level and ADAb testing within their own clinical practice. The transcripts were analysed by thematic framework analysis where themes comprised perceived barriers to testing. Ethical approval was obtained from The University of Manchester's Research Ethics Committee.

Results: Eleven rheumatologists provided informed consent to participate in the study. All rheumatologists demonstrated an awareness of tests that were available to measure anti-TNF drug levels and ADAb. However, the majority ($n=10$) did not use these tests in their routine clinical decision-making. Five potential barriers against testing were identified as themes:¹ recognising the clinical problem within their own patients;² understanding the purpose of testing drug levels and ADAb,³ a lack of robust evidence to support testing,⁴ insufficient capacity to implement testing locally, and⁵ the additional cost associated with testing.

Conclusions: The potential barriers against measuring anti-TNF drug levels and ADAb suggest that introducing these tests into practice for rheumatology may be challenging. Authoritative guidance for measuring anti-TNF drug levels and ADAb in specific rheumatic diseases may reduce the uncertainty over the purpose of testing in routine clinical settings. The generation and dissemination of robust evidence for the accuracy, effectiveness, and cost-effectiveness of testing is likely to be informative to rheumatologists and decision-makers that allocate resources for health care. Decisions to introduce testing in clinical practice may benefit from considering the implications of capacity constraints when analysing samples and the mechanisms to pay for the additional cost of testing. These barriers against testing are not unique to the health care system in England and may generalise to the delivery of care for rheumatic diseases within health care systems internationally.

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AB1265 LOSS OF SPECIALTY MEDICAL CARE FOR ELDERLY RHEUMATOID ARTHRITIS PATIENTS WHO DISCHARGED FROM HOSPITAL

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Background: As the ageing of the population progresses, the proportion of the population over the age of 65 reaches 27.3% in 2016, in Japan. Even elderly rheumatoid arthritis (RA) patients often require immunosuppressive agents or biological disease modifying antirheumatic drugs (DMARDs) due to their high disease activity. Therefore, they need to continuously receive treatment by specialty rheumatologists. Due to the deterioration of the ability of daily living activities, some patients may drop out of specialty medical care.

In recent years, the age of RA patients who need to be hospitalised has also increased. However, it is unclear whether elderly patients discharged from the hospital are able to continue receiving specialty medical care.

Objectives: To clarify whether a patient who has been discharged from a rheumatology specialty hospital can continue receiving rheumatology specialty medical care.

Methods: RA patients who discharged from our rheumatology unit from January 1, 2016 to December 31, 2016, were included. We investigated the backgrounds and outcomes of those patients retrospectively. We compared the background characteristics of patients who are receiving treatment by specialty rheumatologists at the final follow-up (specialty group) and those who are not (non-specialty group). For the statistical analysis, a chi-squared test and Student's t-test were used.

Results: We identified 147 patients. The mean $\pm$ SD age of patients at discharge was 72.2 ± 9.1 years and 74.8% was female. The reasons for hospitalisation were 87 patients (59.2%) for treatment of RA and 60 (40.8%) for treatment of complications (sepsis, fracture and so on).

After discharge, 134 patients (91.1%) had returned to follow up in our department for RA treatment. The remaining 13 patients were treated at other hospitals, five of whom were treated by a primary care physician who was not specialised for rheumatology. Overall, we compared 142 patients in the specialty group and 5 in the non-specialty group.

The age, the use ratio of immunosuppressive agents/biological DMARDs/prednisolone and the dose of prednisolone in the specialty group and the non-specialty group were 71.9 and 79.0 years old ($p=0.09$), 50.0% and 20.0% ($p=0.37$), 29.6% and 20.0% ($p=1.00$), 78.7% and 80.0% ($p=1.00$), 6.5 and 5.6 mg/day ($p=0.83$), respectively.

Conclusions: In elderly RA patients, some patients drop out of RA specialty medical care. The background of such patients is not different from those of patients who are receiving treatment by specialty rheumatologists. In order to provide specialty medical care for RA patients throughout the community, a co-management medical collaboration system between specialty rheumatologists and primary care doctors should be established.

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AB1266

AUTOIMMUNE DISEASES INDUCED BY BIOLOGICAL AGENTS USED IN PATIENTS WITH ADVANCED CANCER: A NATIONWIDE MULTICENTER REGISTRY OF CASES DIAGNOSED IN DAILY PRACTICE (cBIOGEAS-SEMI)

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Objectives: To characterise the development of autoimmune diseases triggered by the new biological therapies used as immunotherapy in patients with advanced cancer in a real-life clinical setting.

Methods: In 2006, the Study Group on Autoimmune Diseases (GEAS) of the Spanish Society of Internal Medicine created the BIOGEAS project, a multicenter study devoted to collecting data on the use and safety of biological agents in adult patients. In December 2016, the cBIOGEAS-SEMI multicenter registry was formed with the aim of collecting patients with cancer treated with biological immunotherapies who developed autoimmune diseases.

Results: By January 2018, the cBIOGEAS-SEMI Registry includes 40 patients (26 men and 14 women, mean age of 59.7 years) who developed 54 triggered autoimmune diseases, including interstitial lung disease ($n=11$), enterocolitis ($n=8$), hypophysitis ($n=6$), polyarthritis ($n=4$), thyroiditis ($n=3$), vasculitis ($n=3$), severe cutaneous involvement ($n=3$), adrenalitis ($n=2$), Sjögren syndrome ($n=2$), cardiomyopathy ($n=2$), pancreatitis ($n=2$), Guillain-Barre syndrome ($n=2$), hepatitis ($n=2$) and CNS involvement, sclerosing cholangitis, glomerulonephritis and sarcoidosis (one case each). Underlying neoplasia consisted mainly in pulmonary neoplasia ($n=16$), melanoma ($n=11$) and breast cancer ($n=3$). The main pharmacological groups of cancer immunotherapies included PD1 inhibitors ($n=26$), CTL4 inhibitors ($n=7$), growth factor/adhesion molecules inhibitors ($n=4$), combined PD1/CTL4 blockade ($n=2$) and TK inhibitors ($n=1$); biologics included nivolumab ($n=20$), ipilimumab ($n=9$), pembrolizumab ($n=8$), trastuzumab ($n=3$), catumaxomab ($n=1$) and vemurafenib/combinetininib ($n=1$). Glucocorticoids were used in all cases but 4, and 9 patients required intravenous methylprednisolone pulses; 5 patients required additional immunosuppressive therapies (intravenous immunoglobulins in 4, methotrexate in one). All cases responded to treatment with glucocorticoids except 4 patients who died (3 due to ILD and one due to neurological disease).

Conclusions: A wide variety of systemic and organ-specific autoimmune diseases triggered by the new cancer immunotherapies is emerging. In this nationwide real-life Registry, immune checkpoint inhibitors are the biologics involved in nearly 90% of cases. We found an excellent response to glucocorticoids, with a poor prognosis in those patients who developed pulmonary and neurological autoimmune diseases.

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AB1267

BIO-SIMILAR TO BIO-ORIGINATOR SWITCHBACK: NOT A RELIABLE QUALITY INDICATOR

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Background: SB4 in an etanercept biosimilar which was licensed by the EMA in January 2016 for clinical use. Switching etanercept treated patients from reference etanercept (ETN) to SB4 can deliver a substantial saving in drug costs. The SB4 to ETN switchback rate is often scrutinised by commissioners and clinicians, as it may be a quality indicator for the switch process.

Objectives: To evaluate SB4 drug survival and the SB4 to ETN switchback rate in our cohort of patients with Rheumatoid Arthritis, Axial Spondyloarthritis and Psoriatic Arthritis.

Methods: This was a retrospective observational study of 56 patients who were switched from ETN to SB4 in December 2016 at Kings College Hospital. Clinical data was collected 8 months post-switch to establish the number of patients in whom SB4 had been discontinued, the reasons for discontinuation, and the switchback rate.

Results: 84% ($n=47$) of patients remained on SB4 at 8 months following the switch. Of the 9 patients who discontinued SB4, 89% ($n=8$) was due to loss of efficacy, whilst 11% ($n=1$) reported side effects. Of these, 78% ($n=7$) were switched over to a 3rd biologic agent, whilst 22% ($n=2$) were switched back to ETN. The

median pre-SB4 switch DAS score for patients with RA who were switched to a 3rd biologic agent was 4.23 (Range: 2.59–7.65), whilst that of those switched back to ETN was 4.08 (Range: 3.35–4.81).

Abstract AB1267 – Table 1

Demographics (n=56)	No. of patients remaining on SB4 at 8 months (n=47)	No. of patients switched to a 3rd biologic agent at 8 months (n=7)	No. of patients switched back to ETN at 8 months (n=2)
Mean Age	57.2	55.4	39.5
% Female	64%	71%	100%
% Disease	70%	71%	100%
RA	15%	14%	0
AS	15%	14%	0
PsA			
% Etanercept	43%	71%	100%
Monotherapy			
Median Time on SB4 prior to switch (days)	N/A	251 (Range: 79–357)	122.5 (Range: 114–131)

Conclusions: This switch back rate to ETN is considerably lower than what has been reported in the literature.^{1–3} There appears to be a preference for switching patients to an alternative biologic agent, rather than switching patients back to the bio-originator. This could be explained by inadequate disease control on etanercept, which has been unmasked under the scrutiny of the biosimilar switch process. An alternative explanation could be that our local clinical commissioning group offers financial incentives if the department maintains a high percentage of etanercept treated patients on SB4. Hence, as prescribing practice can be influenced by both clinical factors and external targets, utilizing the switchback rate from biosimilar drugs to bio-originators is not a reliable indicator of the quality of biosimilar switch process.

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AB1268

NO DIFFERENCES BETWEEN HOSPITAL AND CLINIC IN PATIENTS WITH RHEUMATOID ARTHRITIS BASED ON REAL-WORLD DATA FROM THE AORA OBSERVATIONAL COHORT STUDY IN JAPAN

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Background: In Japan, orthopaedic surgeons, rather than internists, are often involved in the management of rheumatoid arthritis (RA), including drug treatment. However, the paradigm shift in the RA management has changed, and orthopaedic surgeons have often faced challenges in treating RA. The proportion of RA patients treated by orthopaedic surgeons is high in Akita Prefecture, located in Tohoku region in Japan. Akita Prefecture has the 6th largest area in Japan and the highest ageing rate. As many elderly patients have difficulty commuting to distant clinics or hospitals, specialised centres are desirable for advanced treatment of RA. However, in Akita Prefecture, the focus has been on improving treatment of RA by orthopaedic surgeons in the community. In 2010, the Akita Orthopaedic Group on RA (AORA) was established. Currently, 18 hospitals and 10 clinics are participating in the group, and cover all medical districts throughout the prefecture. In addition to a regular study meeting, a workshop on joint ultrasonography and a

case conference with internists have been held. We established a case registration system (AORA registry) 8 years ago. This system has enabled us to share treatment experiences.

Objectives: This study examined whether the AORA clinics have provided consistent community-based care comparable to that provided by hospitals.

Methods: Data from the 2017 AORA registry (including 2238 registrations [1300 in hospitals and 938 in clinics]) were used.

Results: Patients treated in clinics were younger (68.1 years in hospitals vs. 64.4 years in clinics), and had shorter duration of disease (157.4±4.0 months in hospitals vs. 143.5±4.5 months in clinics). The frequency and amount of methotrexate use were not significantly different between the two groups, while those of prednisolone use were greater in patients treated in hospitals than in those treated in clinics. There were no significant differences in the frequency or amount of biological disease-modifying antirheumatic drug use (19.9% in hospitals vs. 18.9% in clinics). There were also no significant differences in disease activity (Disease Activity Score-28-erythrocyte sedimentation rate) in the total cohort (2.91±0.04 in hospitals vs. 2.90±0.04 in clinics) or in patients aged 80 years or older (n=341) (3.35±0.08 in hospitals vs. 3.37±0.11 in clinics). The frequency and amount of drug use for treatment of osteoporosis were significantly higher in patients treated in hospitals than in those treated in clinics.

Conclusions: The results of this study showed that RA treatment outcomes were not significantly different between hospitals and clinics, indicating that the treatment level provided at orthopaedic clinics in the community was high and in accordance with the treat-to-target strategy. Given that orthopaedic surgeons are better able to examine joints and are able to treat osteoporosis, they are expected to treat more RA patients. We believe that the AORA plays an important role in maintaining the quality of clinical services for RA patients in Akita Prefecture.

Disclosure of Interest: None declared

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AB1269

QUALITY STANDARD FOR THE MANAGEMENT OF PATIENTS WITH PSORIATIC ARTHRITIS: QUANTUM PROJECT

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Background: In the context of complex diseases like psoriatic arthritis (PsA), in which patients are often followed by different professionals, it is important for health professionals, providers and patients to have tools for delivering and demanding optimal care. One way to organise and evaluate health care quality is by the use of validated standards of care and quality indicators.

Objectives: To develop nationally accepted standards of care and quality indicators for care in PsA.

Methods: Qualitative methodology was followed that included: 1) Two focus groups (one with patients with PsA and another with non-rheumatologists specialists involved in the care of patients with PsA); 2) A narrative literature review of published documents related to the quality of care in PsA (including the QUANTUM Report¹); 3) A nominal group meeting in which 15 expert rheumatologists generated and consensuated, a series of quality criteria as well as formulas or quantifiable objective measures to evaluate them; 4) A Delphi to establish the feasibility, priority and agreement with the quality criteria; 5) A final generation of standards of care and their attributes (including quality indicators). A descriptive analysis of the results was carried out.

Results: A total of 59 standards of care were generated, 19 of mandatory compliance, grouped into 4 blocks according to specific objectives: 1) Early diagnosis (n=6); 2) optimising the management of the disease (n=26); 3) multidisciplinary collaboration (n=9); 4) monitoring improvement (n=18). To assess the compliance of these standards of care, in many cases the medical records will be reviewed. Other sources will be the memory of the service and hospital and bibliographic databases. Regarding to the level compliance, for some of the standards of care this is yes/no, for others the compliance will range from 50% to 100%, and in this range for many this will be by 80%.

Conclusions: This set of standards of care should help improve quality of care in APs patients.