Objectives: To understand allopurinol dose-titration relative to sUA levels.

Methods: This retrospective study used the de-identified Humedica electronic medical record database. The study included all sUA and allopurinol records among gout patients (ICD-9-CM: 274.xx) ≥ 18 years old with first gout diagnosis in 2007 – 2015. An episode was defined as an allopurinol initial dose (ID) prior to (closest) and titrated dose (TD) after (within 30 days) an sUA test. Dose-titration was categorized as an episode with a dose-change (up-titration: ID < TD; down-titration: ID > TD), or no-dose-change (ID = TD). For multiple different doses recorded on the same prescription date, the sum of doses was taken as daily dosage. Episodes were considered uncontrolled when sUA ≥ 6 mg/dl. Descriptive episode-level analyses were performed.

Results: Within 64,609 episodes, 57% of episodes were uncontrolled (sUA: 6 to <8 mg/dl: 38%; 8 to <10 mg/dl: 15%; ≥ 10 mg/dl: 4%). Seventy-one percent of uncontrolled episodes were no-dose-change, 21% were up-titrated, and 7% were down-titrated. Within no-dose-change episodes, 51% were uncontrolled and lower doses corresponded to higher percentages of uncontrolled episodes (<100mg/day: 88%; 100mg/day: 70%; >100, <300 mg/day: 49%; 300mg/day: 38%; >300mg/day: 36%). Seventy-eight percent of dose-change episodes were uncontrolled, of which 100 to 300 mg/day (39%) was the most frequent dose titration. Overall, the most frequent TD was 300 mg/day (52%) followed by 100mg/day (36%), >100 – <300mg/day (8%), >300mg/day (3%), and <100mg/day (<1%).

Conclusions: Allopurinol dose is not generally titrated regardless of sUA control. This pattern suggests a need for active management of patients with gout with uncontrolled sUA including consideration of new treatment options in addition to allopurinol.

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THU0609 REGIONAL DIFFERENCES IN HEALTH CARE UTILIZATION IN THE KHOALA COHORT, A FRENCH POPULATION BASED COHORT OF SYMPTOMATIC KNEE AND/OR HIP OA PATIENTS

A.-C. Rat^{1,2}, J.-H. Salmon³, A. Saraux⁴, C. Gard⁵, F. Guillemin^{1,6}, B. Fautrel⁷.

¹Ea 4360 Apemac, Lorraine Université; ²Rheumatology, CHRU Nancy, Nancy; ³Rheumatology, CHU Reims, Reims; ⁴Rheumatology, la Cavale blanche University, hospital and université de Bretagne occidentale, Brest; ⁵Pharmacy, Pitié Salpêtrière hospital, Paris; ⁶CIC 1433 Epidémiologie clinique, Inserm, CHRU, Université de Lorraine, Nancy; ⁷Rheumatology, Université Pierre et Marie Curie (UPMC)-Paris 6 GRC-UMPC 08 (EMOIS), Paris, France

Background: In hip and knee OA, one of the leading causes of global disability, recent population-based data of health care practices and utilization are scarce. Describing patterns of care of patients is important to adapt health care practices and guide interventions to optimize patients' use of health care services.

Objectives: The aim of the project was to describe health care utilization and associated factors of a representative sample of patients with knee or hip symptomatic OA.

Methods: The KHOALA cohort is a French population-based multicenter cohort of patients with symptomatic knee and/or hip OA, aged between 40 and 75 years old recruited between 2007 and 2009. The representativity of the cohort allows for generalizing the results

Results: Among the 878 patients, 609 (69%) were women, 222 (25%) have hip OA, 607 (69%) knee OA and 49 (6%) both hip and knee OA. Groll comorbidity index (0–18) was 3.1 (1.6). Radiographic K&L grades 2, 3 and 4 were 69.8%, 26.1% and 4.1% for hip OA respectively and 44.5%, 30.3%, and 25.2% for knee OA.

In multivariate analyses, increased pain was independently associated with increased number of patients using pain killers (non-opioids and weak opioids), symptomatic slow-acting drugs or steroid injections but not NSAIDs. Increased age or being retired was associated with increased use of non-opioid drugs or decreased prescription of NSAIDs but not with opioid drugs. Weak opioid drugs were more frequently used by patients with low than high education and by those consulting a rheumatologist. The geographical effect was important, independently of the symptoms, with OR=0.3 (95% CI 0.2–0.7) and OR=0.5 (95% CI 0.2–0.9) for south vs north/east and west vs north/east respectively for weak opioids use with the same trend for non-opioids use. On the opposite, physiotherapy was more frequently prescribed in the south than in the north OR=2.1 (95% CI 1.3–3.5). More patients consulted a rheumatologist in large (>50,000) than small cities (<2,000) OR=2.8 (95% CI 1.6–5.1) but this was not the case for orthopedic surgeons consultations. Pain was not independently associated with consultations with the different health care professionals. Instead

the number of patients consulting different health care professionals increased with functional impairment. Consulting an orthopedic surgeon was less frequent for patients with more comorbidities, retired, with decreased vitality or who also did not consult a rheumatologist.

Conclusions: Even if symptoms and patients characteristics are strongly associated with treatments use and health care professional consultations, regional or rural vs cities differences are important independently of pain, function or other quality of life domains. Whether these differences are due to health care professional prescriptions or patients life style and behaviors are still to be explored.

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THU0610 RHEUMA SPACE: STANDARD PRACTICE AIMING CLINICAL EXCELLENCE IN RHEUMATOLOGY

C. Macieira¹, L. Cunha-Miranda², P. Nero³, P. Lucas⁴, J. Eurico da Fonseca^{1,5}, J. Canas da Silva⁶ on behalf of Rheuma Space study group. ¹Department of Rheumatology, Centro Hospitalar Lisboa Norte; ²Department of Rheumatology, Instituto Português de Reumatologia; ³Department of Rheumatology, Hospital CUF Descobertas, Lisbon; ⁴QuintilesIMS, Porto Salvo; ⁵Faculdade de Medicina da Universidade de Lisboa, Lisbon; ⁶Department of Rheumatology, Hospital Garcia de Orta, Almada, Portugal

Background: The quality of medical care and the implementation of measures to improve it are crucial steps for the development of Rheumatology in Europe. Quality indicators were obtained through a four-step rand-modified Delphi methodology. A final set of 26 quality indicators was defined within Donabedian framework dimensions: 9 "structure", 11 "processes" and 6 "outcomes" indicators. Herein we describe the second implementation phase of a national program, Rheuma Space (RS), aiming at quality improvement in Rheumatology.

Objectives: To develop a quality improvement plan for care provided by Rheumatology Departments (RD). In this second phase we present the results of the RD evaluation.

Methods: A measurement scale on quality/excellence thresholds was developed for each of the 26 criteria. Eight RD participated in the project and each one set up an Investigation Team of 2–3 members for field criteria measurement and evaluation that required the use of different data sources and focused on the period: 2014 – 1st semester of 2015. After data analysis an individual report was delivered and discussed with each of the 8 RD. Afterwards public presentation and discussion of the results took place.

Results: "Structure" was evaluated in terms of personal, training, facilities, equipment and budgeting:

- RD lack Rheumatology specialists and need fully dedicated nurses
- Training plans exist in all RD, but physicians allocate few time to research
- Equipment is appropriate, nonetheless microscopes and computers could be updated
- Internal contracting is well established and professionals are committed to targets

"Processes" were evaluated in terms of access and medical care, clinical records, physician-patient communication and multidisciplinary patient management:

- Triage criteria for first appointments should be standardized, despite compliance for "High Priority" patients
- Follow up could be more frequent, but direct access in emergencies is guaranteed
- Reuma.pt registry is mainly used for patients under biologics and data completion could improve
- Multidisciplinary care is provided, but patient coverage and specialty diversity can increase.

"Outcomes" were evaluated in terms of clinical outcomes, patient and personal satisfaction:

- Average working absence is <15days/patient/year, but is much higher in more affected patients
- Almost 1/3 of patients requested early retirement at a median age >50years
- Patients are satisfied with provided care and physicians' attitude, but less with RD facilities
- Professionals are satisfied with working environment, however criticize career related aspects.

Conclusions: The 26 quality indicators set the basis of this quality management tool that was applied to 8 Portuguese RD. Strengths and weakness were identified and an individual Department report was elaborated and discussed. Interventions are now being planned based on these results in order to ensure quality standards of structure and process criteria for a patient oriented clinical practice, favouring desirable continuous quality improvement on health outcomes.

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