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

The mean duration of symptoms was 62.4 months (minimum 1 month; maximum 40 years). From the evacuation request until effective journey patients waited a mean of 13.9 months (missing data in 37 patients). At arrival, only 25.9% of patients were or had been on corticosteroids and only 15.5% on conventional disease modifying antirheumatic drug (DMARD) treatment, versus 62% and 67.2%, respectively, after assessment in Portugal (graphic). Even common and cheap drugs, like prednisolone and hydroxychloroquine were underprescribed before our assessment. Twelve percent of patients required biologics. Hospitalizations related to disease activity or complications were required in 43.1%. Severe damage, measured by indication for orthopaedic, cardiothoracic or vascular surgery, need of chronic dialysis or long-term oxygen therapy and permanent neurologic deficits was present in 34.5% of the patients. Three patients died. Regarding infectious comorbidities, 12.1% of patients were diagnosed with tuberculosis, 8.6% had chronic hepatitis B infection and 12.1% had evidence of previous contact with hepatitis B virus.

Abstract AB1271 – Figure 1

Conclusions: PALOP patients present with long-lasting and severe rheumatic diseases with chronic damage, due to lack of precise diagnosis, ineffective referrals and lack of appropriate treatment. They also frequently present with important infectious comorbidities and social needs that may delay treatment. Despite the obvious advantages of the evacuation of patients to a more resourceful country, we believe there is a need for identification of onsite barriers and improvement of local awareness on Rheumatic diseases and Rheumatology speciality.

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AB1272 INCREASING STRENGTHS OF EVIDENCE FOR ROLE OF NURSES IN THE MANAGEMENT OF CHRONIC INFLAMMATORY ARTHRITIS: RESULTS OF A SYSTEMATIC LITERATURE REVIEW

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Background: In 2011 EULAR first published European recommendations for the potential role of nurses in the management of patients with rheumatic diseases.¹ Since then, the EULAR recommendations were well disseminated and positively evaluated both across Europe and the United States (US).²

Objectives: To assess new evidence for the role of nurses in the management of chronic inflammatory arthritis (CIA) obtained since the 2011 EULAR recommendations.

Methods: A systematic literature search was performed for the time between 1/2010 and 9/2016 based on the PRISMA guidelines, using the search strategies and eligibility criteria and categorising evidence as did the EULAR taskforce.

Results: A total of 44 articles and 10 abstracts were identified fulfilling the eligibility and exclusion criteria. Strong new evidence exists for recommendation 3 with nurse-led telephone services to enhance continuity of care and to provide ongoing support (evidence level 3), and – at least in part – for recommendation 6, that nurses should promote self-efficacy (evidence level 1B) and empowerment (evidence level 2B), but sense of control was not studied. Some new evidence also exists for recommendations 7 and 8 (level 2B).

Conclusions: This literature review reveals new evidence for a role of nurses in managing CIA-patients especially with RA and in stable and low disease activity, and thus further supports the existing 2011 EULAR-recommendations.

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AB1273 UPTAKE OF PNEUMOCOCCAL AND INFLUENZA VACCINATION IN PATIENTS RECEIVING BIOLOGICAL DMARDS (bDMARDS) IN IRELAND

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Background: Biological disease-modifying antirheumatic drugs (bDMARDs) have made significant positive outcomes in the lives of patients with rheumatic disease. This treatment has proven efficacy in delaying joint destruction and inducing disease remission.¹ Studies have shown that pneumococcal vaccination is cost effective while the influenza vaccination significantly prevents morbidity and mortality in the elderly and in patients with chronic disease.¹

Objectives: To evaluate the pneumococcal and influenza vaccination status in patients receiving biological disease-modifying antirheumatic drugs (bDMARDs).

Methods: Patients on bDMARDs attending the rheumatology infusion unit were asked about their vaccination status on pneumococcal and influenza using a questionnaire. The patients' diagnosis, current bDMARD and reasons for not having had vaccination were recorded.

Results: 92 patients were recruited. Mean age of 53.2 years with 63 (68.5%) female and 29 (31.5%) male. A total of 30 (32.6%) patients received both pneumococcal and influenza vaccination, 1 (1.1%) received pneumococcal vaccination alone, 22 (23.9%) received influenza vaccination alone and 39 (42.4%) had neither. Of the 18 (19.6%) patients age >65 years, 5 (27.8%) received influenza vaccination alone and 8 (44.4%) received both. Patients who did not receive vaccinations were given an educational booklet.

The most common diagnosis from our cohort was rheumatoid arthritis (37%), followed by spondyloarthritis (13%), Behçet's disease (9.8%), myositis (7.6%), vasculitis (5.4%), systemic lupus erythematosus (5.4%), psoriatic arthritis (4.4%) and others (17.4%). 48 (52.2%) were on rituximab, 37 (40.2%) on infliximab, 6 (6.5%) were on tocilizumab and 1 (1.1%) was on abatacept.

Of the 61 (66.3%) patients who did not receive the pneumococcal vaccine, 44 (72.1%) were unaware of its availability, 6 (9.8%) were not interested in receiving it, 4 (6.6%) were afraid of the side effects, 4 (6.6%) declined vaccination and 3 (4.9%) were unaware it was recommended. 40 (43.5%) who did not receive the influenza vaccine stated that they were either unaware (45%), not interested (25%), declined vaccination (10%), forgotten (5%), unaware it was recommended (5%) and afraid of the side effects (2.5%). 3 (7.5%) had previous bad experiences from influenza vaccination.

Conclusions: This is the first study in Ireland looking at vaccination uptake in patients on bDMARDs. The vaccination rate in our cohort was less than satisfactory. Patients on immunosuppressants are recommended to have these vaccinations and preferably to receive them before commencing on the immunosuppressants.² The lack of awareness is the main reason for failure to be vaccinated. Hence, primary care physicians and the rheumatology team should take active roles in increasing awareness amongst patients about the recommendation for pneumococcal and influenza vaccination.

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