intervention may avert the requirement of expensive biological therapy as second-line treatment, which leads to improved overall cost-effectiveness. As a first step to address this issue, we performed a systematic literature review to appraise existing evidence relating to delay in diagnosis and cost-of-illness in DMARD-naive newly-diagnosed RA patients.

Objectives: To identify whether disease duration before initiation of first DMARD therapy is a determinant of subsequent direct and indirect costs in DMARD-naive RA patients.

Methods: We systematically searched Pubmed, EMBASE, CINAHL and Medline databases for published literature relating to rheumatoid arthritis, and direct and indirect costs. We included studies with DMARD-naive patients who fulfilled the 1987 ACR or 2010 ACR/EULAR classification criteria for RA. We excluded studies on non-rheumatoid arthritis patients; conference abstracts, systematic reviews or review articles; studies with no documented symptom duration prior to diagnosis; studies which did not report direct and/or direct costs and/or health utilisation. All studies were required to report their methods and sources of respective cost measurements. We extracted the following data from each study; study design; potential determinants of RA cost; health economic outcomes and source of unit cost for the health-resources.

Results: A total of 173 records were identified in the systematic search, five of which included in the analysis. Two were cost-of-illness studies within the context of observational studies and the remaining were cost-of-illness studies alongside clinical trials. The health outcomes reported were heterogeneous: 1) Direct medical costs were reported in three studies; 2) Indirect non-medical costs were reported in one study and 3) Health-care utilisation was reported in one study. Only one study reported indirect costs from the societal perspective e.g. work disability. The definition of symptom duration was not specified in any studies. Three studies reported disease duration of one year or less and two studies reported symptom duration of six months and <two years. The timing and duration of the reported health economic outcomes varied widely (figure 1). The direct medical costs for three papers were adjusted for purchasing power parities and consumer price index for 2017 US Dollars.

Background: This study looks at the diagnoses and management of those discharged from the EIA pathway who do not have EIA and this should be taken into account when such a service is developed.

Conclusions: Data on the relationship between symptom duration and costs in DMARD-naive RA patients is limited. Comparability between studies is hampered due to heterogeneity of the definition for symptom/disease duration and the health economic outcomes reported. An inception cohort of suspected early RA should include data in resource utilisation and costs studies to identify the relationship between symptom duration and health economic outcomes.

Disclosure of Interest: None declared

Conclusions: Presenteeism, impairment of work productivity and activity were correlated with disease activity and physical functioning, with the increase of VAS scores. Economic reasons were the most common reason for therapeutic failure. It entails a high health care cost, both direct and indirect, affecting the patient and society. The combination of both types in order to ensure that the data are as close as possible to reality.

Methods: We carried out an anonymous voluntary survey in October 2017 concerning the degree of satisfaction and therapeutic adherence of patients under follow-up in outpatient Rheumatology Consultations, selecting demographic data from them and using a MARS questionnaire for chronic diseases, which is validated in Spanish. This questionnaire consists of 30 questions that include items about beliefs, experiences and behaviour in terms of health. A score higher than 25 indicates good compliance, while a score lower means a suboptimal compliance.

Results: 201 surveys were collected, excluding those patients whose consultation was the first one and those who rejected their participation. The data analysis was performed descriptively with Microsoft Excel. 61% of the surveys collected were carried out by women, with an age range between 55 and 70 years (35%). 45% of the patients surveyed had a basic level of education and 28% had an average level of education, representing both of them three quarters of our sample. When we analyse the treatments that our patients receive, the most prevalent are the DMARDs, which represent 35% of the treatments, followed by the corticosteroids (30%), disulfiram (14.9%) and corticosteroids (9.1%). In patients with psoriasis and psoriatic arthritis, we identified six themes (with subthemes): suffering uncontrollable and ongoing upheaval (dictating life choices and course, disrupting role functioning, limited by debilitating symptoms, unstoppable and far reaching fatigue); weighed down by mental load (struggling with unrecognised distress, anxiety provoked by the volatility and consistency of symptoms, depleting motivation and pleasure); harbouring shame and judgement (marked as unhygienic and contagious, rejected and isolated, resenting own appearance, pain and embarrassment in intimate); demoralised by inadequacies and burden of therapy (disapponted by unmet expectations of treatment benefit, daily drudgery, deterred by unpalatable or inconvenient treatments, disempowered by lack of personalised care, fearing long term side effects); gaining control (making sense of the condition, shutting the disease out, accepting a new health status, attuning to the body); and making confident treatment decisions (trading off perceptible benefits against safety and convenience, relying on family input, reassured by clinician acknowledgement of fears, seeking empowering relationships with clinicians).

Conclusions: Patients with psoriasis and psoriatic arthritis contend with profound disruption in their functioning, roles and life course; fear deterioration of their health; and have unmet expectations about their treatment and care. Patients with psoriasis feel marked by their disease, stigmatised and rejected by others while patients with psoriatic arthritis experience social withdrawal and depleted motivation due to fatigue, joint impairment and pain. Establishing therapeutic relationships, addressing treatment expectations, and supporting psychosocial needs may help to improve satisfaction and outcomes in patients with psoriasis and psoriatic arthritis.

REFERENCES:

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