prevention of fragility fracture relies on the triad -balanced nutrition, including calcium, protein and vitamin D, -weight-bearing or balance improving physical exercises and -pharmacological therapies. Among the latter, the anti-resorptives are the most widely used. Alendronate, basedoxifene, denosumab, ibandronate, raloxifene, risedronate, menopausal hormone therapy (MHT) and zoledronate decrease vertebral fracture risk. The relative risk reduction is as high as 60 to 70% by one year of therapy only, indicating an early marked efficacy. For hip fracture, alendronate, denosumab, risedronate, and zoledronate reduce the risk in women with osteoporosis, MHT in postmenopausal women, and calcium and vitamin D in institutionalized patients. Facture risk reduction is observed from approximately 18 months of therapy on. Regarding combination therapies, the added costs and risks of side effects must be considered. Until now we have no clear evidence that using drugs together provides greater fracture risk reduction than monotherapy. In terms of sequential therapies, reasons to switch an anti-resorptive drug to another one include intolerance to current treatment, concern about adherence to treatment, inadequate clinical response, such as bone loss or occurrence of fracture on therapy, or failure to achieve turnover markers reduction. To prevent rapid bone loss and increased vertebral fracture risk after discontinuing denosumab, a bisphosphonate treatment may be envisaged. When clinical response to bisphosphonate therapy is inadequate, a switch to teriparatide, romosozumab or to denosumab could be recommended. However, switching denosumab to teriparatide is not recommended. An anabolic treatment like the amino-terminal fragment of PTH, teriparatide, an analog of parathyroid hormone related protein, abaloparatide, or the monoclonal antibody against sclerostin, romosozumab (the latter when tested against alendronate), decreases vertebral and non-vertebral fracture risk by one year of treatment too. In sequential therapies, teriparatide, abaloparatide or romosozumab therapy should be followed with denosumab or a bisphosphonate to maintain the early antifracture efficacy. Because of a high magnitude and early antifracture efficacy, such a sequential regimen should become the standard of care for patients at high, very high or at imminent risk of fracture.

ESCEO5
MANAGEMENT OF HAND OSTEOARTHRITIS: WHAT REALLY MATTERS FOR THE PATIENT

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Hand osteoarthritis is a highly prevalent disease which is associated with substantial morbidity and mortality. A patient-centered approach to hand osteoarthritis care has the potential to facilitate true, shared, decision making, improve patient investment in management and adherence to therapy. This talk, informed by an expert ESCEO working group, will highlight the elements of clinical care and therapeutics which are particularly important to patients as well as advocating for an increasing role for patients in personal healthcare decisions, formulating policy recommendations and in mapping the future direction of hand osteoarthritis research.

ESCEO6
MANAGEMENT OF HAND OSTEOARTHRITIS: HOW CAN THE ACR GUIDELINES BE APPLIED TO AN EUROPEAN POPULATION IN A PATIENT-CENTRIC APPROACH

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Hand Osteoarthritis (HOA) is a disease and not a normal process of ageing. HOA deserves a multimodal treatment, including non-pharmacological and pharmacological approaches. The *American College of Rheumatology* (ACR) guidelines were written in a predominantly US-centric approach but, due to their robust methodology, they can globally be endorsed by ESCEO for the management of European patients. ESCEO agrees that within the SYSADOAs family, Chondroitin Sulfate (CS) is the only one which has successfully demonstrated efficacy on pain and function in this particular indication. This proof of efficacy being complemented by a very good tolerance justifies the positive recommendation from the ACR to be applied to the European population. It would nevertheless be interesting to see another trial confirming the Gabay's study despite the fact that this study has been conducted with the most robust methodology and an independent statistical analysis of the outcomes. After having carefully listened to the patients, it is clear that patients want to have pharmacological approaches which combine an efficacy on pain and function with a high safety profile. They mentioned that they are prepared to pay a reasonable price premium to use a pharmacological approach which provides a high risk/benefit ratio. The aesthetic component of HOA should not be neglected. Hyaluronic Acid (HA) and Corticosteroids (CS) injections appear to be promising approaches in some acute phases, i.e. flares, but they need further demonstration of efficacy/safety. Patients expressed their preference for injectable preparations which contain a low volume, a small needle and a limited number of injections. Patients' preferences and derived health economic analyses support the use of a pharmacological management of HOA.