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THU0627 TREATMENT OF RHEUMATOID ARTHRITIS: ADHERENCE TO GUIDELINES IN PRIVATE PRACTICE

L.B. Fernandes, F.A. Palacios, P.G. Lerner, C.G. Macedo, F. Omura, E.A.K. Azeka, I.M.M. Laurindo, P. Toth, R.C. Ferreira, R.A.O. Aurichio, A.P. Bazilio, J. Brudniewski, A.L. Hayata. *Private Office, São Paulo, Brazil*

Background: Guidelines and therapeutic strategies in the treatment of rheumatoid arthritis (RA) have been developed and adopted by most Societies of Rheumatology. However, the extent to which they have been supported by rheumatologists in their individual clinical practice is unclear.
Objectives: Our aim was to analyze, at private offices, adherence to guidelines and characteristics of RA patients in regular follow-up.
Methods: This was a cross-sectional study developed by a group of rheumatologists (n=13) working exclusively in private offices and hospitals in São Paulo, Brazil. It consisted of a web-based questionnaire addressing patient's demographics, social characteristics and treatment. Patients having the diagnosis of RA should be included sequentially. As Brazil's private health has no reference flowchart, patients can consult any physician from their insurance health program, or any physician at all if bearing the costs. Insurance programs can be either personal or tied to employers, in which case job changes imply in insurance and health professional changes.
Results: Data from 235 RA patients were collected, 84% were female, mean age (SD) 57.3 (13.3) yrs., disease duration 9.5 (1–54) yrs., 73% RF positive (74% of the 61 RF negative patients had an anti-CCP test and 8 were positive), The mean duration of symptoms until diagnosis was 1.7yrs (0–23), number of physicians until diagnosis 2.4 (1 – 12), including GP (102 patients), orthopedists (110 patients) and rheumatologists (129 patients). Even after diagnosis, patients switched professionals at a mean number of 2 physicians (1–6), justified by shift of health insurance (66 patients), lack of resolution (33 patients), dislike of the physician (26 patients) and cost (11 patients). Regarding treatment, 51% of patients were on biologic agents: 23% adalimumab, 15% abatacept and rituximab, 14% etanercept, 12% tocilizumab, 7.6% golimumab, 5% certolizumab and infliximab and 4% tofacitinib. Interestingly, most patients (75%) using abatacept, tofacitinib and tocilizumab were not on methotrexate (MTX), while from the 65 patients on an anti-TNF agent, 75% were also using MTX or leflunomide (LFN). Regarding traditional DMARDs, 91% of patients were on (n=94) or had used MTX (n=120); 43% were on (n=37) or had used (n=64) LFN. Concerning treatment and disease activity, 91% of patients were considered adherent to the treatment with a mean number of 4 annual visits, 82% were also deemed to be in regular monitoring. According to rheumatologist's assessment, 63% of patients had RA "under control". In fact, 72% of patients were on low disease activity (22%) or on remission (50%), according to the DAS28. However, when patients in disease activity were analyzed, few of them (0.28 CI 0.18–0.40) were on biologic or target DMARDS, pointing to a possible therapeutic transitional moment. Only 3 of these could be labeled "refractory", having previously used 3 biologic agents.
Conclusions: *Treat-to-target* strategy seems to have been adopted by most rheumatologists in their individual practice, although there is room for improvement and optimization of therapy. While treatment guidelines are roughly followed, the delay in diagnosis and changes of healthcare are particularly worrisome and need to be addressed.
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THU0628 PATTERNS OF ETANERCEPT DOSE ADJUSTMENTS IN A REAL–WORLD SETTING: A CANADIAN RETROSPECTIVE COHORT STUDY

M. Khraishi[1], Y. Zhang[2], J. Ivanovic[2], B. Millson[2], E. Singh[3], J. Woolcott[4], H. Jones[3]. [1]*Faculty of Medicine, Memorial University of Newfoundland, St. Johns;* [2]*Health Access & Outcomes, QuintilesIMS, Kanata, Canada;* [3]*Inflammation and Immunology, Global Medical Affairs, Pfizer Inc., Collegeville, United States;* [4]*Health Economics and Outcomes Research, Pfizer Inc., Kirkland, Canada*

Background: Etanercept is a soluble TNF receptor (humanized protein) indicated for treatment of immune-mediated inflammatory diseases, including rheumatoid arthritis (RA), psoriatic arthritis (PsA), psoriasis (PsO), and ankylosing spondylitis (AS). Canadian monograph recommended dosing of etanercept is 50mg/week, with select indications also requiring an initial loading phase of 100mg/week for 12 weeks. Evidence suggests that real-world practices differ from monograph, with patients titrating to lower or higher weekly dosing as needed. Limited research exists on how etanercept patients are dose optimized in the real-world Canadian setting.
Objectives: To describe etanercept treatment dynamics, including dose de-escalation/escalation in the Canadian real-world setting.
Methods: A retrospective cohort study was conducted utilizing claims-level data from QuintilesIMS Private Drug Plan database, Ontario Public Drug Plan database, and Quebec Public Drug Plan database. Between 07/2013–06/2015, bio-naïve patients who initiated etanercept and who retained on therapy for 12 months were identified. Weekly dosing of each patient was calculated and analyzed for the prevalence and magnitude of dose de-escalation/escalation. Patients with at least 20% lower/higher average dose than monograph recommended dose (50mg/week) were flagged as dose de-escalators/dose escalators, respectively. The first 3 claims of etanercept were excluded from average dose calculations to exclude a possible loading phase.
Results: The study identified 3,051 etanercept patients (60% female, 77% aged between 18 and 65, 87% rheumatic diseases, and 13% PsO) across Canada in the selection period. Overall, 11% (n=332) of patients de-escalated during their first year of therapy, led by AS (15%, n=24) and RA (12%, n=286); 15% (n=449) of patients escalated, led by PsO (64%, n=262) versus 7% (n=168) in RA; 74% (n=2,270) of patients maintained a consistent dose. Average dosing across rheumatic disease patients stabilized to monograph levels by week 20 of their therapy; PsO patients' dosing was observed to be lower than monograph during the loading phase, while higher than monograph in the maintenance phase.
Conclusions: In Canadian real-world practice, the average patient utilization of etanercept remained consistent over the first year in majority of patients, with the exception of those with PsO. A notable proportion of etanercept patients with rheumatic diseases reduced their average dosing over time while on therapy, with almost twice as many patients titrating their dose downwards than upwards. However, in PsO patients, a majority of patients increased their etanercept.
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THU0629 THE PERSPECTIVES OF PATIENTS, THEIR FIRST DEGREE RELATIVES, AND RHEUMATOLOGISTS AROUND PREVENTATIVE TREATMENTS FOR RHEUMATOID ARTHRITIS

L. Spooner[1], K. Milbers[2], S. Munro[1], N. Tsao[1], M. Hudson[3], C. Koehn[4], N. Bansback[1], M. Harrison[1,2]. [1]*University of British Columbia;* [2]*Centre for Health Evaluation and Outcome Sciences, Vancouver;* [3]*McGill University, Montreal;* [4]*Arthritis Consumer Experts, Vancouver, Canada*

Background: Ongoing randomized controlled trials are looking at the efficacy of preventing RA through treatment with anti-rheumatic medications. However even if these trials are successful, uncertainty around the potential benefits of preventative programs in practice will affect the uptake of a preventative treatment program. The views of rheumatologists, patients with RA and people considered at-risk of RA (potential recipients) will be important to consider.
Objectives: To identify relevant attributes for a discrete choice experiment (DCE) representing the factors that influence the preferences of patients, first-degree relatives (FDRs), and rheumatologists about preventative treatment for rheumatoid arthritis (RA).
Methods: Semi-structured focus groups were conducted with 1) RA patients in British Columbia (BC), Canada 2) FDRs of people with RA, and 3) rheumatologists from across Canada. Participants were recruited through a combination of convenience and homogenous sampling. Focus group guides were adapted from a previous study which used a DCE to represent an RA treatment decision. In the first round of focus groups, moderated discussions with RA patients, FDRs, and rheumatologists elicited open-ended responses to the interview guide questions. Findings from analysis of these discussions were reduced to a list of potential attributes for the DCE. In the second round, RA patients and FDRs provided feedback to improve the validity and representation of the potential attributes. All focus groups were audio recorded, transcribed, and analyzed using Framework Analysis.
Results: Five focus groups were conducted with 13 RA patients, 5 FDRs, and 7 rheumatologists from four Canadian provinces. Analysis of the discussions revealed that all groups considered competing risks when considering a preventative treatment decision: risks of developing RA and when it might occur; accuracy of predictive tests and the risk of a false positive; and the risks of treatment itself. For rheumatologists, the empirical evidence supporting preventative tests and preventative treatments for RA, as well as treatment side effects were of significant importance. Interestingly, some rheumatologists did not consider prevention to be part of their role. FDRs frequently mentioned the impact that a preventive treatment would have on their lifestyle, the accuracy of predictive test, and weighing the potential benefits against side effects of treatment as key factors in decisions to take a preventative treatment. The health care provider's (nurse/family physician/rheumatologist) knowledge of RA and perceived trustworthiness was also important to FDRs in considering a heath care provider's recommendation for preventative treatment.
Conclusions: Our Framework Analysis highlighted key themes in this discussion which informed the attributes to be included in a DCE. Our findings suggest there are important differences in how patients, FDRs and rheumatologists value the uncertainties surrounding the potential benefits of a preventative treatment for RA.