal frequency in the hand/wrist, and a lower frequency in the neck and shoulder.

Methods: Telephone-interviews were performed in DWEC in 1995, 2000 and 2005. The interview included questions about working conditions and musculoskeletal health status. 2810 employees participated and the body regions included were the neck, shoulder, hand/wrist and low back. Recurrent symptoms in a body region were defined by if an employee consistently reported symptoms within the last 12 months in 1990, 1995 as well as 2000.

Physical exposure at work was quantified in terms of the amount of sedentary work based on the reported work day duration of sitting posture as follows: Long duration = sitting almost all or more than 75% of the work day, Medium duration= about 25% or 50% of the work day, and Short duration = very little or ‘never’. The Chi square, Mantel Haenszel Chi square and Fisher’s exact test were used to test for associations with gender, age and physical activity. A multiple logistic regression analyses stratified for gender and adjusted for age, smoking, height and body mass were used for testing recurrent symptoms of each specific body region and short/long duration of sedentary work.

Results: For the neck 18% of the females and 10% of the males had recurrent symptoms and for the shoulder 24 % of the females and 6 % of the males had recurrent symptoms. Recurrent low back symptoms were present in 20% of the females and 18 % of the males and recurrent hand/wrist symptoms were present in 4% of the females and 2 % of the males. The prevalence of recurrent symptoms in the hand/wrist and low back was higher for those with a short duration of sedentary work (p=0.013, p=0.0001) compared to a long duration of sedentary work. In contrast the prevalence of recurrent neck symptoms was higher among those with a long duration of sedentary work (p=0.045) compared to those with a short duration of sedentary work.

Conclusions: Recurrent musculoskeletal symptoms are present to a large extent among employees. Those with high work activity have a higher frequency of recurrent low back and hand/wrist symptoms compared to employees with mainly sitting work, who experience a higher frequency of recurrent neck symptoms. For prevention a variation in occupational physical activity must be recommended since both too long and too short amount of sitting work is associated with recurrent WMSD although affecting different body regions.

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SICK LEAVE IN OA PATIENTS BEFORE AND AFTER TOTAL KNEE OR HIP REPLACEMENT

M. Englund, L. Dahlberg, T. Lithman, L. Lidgren, I.F. Petersson
Lund Univ., Lund, Sweden

Purpose: Total knee and hip replacement (TKR/THR) are successful treatments for disabling and painful osteoarthritis (OA) when other treatments are unsatisfactory. However, in younger patients still working the result of joint replacement surgery on sick leave has been insufficiently studied. Our objective was to assess the patterns of sick leave before and after TKR/THR in OA patients using prospective observational data.

Methods: We identified all hip and knee OA patients in southern Sweden aged 58 years or younger who have had a TKR or THR between Jan 2003 and Oct 2006 using the Skåne Health Care Register. Subjects who died, started on disability pension, or had had more than one TKR/THR during the study period were excluded. The sample included n=199 with TKR (56% women) and n=276 with THR (46% women). Data was cross-referenced individually with data for sick leave from the National Insurance Agency (handles all sick leave payments for Swedish residents).

We calculated the proportion of patients with ongoing sick leave in 30-days intervals from 360 days before until 360 days after the TKR/THR. We also compared the 6 month preoperative period (day -210 to -30) vs. the 6 month postoperative period (day 180 to 360) using paired t-tests.

Results: The pre- and postoperative share of subjects with ongoing sick leave was higher among OA patients with THR compared to OA patients with THR. The peak proportion on sick leave occurred at the time of surgery where approximately 80% were
sick-listed. The level returned towards the preoperative level by the end of the study period (Figure 1). Hip OA patients tended to have more sick days before than after the THR (mean [SD] 98 [74] vs. 83 [82], p=0.08), while there was no such trend for TKR patients (96 [79] vs. 104 [79], p=0.3).

Conclusions: Return to work is faster after THR than TKR for OA. After joint replacement surgery. Close to 20-30% of patients remain sick-listed one year after surgery, the higher share being in patients after TKR, which is similar proportions seen preoperatively.

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PREVALENCE OF GENERALISED JOINT HYPERMOBILITY, HYPERMOBILITY SYNDROME, MOTOR COMPETENCE AND PHYSICAL ACTIVITY LEVEL IN 8-YEAR OLD SCHOOL CHILDREN
B. Juel-Kristensen Sr.,2, J. Halkjær Kristensen Sr., B. Frausing Jr., D. Vendelboe Jensen Sr., H. Røgind Sr., L. Remvig Sr.1 1Univ. of Southern Denmark, Res. Initiative in Physiotherapy, Odense, Denmark; 2Dept. of Rheumatology, Rigshosp.et, Copenhagen, Denmark

Purpose: Diverging results exist for children regarding the relation between Generalised Joint Hypermobility (GJH) and musculoskeletal complaints, as well as relations between GJH and an insufficient motor development, and/or reduced physical activity level. With the different criteria used for diagnosing GJH, the prevalence of GJH varies considerable. The aim of this study was to survey the prevalence of GJH defined by a Beighton score either ≥ 4 (GJH4), ≥ 5 (GJH5) or ≥ 6 (GJH6) positive tests out of 9, and Benign Joint Hypermobility Syndrome (BJHS) in a Danish population of primary school children at 8-years age. A second aim was to compare children with and without GJH and BJHS regarding motor competence measured by physical performance test, self reported level and duration of daily physical activity, in addition to self reported incidence of musculoskeletal pain (arthralgia) and injuries. A higher level of pain. GPs prescribe more likely NSAIDs (oral, low-dose and topical) whereas RHs treat patients with SYSADOA more often and perform intra-articular injection of steroids and hyaluronic acid.

Methods: The study was a cross-sectional study, where a population of 524 children in the second grade from 10 public schools in a mid size Danish municipality was invited to participate through letters to their parents. Clinical examinations including Beighton and Brighton tests for GJH and BJHS were performed. Further, physical tests to measure motor competence (agility, static balance, speed and hand reaction test) and a questionnaire including items on daily level and duration of physical activity, in addition to self reported incidence of musculoskeletal pain (arthralgia) and injuries (dislocation/subluxation).

Results: In total, 29% of the children had ≥GJH4, 19% had ≥GJH5, 10% had ≥GJH6 and 9% had BJHS, with no gender difference on the GJH and BJHS criteria. There was no difference in daily level and duration of physical activity, or in frequency of musculoskeletal pain and injuries between those with and without GJH. Children with ≥GJH5 as well as with ≥GJH6 performed better in the motor competence tests (static balance, speed and hand reaction test) than those <GJH5 and <GJH6.

Conclusions: Motor competence measured by physical performance tests and self reported daily level and duration of physical activity are not reduced in primary school children with GJH or BJHS at the age of 8. Future research designs must include longitudinal studies to detect a potential negative influence on the musculoskeletal system over time, due to GJH.

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MANAGEMENT OF KNEE OSTEOARTHRITIS: COMPARISON OF GENERAL PRACTITIONERS AND RHEUMATOLOGISTS’ PRACTICES
P. Richtee1, P. Hilliquin2, P. Bertin3, P. Carni4, B. Savarieau5, V. Berger5, M. Marty6
11CHU Lariboisière, Paris, France; 2CHU, Corbeil-Essonnes, France; 3CHU, Limoges, France; 4CenBiotech, Dijon, France; 5Nukleus, Paris, France; 6CHU H Mondor, Créteil, France

Purpose: Little is known about the practices of primary care general practitioners (GPs) and rheumatologists (RHS) in terms of the management of knee osteoarthritis (OA).

Objectives: To determine potential differences between the profile of patients with knee OA managed by GPs and those managed by RHS, and to evaluate the nature of OA management by both physicians. To identify main factors associated with the prescription of low dose NSAIDs.

Methods: Cross-sectional survey of 808 GPs and 134 RHs in France. Each physician completed a medical questionnaire for the two most recent patients fulfilling the ACR criteria for knee OA. Information was collected on patients’ characteristics, medical history, OA main symptoms and management. Statistical analysis was performed using SAS® software.

Results: The number of patients included by GPs and RHs were 1570 and 251 patients, respectively. For the total population (56.2% women), mean age was 67.4±9.7 years and mean BMI 29.0±4.8 kg/m2. Of these patients, 89.7% reported disability in daily life, 47.2% had nocturnal pain and 30.1% had knee joint effusion. GP and RH patients suffered knee OA for 7.9±5.7 years and 6.8±5.5 years, respectively (p<0.01). Mean pain level in the knee (VAS 0-100 mm) was greater in GPs’ than in RHs’ patients: 49.8±16.3 mm vs. 46.2±17.1 mm, respectively (p<0.01). The proportion of GP patients with another joint affected by OA was greater than in RH patients: 71.2% vs. 63.7% (p<0.0001).

GPs and RHs prescribed drugs to 89.0% and 83.3% of their patients, respectively (p<0.0001). Drugs were acetaminophen (43.4%), low dose NSAIDs (13.4%), oral NSAIDs (33.7%), topical NSAID (29.0%), coxibs (8.5%), weak opioid analgesics (30.5%), strong opioid analgesics (1.8%) and SYSADOA (39.9%). GPs prescribed low dose NSAIDs (p<0.0001), oral NSAIDs (p=0.05) and topical NSAID (p<0.0001) more frequently, and SYSADOA significantly less frequently (p<0.01), than RHs. Intra-articular injection of steroid or hyaluronic acid were significantly more performed on RH Patient (31.5% and 46.2%) than on GP patients (7.6% and 2.5%) (p<0.0001). Moreover, GPs recommended rehabilitation (p<0.01) and weight loss for obese patients (p<0.0001) more frequently than RHs. Higher pain level was associated with both physicians prescribing coxibs and weak opioid analgesics more frequently (p<0.001). Overall, the main factors affecting the choice of treatment were safety of the drug and efficacy. In logistic regression analysis, prescription of low dose NSAIDs was significantly associated with GPs, retired patients, associated hip OA, no prescription of oral NSAIDs or coxibs, prescription of topical NSAIDs, no intra-articular injections of steroids and recommendation of rehabilitation.

Conclusions: This study identified variability in key aspects of management of knee OA as a function of medical specialty. Indeed, the clinical profiles of patients suffering from knee OA differed between GPs and RHs and as a consequence, the management varies over medical speciality. GP patients suffer for longer, have another joint affected by OA more frequently and have a higher level of pain. GPs prescribe more likely NSAIDs (oral, low-dose and topical) whereas RHs treat patients with SYSADOA more often and perform intra-articular injection of steroids and hyaluronic acid.