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.

Abstract AB1270 – Table 1. – Regression analysis on indirect cost

	Univariate Analyses			Multivariate Analyses*					
	β	95% CI	p	β	95% CI	p			
Age	-32.5	-242.4 to 5351.7	0.211	-6.4	-66.2 to 53.3	0.830	-11.4	-68.0 to 45.2	0.688
Gender, female	-119.6	-1491.0 to 1251.9	0.862	66.4	-1601.9 to 1734.8	0.937	63.6	-1597.7 to 1725.0	0.939
Disease duration (months)	44.5	-7.5 to 96.7	0.093	17.7	-42.4 to 77.4	0.561	14.2	-48.8 to 77.2	0.632
Baseline VAS pain score	300.8	88.3 to 513.2	0.006	280.5	72.5 to 488.5	0.009	271.4	62.2 to 480.6	0.012
Baseline HAQ	893.8	-15.7 to 1083.3	0.054	-223.5	-1760.2 to 1313.2	0.772	-397.6	-1641.4 to 846.2	0.525
Baseline FACIT	-63.9	-114.9 to -12.8	0.015	-19.6	-0.4 to 0.6	0.635	-40.7	-127.2 to 45.762	0.350
Baseline SF36 PCS	-30.0	-660.0 to -0.017	0.050	17.7	-27.3 to 62.8	0.434	12.4	-38.1 to 62.9	0.625
Baseline SF 36 MCS	-42.6	-72.8 to -12.4	0.006	-26.9	-63.4 to 9.63	0.146	-27.9	-64.3 to 8.6	0.131
Month 6 DAS CRP Score	695.4	137.4 to 1253	0.015	634.8	96.1 to 1175.4	0.022	-	-	-
Cannot achieve early remission/ LDA	1465.3	318.1 to 2612	0.013	-	-	-	1287.5	164.3 to 2410.7	0.025

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AB1270 ACHIEVING EARLY DISEASE CONTROL AND REDUCING INDIRECT COST – THE CRYSTAL REGISTRY IN HONG KONG RHEUMATOID ARTHRITIS PATIENTS

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Background: Rheumatoid arthritis is associated with irreversible joint erosion, jeopardising patients' work ability and incurs substantial indirect cost to the society. While early treatment yield clinical efficacy, its economic outcome remains uncertain in Hong Kong.

Objectives: To ascertain the effect of early disease control in early RA subjects on indirect cost.

Methods: This was a multi-centre, prospective cohort study involved 13 hospitals in Hong Kong. Subjects underwent intensive treatment scheme aiming at remission. Early disease control was defined as achieving remission or low disease activity (LDA) at month 6 indicated by DAS-28 score.

Results: Seventy early RA patients [53 (75.7%) Female, mean age: 53±11 years, mean disease duration 30±11 months] were included in this analysis. Forty-two (60%) subjects achieved early disease control. Subjects with or without early disease control were comparable at baseline. Twenty-two (31.4%) subjects had non-zero indirect cost [median (IQR) indirect cost: USD162 (76–317)]. Among them, early disease control non-achievers (n=11) had significantly higher indirect cost than achievers [median (IQR) indirect cost: USD317 (133–934) vs USD95, ^{48–163} p=0.008] (figure 1). Using multivariate linear regression, after adjusting for age, gender, baseline pain score, fatigue level, physical and mental condition, every 1-unit increase in DAS score at month 6 was associated with USD82 increase in indirect cost [95% CI: 12–151, p=0.022]. When disease activity was categorised, not achieving remission/LDA was associated with USD165 increase in indirect cost [95% CI: 21–310, p=0.025] (table 1).

Model 1 – DAS score as continuous variable

Model 2 – DAS score categorised as early disease control or not

Abstract AB1270 – Figure 1

Conclusions: Early intensive treatment with early disease control yield lower indirect cost. Health care system shall consider reallocating adequate resource for managing early arthritis patients to reduce indirect cost related to disease.

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AB1271 SEVERE OUTCOMES OF AFRICAN PATIENTS FROM PALOP EVACUATED FOR MEDICAL ASSESSMENT IN PORTUGAL – RHEUMATOLOGY AS A CASE STUDY

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Background: Portugal has made an official commitment for improving health in Portuguese speaking African countries (PALOP) by allowing an annual quota of patients evacuated from these countries for medical reasons. The agreements pretend to compensate difficulties in health care access and medical resources of these populations. However, the bureaucratic process that mediates the displacement of patients to Portugal is invariably complex and delayed, so these aims are commonly not achieved.

Objectives: to report our experience dealing with PALOP rheumatic patients and evaluate their outcomes.

Methods: a retrospective analysis of patients evacuated from PALOP and referred due to rheumatic diseases or potentially related conditions, followed-up in our Department for the last 7 years. Clinical data was collected until September 2017.

Results: a total of 58 patients (77.6% female), with an average age of 33.5 years (±SD 15.2; range 2–78 years) were included, representing Guinea-Bissau 44.8%, Cape Verde 27.6%, São Tomé and Príncipe 17.2% and Angola 10.3%. Of all these patients, only 44.8% were primarily referred to our Department. The majority (55.2%) had no previous diagnosis, 19% were considered to have a wrong diagnosis and 25.9% were well diagnosed. After assessment in our Department, we ended up with the diagnoses listed, mainly SLE (17.2%) and Rheumatoid Arthritis (17.2%).

Abstract AB1271 – Table 1

Disease	N
SLE	10
Rheumatoid Arthritis	10
Vasculitis	6
Dermatomyositis	3
Other CTD	4
Osteoarticular infections	3
Psoriatic Arthritis	2
Ankylosing Spondylitis	2
Reactive Arthritis	2
JIA	1
SAPHO Syndrome	1
Non-inflammatory rheumatic diseases	6
Non-confirmed rheumatic diseases	8