

HBsAg, AntiHBs and anti-HBcIgG was tested for 898 patients, in 28 patients (2.4%) HBsAg and AntiHBs were negative and anti-HBcIgG was positive. The liver function tests were increased in two occult hepatitis patients, and lamivudine was administered for one and tenofovir for another patient. HCV-RNA was found negative in 12 of 18 patients that positive for HCV. Only one patient had ribavirin + interferon treatment and no reactivation was detected during follow up. The mean length of immunosuppressive treatment was 22.26±18.21 months for HBV positive patients, 19.43±21.40 months for HCV positive patients and 20.94±19.7 months for occult hepatitis. Furthermore, we 10.1% of the patients were vaccinated, 13.4% had natural immunity and 50.7% of patients has not encounter with virus.

Conclusions: HBV prevalence was 3.99% and HCV prevalence was 0.95% in general population, although there is difference according to geographical region in our country. HBV prevalence was the highest 9.9% in southeast region and the lowest 0.7 – 2.5% in west region. Low HBV prevalence could be associated with included patients that was young and stay in west region. Because hepatitis virus can be reactivate under immunosuppressive treatment, patients should be scanned and be careful for occult hepatitis in these scans.

References:

- [1] Vassilopoulos D, Calabrese LH. Viral hepatitis: review of arthritic complications and therapy for arthritis in the presence of active HBV/HCV. *Curr Rheumatol Rep.* 2013 Apr;15(4):319.
- [2] Chen YM, Chen HH, Chen YH, Hsieh TY, Hsieh CW, Hung WT, Lan JL, Chen DY. A comparison of safety profiles of tumour necrosis factor α inhibitors and rituximab therapy in patients with rheumatoid arthritis and chronic hepatitis C. *Ann Rheum Dis.* 2015 Mar;74(3):626–7.

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AB1087 POVERTY, POOR NEIGHBORHOODS, AND SLE OUTCOMES: THE PATIENT'S PERSPECTIVE

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Background: Studies have shown that persons in poverty experience worse outcomes of SLE and that the effect of poverty on outcomes is exacerbated for those living in neighborhoods with a high proportion of households in poverty. We report the results of a project to explore the viewpoint of SLE patients on how income and neighborhood affect disease outcomes.

Objectives: To explore the perspective of SLE patients with SLE on the effect of income, neighborhood, and stress on outcomes: 1) How does presence or absence of money affect care for SLE and in dealing with disease? 2) What role, positive or negative, does neighborhood play in SLE care and outcomes? 3) What are specific stresses that make dealing with SLE difficult?

Methods: We recruited SLE patients for qualitative interviews from a national longitudinal study of SLE conducted between 2003 and 2015. Subjects were selected to highlight the effects of income (those in the highest and lowest income quintiles), neighborhoods (living in neighborhoods with a high proportion of households in poverty vs. not), geographic diversity (four regions of the U.S.; urban, suburban, and rural residents), and range of SLE outcomes. An experienced interviewer conducted hour-long semi-structured interviews which were recorded, transcribed, and analyzed using grounded theory methods.

Results: 28 qualitative interviews were completed; 11 from the highest income group and 17 from the lowest (11 from poor neighborhoods). 3 were men, 20 members of racial/ethnic minorities, and mean age was 49, range 22–70. Among the poor, none cited lack of money as limiting their access to care, but all stated that it necessitated choosing which pressing needs to focus on, with food and housing a higher priority than dealing with their SLE. Among the more affluent, financial resources were used to provide help in daily chores or to withdraw from work to reduce stress and allow for more time to manage their disease. Among the poor, none cited a positive benefit of neighborhood in finding health care resources or in mitigating how they dealt with disease but all cited a negative effect of being exposed to high rates of crime, the principal stress mentioned (*From a central city resident:* "A good neighborhood for someone with lupus is a place where you're not robbed twice in a year inside your apartment and not raped on way home from the bus". *From a rural resident:* "I don't worry about safety anymore. I sleep with a 357 Magnum"). Among the more affluent, local neighborhoods played no role in accessing care or in dealing with disease, with several stating they used professional networks not based in their neighborhood to find skilled providers or support (*From a resident of suburban Phoenix:* My physician's classmate in medical school was a rheumatologist at Mayo who knew someone here in Arizona").

Conclusions: Poverty forced choices in priorities, with SLE often having a lower priority than housing or food security. Exposure to crime was the stress repeatedly mentioned by the poor as exacerbating the disease. The affluent in this study indicated that they were able to reduce stress by paying for personal assistance, withdrawing from work, and using networks that extend beyond their neighborhoods to help gain access to resources. Mitigating poverty and reducing exposure to crime by helping the poor move to safer neighborhoods through housing vouchers may improve outcomes in SLE for the poor.

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AB1088 THE PATIENTS' VIEWPOINT ON A SPECIALISED BIOLOGIC SERVICE

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Background: Biologic disease modifying anti-rheumatic drugs (DMARDs) have been a major breakthrough in the treatment of inflammatory arthritis. In clinical practice, providing timely monitoring to ensure continued efficacy and safety remains a challenge. The availability of a dedicated clinic for patients on biologics may help meet these standards.

Objectives: The aim of this study was to get the patients' perspective of our dedicated biologic clinic and identify any unmet needs.

Methods: Patients attending the biologic clinic between April and September 2016 and who were on a biologic for more than 2 years were interviewed by a trainee following their clinic visit. The patients were asked about their level of satisfaction on various aspects including waiting times, education, involvement in decision-making and duration of consultations.

Results: 44 patients (23 females, 21 males) participated in the survey, of whom 21 suffered from rheumatoid arthritis, 17 from ankylosing spondylitis and 6 from psoriatic arthritis. The mean age of participants was 55.1 (SD 12.62) years. The mean DAS28 was 2.26 (SD 1.03) and the mean BASDAI was 4.21 (SD 2.4). Disease duration was less than 5 years in 20%, 6 to 10 years in 30% and more than 10 years in 50%. Overall satisfaction with arthritis education before initiation of treatment was 91%, which then dropped to 76% after treatment initiation. Satisfaction with education regarding biologic therapy was more consistent at 84% and 81% before and after starting treatment, respectively. 84% of patients reported to be satisfied with their involvement in the decision to start and continue biologic therapy. 77% of patients were satisfied with a consultation lasting 15 to 20 minutes and 77% were also satisfied with 6-monthly visits. The most valued source of education was communication with the caring rheumatologist (n=32), followed by specialist nurse education (n=15), Internet resources (n=14) and use of leaflets (n=13). 95% of patients reported to have rarely or never missed an appointment. The rheumatology advice line was used by 54% of patients, whilst the rest reported that they did not need it since starting the biologic. The greater majority of advice line users were very satisfied with the service provided. Amongst the unmet needs mentioned, were better arthritis education and the introduction of telephone consultations.

Conclusions: Even though most patients were clinically well-controlled, continued education delivered by the caring rheumatologist and specialist nurse is still greatly valued. Patients attending this clinic highly valued the staff dedication and had good communication with their caring clinician. They were highly satisfied with the length and frequency of consultations. Nonetheless, a significant number suggested the need to introduce telephone consultations, which could be considered for those stable patients after receiving proper education.

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AB1089 USE OF NATURAL LANGUAGE PROCESSING TO ENHANCE RETRIEVAL OF RHEUMATOID ARTHRITIS DISEASE ACTIVITY OUTCOMES MEASURES IN US VETERANS

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Background: Rheumatoid arthritis (RA) disease activity measures in the Veterans Affairs RA (VARA) registry are extracted automatically through natural language processing (NLP). While this system is very effective at extracting data when templated notes are properly used, it lacked an error detection and feedback mechanism. Accuracy of the registry is essential for credible epidemiological research and patient care. We report a new automated approach with an active error monitoring and reporting system to alert providers of missing or potentially erroneous elements that can be easily corrected using standardized addendums available in the electronic medical record. The automated NLP system was revised to identify, extract, and integrate these updates to support the calculation of DAS28 and other composite outcome measures for the VARA database.

Objectives: 1. To describe the systems to identify needed corrections of VARA data.

2. To outline the procedures that allow providers to easily use addendums to enter corrections into the medical record to be automatically captured and loaded into the VARA database.

Methods: Procedures were developed and tested at a single pilot VARA site using data available in the Corporate Data Warehouse (CDW) from 01/01/2016 to 12/31/2016. A Java program was designed to retrieve Rheumatology notes, and corresponding addendums, based on "local" and "national" note titles. Notes were then processed to extract defined elements of RA disease activity listed in the table below. After each scheduled NLP run the system generates a log file that provides a summary, and patient-level report of completed and missing data elements. Providers receive the report and are asked to review the clinical notes of patient visits with missing data elements and follow simple procedures that leverage addendums to add or correct data elements when template violations occur. Addendums are also used to terminate the flag and request for review when the items are not available in the notes. Updating the VARA database from addendums occurs during the next NLP run.