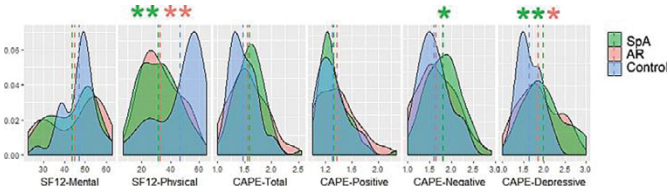
	SF-12		CAPE			
	Physical	Mental	Positive	Negative	Depressive	Total
SpA	31.8 (13.6)**	43.8 (10.6)	1.32 (0.2)	1.81 (0.4)*	1.98 (0.5)**	1.59 (0.3)*
RA	33.1 (13.1)**	44.9 (12.7)	1.37 (0.3)	1.66 (0.4)	1.86 (0.5)*	1.55 (0.3)
Control	47.0 (16.1)	47.2 (7.5)	1.30 (0.2)	1.61 (0.4)	1.65 (0.3)	1.47 (0.2)

differences, according a t de Student test with control group is shown in both (* $p<0.05$, ** $p<0.01$).
There were no significant differences in the mental component of the SF-12. These differences appear at the physical component, since patients have impaired their mobility and function due to their disease. About the CAPE questionnaire, patients had a little bit higher score due mainly to the appearance of depressive symptoms. The values of positive symptoms of psychosis remained within the normal range for diseases analyzed.



Conclusions: In our study, we found significant differences in the dimensions, especially depressive, of the CAPE scale among patients with rheumatic diseases (especially in SpA) and healthy subjects. This gives us an idea of the importance of considering the psychological problems of patients (anxiety, depression, ...) to improve the treatment of rheumatic disease.
Acknowledgements: We would like to thank these patients' organizations for their collaboration in our study: Coordinadora Española de Asociaciones De Espondiloartritis (CEADE), Asociación Cordobesa de Enfermos de Espondilitis (ACEADE), Asociación Cordobesa de Enfermos de Artritis Reumatoide (ACOARE).
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THU0625 DESIGN OF AN INFORMATION AND COMMUNICATIONS TECHNOLOGY PLATFORM TO SUPPORT COORDINATION OF CARE FOR RHEUMATOID ARTHRITIS PATIENTS WITH CARDIOVASCULAR CO-MORBIDITIES – FIRST EXPERIENCES

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Background: Coordination of care plans between healthcare sectors and efficient management of patients (pts) with co-morbidities is of large demand. Rheumatoid arthritis (RA) pts are at increased risk of cardiovascular diseases (CVD). Different stakeholders are potentially involved in the EULAR recommended management processes. Optimized orchestration of accumulated information is of major importance to ensure data quality, meaningful management processes and cost effectiveness. A newly developed information and communications technology (ICT) platform within the Horizon2020-funded PICASO-project (www.picaso-project.eu) will support a continuum of care from hospitals and outpatient clinics to the home.
Objectives: Explore challenges to provide an efficient ICT integrated solution across many healthcare professionals working for various organisations and potentially crossing national borders that complies to privacy and regulatory constraints allowing more efficient care management. Suitable system architecture and appropriate features require identification of target users' user requirements. PICASO platform will be developed and trialed with pts and clinician. The proposed system architecture will be evaluated for suitability for a larger scale rollout.
Methods: Projects' pre-defined clinical and technological driven work packages started. Various stakeholders (e.g. pts, local data security and IT representatives, health care insurances' representatives, clinicians) were integrated in the design phase. A PICASO ethical board including external members (e.g. Chair of the Standing Committee of PARE) addressed ethical and legal concerns.
Results: Current work-flows for the care plan management including stakeholders' hand-over procedures were elaborated. Vision scenarios (n=11) and To-Be Use Cases (n=18) addressing solutions including home monitoring were developed (1). A comprehensive list of user requirements (currently n=87) resulted. Detailed system architecture descriptions are stipulated. Ethical issues and how to handle these, in particular data-protection and -privacy challenges were pre-assigned as these affect platforms' architecture. PICASO ethical principles and guidelines were stated (2). The platform is under development. The first trial running over nine months including RA-pts will start in spring 2017. First experiences will be reported at EULAR.
Conclusions: Considering the needs of a highly valued, specialised health care system relevant To-Be Use Cases, numerous user requirements and EU-wide ethical and legal issues were gathered to serve as basis for appropriate design, development and implementation of the ICT platform. Software development will take place in iterative cycles followed by prototypes' thoroughly evaluated by real end users investigating usability and acceptance. The platform will become available for RA-pts in routine care but also for wider applicability in Rheumatology and other chronic diseases.
References:
[1] PICASO Consortium (2016), D2.1 Scenarios and Use Cases for Integrated Care. http://www.picaso-project.eu/download/4894.
[2] PICASO Consortium (2016), D3.3 PICASO Ethical Guidelines. http://www.picaso-project.eu/download/520/; both last accessed 27/01/2017.
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THU0626 COST-EFFECTIVENESS OF EARLY TREATMENT OF ACPA POSITIVE RHEUMATOID ARTHRITIS PATIENTS WITH ABATACEPT

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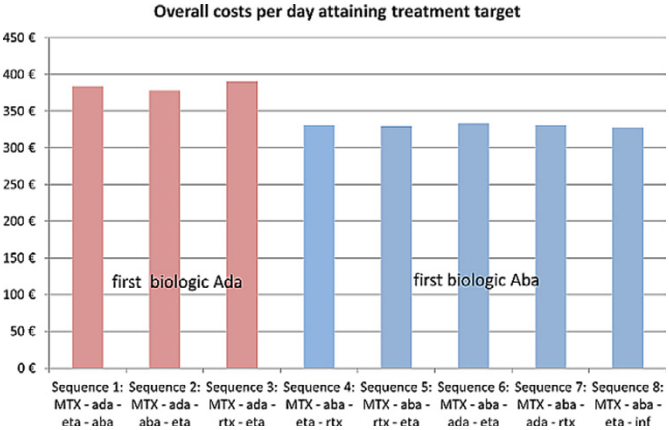
Background: Studies have reported that the presence of elevated anti-citrullinated protein antibodies (ACPA)/RF levels, together with joint erosions, is associated with higher disease burden in terms of disability, and mortality in rheumatoid arthritis (RA). Abatacept has been shown to be effective in this patient population with favorable comparative data against adalimumab.(1) However, few studies have investigated the cost effectiveness of abatacept in this population to similar treatments such as TNFs.
Objectives: The objective of the study was to compare the cost-effectiveness of abatacept to adalimumab as a first bDMARD in ACPA positive RA patients who failed treatment with methotrexate (MTX) in Germany.
Methods: A decision tree model was used to estimate the cost-effectiveness, from a payer's perspective, of different treatment sequences in RA over a two year time frame. The effectiveness criteria were defined as achieving the treatment target measured by the Disease Activity Score 28 (DAS28 (CRP)<2.6; "remission"). A treatment switch to a different biologic as 2nd line and 3rd line bDMARD was allowed -in case of not achieving remission with therapy- every 6 months over a two year time period. Effectiveness data was based on randomized controlled trials (RCT) identified by an updated previous systematic literature search by the Institute for Quality and Efficiency in Health Care (IQWiG). Costs of medication and other direct medical costs were taken from a recent publication (2) and included in the analysis. Cost-effectiveness of RA treatment was investigated in ACPA positive patients in this study and presented as overall costs per day in remission. To manage uncertainty in the model, a fully probabilistic approach was used with 10,000 runs.
Results: For ACPA positive patients, treatment strategies including early treatment with abatacept had lower total costs per clinical outcome compared to later use. Figure 1 summarizes the costs per day in remission for the treatment sequences investigated: treatment sequences starting with abatacept resulted in lower costs for reaching remission (mean 330 €/day, range 328 €-333 €/day) compared to sequences starting with adalimumab (mean 384 €/day, range 378 €-390 €/day). Choice of the second or third biologic in the treatment sequences appears to have little impact on the costs per outcome.



Conclusions: The results of this analysis suggest that in ACPA positive RA patients treatment with abatacept appears to be more cost-effective compared to treatment with adalimumab as a first bDMARD.
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Disclosure of Interest: A. Neubauer Grant/research support from: BMS, Intercept, Roche, Santen, C. Minartz Grant/research support from: BMS, Intercept, Roche, K. Herrmann Employee of: BMS, R. Postema Employee of: BMS, C. Baerwald Grant/research support from: Abbvie, Biogen, BMS, Chugai, Hexal, Medac, Pfizer, Roche, Sanofi Aventis, UCB
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THU0627 TREATMENT OF RHEUMATOID ARTHRITIS: ADHERENCE TO GUIDELINES IN PRIVATE PRACTICE

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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.
Disclosure of Interest: None declared
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THU0628 PATTERNS OF ETANERCEPT DOSE ADJUSTMENTS IN A REAL–WORLD SETTING: A CANADIAN RETROSPECTIVE COHORT STUDY

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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.
Disclosure of Interest: M. Khraishi Consultant for: Pfizer Canada and Amgen Canada, Y. Zhang: None declared, J. Ivanovic: None declared, B. Millson: None declared, E. Singh: None declared, J. Woolcott: None declared, H. Jones: None declared
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THU0629 THE PERSPECTIVES OF PATIENTS, THEIR FIRST DEGREE RELATIVES, AND RHEUMATOLOGISTS AROUND PREVENTATIVE TREATMENTS FOR RHEUMATOID ARTHRITIS

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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.