

including cardiovascular disease (40-70% incidence⁽²⁾; 5-12.9% prevalence⁽³⁾), diabetes (IR of 8.6 per 1000 person-years⁽⁴⁾; 20%⁽⁵⁾), interstitial lung disease (7.7%⁽⁶⁾); up to 60% (interstitial lung abnormalities in early RA)⁽⁷⁾ and depression (up to 200%⁽⁸⁾; 16.8%⁽⁹⁾). In addition to differing health care delivery systems throughout Europe, there is also variability in the roles and responsibilities of healthcare professionals (HCPs) across and within countries⁽¹⁰⁾.

Objectives: This study aimed to identify good practices within the roles of HCPs in the care of RA and associated comorbidities and to understand how these practices may be implemented in other centres.

Methods: This study interviewed multidisciplinary teams at 12 selected specialist centres across Europe (1 centre per country) and examples of HCPs who had expanded roles and responsibilities were identified. Further, the questions whether these practices improved quality of care and could be implemented in other centres were addressed.

Results: This Europe-wide study identified good practice examples of enhanced roles and responsibilities for HCPs such as nurses, physiotherapists, occupational therapists and podiatrists that varied with different categories of patients and their corresponding needs. The scope and depth of extended roles also varied between different countries and health systems. Examples included:

Examples identified	Patient categories		
	suspected RA	newly diagnosed RA	established RA
Providing education on RA and comorbidities		x	x
Conducting history and joint examination	x	x	x
Coordinating care		x	x
Delivering preliminary comorbidity screening		x	
Providing treatment		x	x
Being first point-of-contact		x	x
Collaborating with community-based teams		x	x
Providing holistic support	x	x	x
Empowering self-management		x	x

Conclusion: Expanding the roles of HCP team members can help broaden perspectives on healthcare delivery, relieve the burden put on specialists and enable the provision of well-rounded, patient-centred holistic care that may improve quality of life for patients with RA, especially related to their associated comorbidities.

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AB1369-HPR THE EFFECTS OF CLINICAL PILATES TRAINING IN INDIVIDUALS WITH PRIMARY SJOGREN S SYNDROME

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Background: Primary Sjogrens syndrome (PSS), occurs in people with no other rheumatic disease, is a chronic, systemic, autoimmune disease characterized by lymphocytic infiltration of all exocrine glands, especially tears and salivary glands (1,2). Exercise training is commonly recommended in the approach of individuals with rheumatic disease and clinical pilates training have positive effects on endurance, functional mobility and quality of life. Nonetheless there is limited study related exercise training and no study which examined the efficacy of clinical pilates training in individuals with PSS in literature. Therefore, our study is very important.

Objectives: The aim of the study was to examine the effects of clinical pilates training on trunk and lower extremity endurance, functional mobility, emosyonel status, sleep quality, functional level and quality of life in individuals with PSS.

Methods: The study included 23 voluntary individuals (22 female, 1 male; mean age: 50.529.38 years), with PSS who were diagnosed with primary Sjogrens syndrome according to 2016 American College of Rheumatology/ European League Against Rheumatism Classification Criteria and according to Chisholm-Mason classification between grade 3 and 4 who applied to Pamukkale University Department of Internal Medicine, Department of Rheumatology. Anterior and lateral bridge was used to determine trunk endurance, 30-Second Chair Stand Test (30s-CST) and The Timed Up and Go (TUG) Test for lower extremity endurance, Lower Extremity Functional Scale (LEFS) for functional mobility, Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI) for emotional status, Pittsburgh Sleep Quality Index (PSQI) for sleep quality, Health Assessment Questionnaire (HAQ) for functional level and Short Form 36 (SF-36) for quality of life, right after demographic information and disease related data were recorded. The all assessments were made before and after clinical pilates training. All participants attended 60-min exercises training (5-min warm up, 45-min clinical pilates exercises, 10-min cool down) three times a week for 8 weeks which was progressively challenged and applied by a Physiotherapist with 2 years of experience in this field. Wilcoxon test were used to examine the factors related to functional level.

Results: After training in all evaluations a statistically advanced level of significant improvement compared to pre-training values in individuals with PSS (p<0.001).

Conclusion: Muscular endurance and functional level and the associated with emosyonel status, sleep and quality of life are important for individuals with PSS. Exercise approaches for these parameters are recommended. This study showed that clinical pilates exercise programs have positive effects on trunk and lower extremity endurance, functional mobility, emosyonel status, sleep quality, functional level and quality of life in individuals with PSS.

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