

need for standardization in sarcopenia research by developing a Core Outcome Set (COS). COS in sarcopenia studies would ensure consistent and comparable findings, ultimately enhancing the reliability and effectiveness of interventions.

P315 TOWARDS DEVELOPING A CORE OUTCOME SET (COS) FOR SARCOPENIA INTERVENTION STUDIES

S. van Heden¹, O. Bruyère², J.-Y. Reginster², M. Surquin³, D. Sanchez-Rodriguez³, C. Beaudart¹

¹Clinical Pharmacology and Toxicology Research Unit (URPC), NARILIS, Dept. of Biomedical Sciences, Faculty of Medicine, Univ. of Namur, Namur, ²WHO Collaborating Center for Public Health Aspects of Musculo-Skeletal Health and Ageing, Division of Public Health, Epidemiology and Health Economics, Univ. of Liège, Liège, ³Medicine Dept., Geriatrics Dept., Brugmann Univ. Hospital, Université Libre de Bruxelles, Brussels, Belgium

Objective: In recent years, there has been a significant surge in clinical research focused on sarcopenia, driven by its recognized reversibility. The interest in developing effective interventions is underscored by the need for well-defined outcomes, currently impeded by the absence of a standardized set of outcomes, known as Core Outcome Sets (COS). Utilizing COSs harmonizes assessment criteria, facilitating the comparative analysis of diverse interventions. Establishing a sarcopenia-specific COS is crucial to augment the precision and effectiveness of clinical trials in this field. This project aims to develop a COS for intervention studies in sarcopenia, designed to address unmet needs in sarcopenia research and clinical practice and to pave the way for the development of effective treatments for the disease.

Methods: The methodology for this study adheres to the recommendations outlined in COS-STAD and COS-STAP. The study protocol has been registered in the database of the COMET initiative (<https://www.cometinitiative.org/Studies/Details/2991>). A Working Group (WG) will be assembled to collaborate on this project, consisting of individuals with sarcopenia, clinicians, and researchers. Subsequently, the study will progress through three key phases. Firstly, the development of an outcome list will be pursued through two distinct methods: a systematic literature review following PRISMA guidelines and semi-structured interviews with 5 to 10 participants aged 65 years and older, diagnosed with sarcopenia. The literature review will comprehensively identify potential outcomes reported in phase III clinical trials on sarcopenia, while the interviews will delve into the values and preferences of the participants. Following the outcome list development, a two-round modified Delphi process will be initiated, engaging key stakeholders to identify and prioritize relevant outcomes. Finally, a consensus meeting involving the Working Group will be convened to validate the results.

Results: Ongoing project, results are not available yet.

Conclusion: A core outcome set of sarcopenia would improve the efficiency of research and allow direct and indirect comparisons of sarcopenia clinical trials. This protocol aims to define the scope and methodology, stakeholder involvement, procedures

and consensus processes of the COS for sarcopenia intervention trials. Our ultimate goal is to improve the lives of people with sarcopenia.

P316 THE SOCIETAL COSTS AND HEALTH UTILITIES OF KNEE OSTEOARTHRITIS IN THE NETHERLANDS

C. Beaudart^{1,2}, A. Boonen^{3,4}, T. A E J Boymans⁵, P. J Emans⁵, M. Hilgsmann⁶

¹Department of Biomedical Sciences, Clinical Pharmacology and Toxicology Research Unit, Namur Research Institute for Life Sciences (NARILIS), Faculty of Medicine, University of Namur, Namur, Belgium, ²WHO Collaborating Centre for Public Health Aspects of Musculo-Skeletal Health and Ageing, Division of Public Health, Epidemiology and Health Economics, University of Liège, Liège, Belgium, ³Department of Internal Medicine, Division of Rheumatology, Maastricht University Medical Centre, Maastricht, Netherlands, ⁴Care and Public Health Research Institute (CAPHRI), Maastricht University, Maastricht, Netherlands, ⁵Department of Rheumatology, Maastricht University Medical Center, Maastricht, The Netherlands, ⁶Department of Health Services Research, Care and Public Health Research Institute (CAPHRI), Maastricht University, Maastricht, The Netherlands

Objective: To estimate the average annualized healthcare costs, societal costs and health utilities associated with knee osteoarthritis using data from the Maastricht Study (DMS).

Methods: The twelve-month costs per patient and health utilities related to knee osteoarthritis for the year 2022 were measured utilizing data from the DMS, an observational, prospective, population-based cohort developed in the South of the Netherlands, with an overrepresentation of individuals with diabetes. Participants who completed the baseline assessment of the DMS and for whom all relevant variables for these analyses were collected were included. The identification of knee osteoarthritis was based on the clinical criteria developed by the American College of Rheumatology (ACR). Costs were assessed throughout a resource-use questionnaire, completed by participants. Cost prices were based on Dutch costing guidelines. Healthcare costs, non-healthcare costs, total societal costs and health utilities (measured by EQ5D) were compared between patients with knee osteoarthritis and those without. Analyses were adjusted on age, gender (female), educational level (high) and presence of type II diabetes (yes). **Results:** 7928 individuals were included in our analyses (50.6% of women, mean age of 59.4 years, 20% of people with type II diabetes) of whom 970 (i.e. 12.2%) were identified with knee osteoarthritis. Patients with knee osteoarthritis were more often of female gender, older and with lower educational levels compared to patients without knee osteoarthritis. Moreover, they had a higher prevalence of diabetes (i.e. 29.1%) compared to those without knee OA (i.e. 18.8%). Globally, the presence of osteoarthritis was significantly associated with higher use of general practitioners, medical specialists and paramedics as well as higher paid home care and informal care received and higher productivity losses (all p-values <0.05 both in univariate and