students must be encouraged, particularly supporting research seedbeds and young researchers.

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Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.3497

THU0657

EFFECTS OF ADALIMUMAB INITIATION ON CORTICOSTEROID UTILISATION AND MEDICAL COSTS AMONG PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Treatment guidelines recommend low dose corticosteroids (steroids) as a short-term (<3 months) therapy among rheumatoid arthritis (RA) patients to 'bridge' patients until benefits of disease modifying anti-rheumatic drugs (DMARDs) are observed.¹ However, for many patients it may be difficult to wean/eliminate steroids once they are initiated. Initiation of more effective therapies such as biologics may help promote reduction in steroid use.

Objectives: This study examined the impact of initiating adalimumab (ADA) on steroid utilisation and medical costs among patients with RA.

Methods: A retrospective analysis was conducted among adult RA patients initiating ADA as the initial biologic in the MarketScan Database (2012–2016). Study outcomes included whether oral/injectable steroids were used, daily dose, dosage categories (<5 and ≥5 mg/day), number of steroid injections, and medical costs. Outcomes were compared 6 months pre- and post ADA initiation using Chi-square tests for categorical variables and paired t-tests and Wilcoxon rank sum tests for continuous variables. Because various types of variables were used for study outcomes, mixed effects logistic, classical linear, multinomial logistic models, and linear model with a log link and gamma distribution were used to adjust for patient demographic and health characteristics such as age, gender, health plan type, census region, and Charlson Comorbidity Index.

Results: The study sample included 6,214 ADA initiators. As compared to the 6 months prior to ADA initiation, there was a reduction in proportions of patients using oral steroids (from 72% to 59.5%) and injectable steroids (from 34.9% to 26.9%), average daily dose of oral steroids (from 3.3 mg/day to 2.5 mg/day), patients with dose ≥5 mg/day (from 22.3% to 15.1%), number of steroid injections (from 0.63 to 0.47), and medical costs (from \$5,233.5 to \$4,807.9) ($p < 0.01$ for all comparisons). Multivariate analysis produced similar patterns. In the 6 months post-ADA initiation, patients were less likely to use oral steroids (Odds Ratio (OR): 0.40; 95% Confidence Interval (CI): 0.36–0.45) or steroid injections (OR: 0.59; 95% CI: 0.54–0.65). Coefficient estimate for daily dose reduction was -0.87 (95% CI: -1.00 – -0.74). Post-ADA relative risk ratios for dosage categories <5 mg/day and ≥5 mg/day compared to zero were 0.48 (95% CI: 0.43–0.53) and 0.36 (95% CI: 0.32–0.41), respectively. Post-ADA incidence rate ratio for number of steroid injections was 0.72 (95% CI: 0.69–0.76). Ratio estimate for medical costs was 0.84 (95% CI: 0.79–0.89). All multivariate results reported were significant ($p < 0.01$).

Conclusions: Among patients with RA, following ADA initiation, there is a reduction in steroid utilisation and its dose, and patients' medical costs. Prospective studies should be conducted to confirm this relationship in the future.

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Acknowledgements: Financial support for the study was provided by AbbVie. AbbVie participated in the interpretation of data, review, and approval of the abstract.

Disclosure of Interest: Y. Qiao Grant/research support from: AbbVie, K. Winthrop Grant/research support from: AbbVie, Consultant for: AbbVie, J. Griffith Shareholder of: AbbVie, Employee of: AbbVie, C. Kaplan Grant/research support from: AbbVie, C. Spivey Grant/research support from: AbbVie, A. Postlethwaite Grant/research support from: AbbVie, J. Wang Grant/research support from: AbbVie

DOI: 10.1136/annrheumdis-2018-eular.1436

THU0658

RECOMMENDATIONS FOR THE ASSESSMENT AND OPTIMISATION OF ADHERENCE TO DISEASE-MODIFYING DRUGS IN CHRONIC INFLAMMATORY RHEUMATIC DISEASES: A PROCESS BASED ON LITERATURE REVIEWS AND CONSENSUS

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Background: In chronic inflammatory rheumatic diseases including rheumatoid arthritis (RA), spondyloarthritis (SpA), psoriatic arthritis (PsA) and connective tissue diseases (CTD), adherence to disease-modifying drugs is only moderate over the long term and non-adherence may lead to complications, unnecessary treatment switches and heightened costs.

Objectives: To develop recommendations to facilitate in daily practice, the measurement of non-adherence, the individualised assessment of risk of non-adherence and the management of non-adherence with the objective to optimise adherence to treatments in patients with chronic inflammatory rheumatic diseases.

Methods: The project scope was limited to chronic inflammatory rheumatic diseases (i.e., RA, SpA, PsA, CTD, crystal-induced arthritis, vasculitis and auto-inflammatory diseases), and to disease-modifying drugs (i.e., mainly conventional DMARDs, biologics and targeted synthetic DMARDs). The process comprised (a) systematic literature reviews of data from 3 key databases and several websites, of methods (including questionnaires) to measure non-adherence, risk factors for non-adherence and management options for non-adherence with their reported efficacy. (b) a consensus of 104 rheumatologist and nurse experts during a 2 day face-to-face meeting. (c) Final recommendations were anonymously evaluated by the participants for agreement and ease of applicability (1–5 is highest).

Results: (a) After screening 1131 publications and 194 other documents, 231 relevant papers were analysed. (b) The consensus process led to 5 overarching principles and 10 recommendations regarding adherence. In summary, adherence is important, imperfect, and multi-factorial. Patient-physician interactions play an important role, as do patient beliefs. Adherence should be assessed at each outpatient visit, at least using an open question. Questionnaires and hydroxychloroquine blood level assessments may also be useful. People who are younger, worried of side effects, do not see the necessity of the treatment, and are in psychological distress are more prone to non-adherence. Patient information and education, and patient/physician shared decision, are key to optimise adherence. Other techniques such as formalised education sessions, motivational interviewing and cognitive behavioural therapy may be useful. All health professionals can get involved and e-health may be a support. (c) The agreement with the recommendations was high (range of means, 3.88–4.47) but ease of applicability was lower (2.69–4.38).

Conclusions: Using an evidence-based approach followed by expert consensus, this initiative should improve the assessment and optimisation of adherence in chronic inflammatory rheumatic disorders. Next steps include dissemination and implementation.

Acknowledgements: AbbVie France funded this initiative but played no role in the recommendations.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.2340

THU0659

EUORHEUMAVISION: ARE THE LARGEST EUROPEAN RHEUMATOLOGY SOCIETIES THE ONES WITH THE MOST ORAL COMMUNICATIONS?

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Background: Between June 14 and 17, 2017, coinciding with the 70th anniversary of its foundation, the annual EULAR congress took place in Madrid. With 14,000 participants from 130 countries, 4845 accepted abstracts, 2300 posters and more than 800 oral communications, it became a record congress in the history of European rheumatology.

Now, EULAR is formed, among others, by 45 national rheumatology societies. Are the various countries proportionally represented at a scientific level? Those with the greatest number of rheumatologists have a greater weight in communications to the congress?

Objectives: To assess the scientific weight of the different European rheumatological societies in the EULAR congress

Secondary objective: To analyse the characteristics of these societies in terms of the number of rheumatologists, specialists for 100,000 inhabitants and percentage with the total number of doctors

Methods: The scientific communications of the 2017 EULAR congress (Madrid) are analysed, according to the country of origin of the speakers.

The number of rheumatologists in each country is assessed, their specific weight with respect to the total of European rheumatologists and in relation to the total number of doctors in their respective countries.

Results: Results: The countries with the highest number of rheumatologists in Western Europe are France 2,600, Italy (1800), Spain (1155), UK (950), Germany (800) and Netherlands (775). However, in number of communications The order changes, so the UK is the most productive (121), followed by the Netherlands (101), Germany (91), France (74), Italy (51), Sweden³⁷ and Spain.³⁶

In proportion, the Dutch presented 1 communication for every 7.6 rheumatologists, 1 German for every 8.7, 1 for every 7.8 British. The Mediterranean countries are far away, with 1 communication for every 32 Spanish rheumatologists and 1 for every 35 in the case of France and Italy

Oral Communications EULAR Madrid 2017

UNITED KINGDOM	121
GERMANY	91
FRANCE	74
ITALY	51
SPAIN	36
NETHERLANDS	101
REST OF EU	250 (37 Swe, 17 Port., Swith, Denma, Norw, Bel, Irel..)
REST OF THE WORLD	156

Country	N° of rheumatologist (N° of communications x rheumatologist)
UK	950 (1 com x 7,82 reum)
GER	800 (1 com x 8,79 reum)
FRA	2600 (1 com x 35,1 reum)
ITA	1800 (1 com x 35,29 reum)
SPA	1155 (1 com x 32 reum)
NETHE	775 (1 com x 7,6 reum)

REPRESENTATION AT A SCALE OF COUNTRIES BY EULAR ACADEMIC POWER

Conclusions: There is a marked disparity between the number of rheumatologists by country and number of oral communications. While the Netherlands, United Kingdom and Germany are protagonists of more than a third of the oral communications, nations such as Spain, France or Italy only contribute, together, to the 18% although nearly 5600 rheumatologists work in their countries. Therefore, with twice as many specialists, they present half of communications.

Disclosure of Interest: None declared

DOI: 10.1136/annrheumdis-2018-eular.1352

THU0660

GOLIMUMAB IMPROVES SOCIO- AND HEALTH ECONOMIC PARAMETERS IN PATIENTS WITH RA, PSA AND AS: REAL WORLD-DATA FROM A NON-INTERVENTIONAL CLINICAL STUDY IN GERMANY

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Background: Golimumab (GLM) has shown its efficacy and safety in various clinical trials. Data from socio- and health economic parameters in daily clinical practice in Germany are rare.

Objectives: Our objective was to describe effects on socio- and health economic parameters and on health care resource use in patients in Germany with rheumatoid arthritis (RA), psoriatic arthritis (PsA), and ankylosing spondylitis (AS) who were initiated on subcutaneous GLM.

Methods: Descriptive post-hoc analysis of socio- and health-economic parameters of the non-interventional, multicenter, prospective GO-NICE study (n=1458) at baseline (BL) compared to the situation at 24 months (M24) (n=664, 45.5%) to explore the impact of GLM on days of sick leave/absenteeism, and days of impaired capability/presentism, as well as the work productivity, quality of work and normal course of life (in the past 30 days and 6 months) using. Further gather the number of consultations, ambulatory treatments, alternative treatments days of hospitalizations and rehabilitation measures in the past 6 months.

Results: The mean number of sick leave days in the previous 30 days decreased from baseline (BL) 4.0 to 0.9, and in the past 6 months from BL 13.7 to 3.3 at M24. The improvement was greatest in patients with RA. The mean number of days with impaired capability in the previous 30 days decreased from BL 14.9 to 4.5, in the previous 6 months from BL 65.8 to 19.8 at M24. The improvement was greatest in patients with AS. On a numeric rating scale (range: 1=no limitation to 10=very strong limitation), the patients' mean ratings on the impact of disease during the previous 6 months of work productivity decreased from BL 5.5 to 2.5 points, on quality of work from 4.8 to 2.2 points, and on the normal course of life from 5.3 to 2.4 points at M24, respectively. The decrease in the mean scores BL to M24 was comparable in patients with RA, PsA and AS. Intersubject variability was high. On retrospective evaluation for the past 6 months, the percentage of patients with physician consultations declined from BL to M24: with general practitioners in patients with PsA -19.7%, AS by -17.8%, RA -6.8% in patients with RA. A marked decline was also observed in the percentage of patients with PsA having dermatologist consultations (-15.0%). The percentage of patients receiving physiotherapy, massages, occupational therapy and packs declined from BL to M24, primarily the application of physiotherapy (-16.9%, -10.9% and -9.1%) in patients with AS, PsA and RA. The frequency of hospitalizations decreased from 10.4/7.6/14.0% at BL to 1.7/2.2/0.8%, and the frequency of rehabilitation decreased from 3.3/3.7/7.5% at BL to 0.6/1.8/2.1% at M24 in patients with RA, PsA, and AS.

Conclusions: This evaluation showed remarkable improvements in socio- and health-economic parameters. On GLM treatment, there was a reduction in the days of absenteeism from work, impaired capability/presentism and the days with limited productivity, while the quality of work increased, in a very similar manner across the three indications.

The proportion of patients requiring physician consultations, days of hospitalisation and furthermore the need for rehabilitation measures decreased on GLM 50 mg treatment.

Disclosure of Interest: K. Krüger Consultant for: AbbVie, BMS, Celgene, Janssen Biologics, Lilly, MSD, Pfizer, Roche, and Sanofi-Aventis, and UCB, G. Burmester Consultant for: AbbVie, BMS, MSD, Pfizer, Roche, and UCB, M. Thomas Employee of: MSD Sharp and Dohme GmbH Germany, S. Wassenberg Consultant for: AbbVie, Chugai, Janssen Biologics, MSD, Novartis, Pfizer, Roche, and UCB

DOI: 10.1136/annrheumdis-2018-eular.2949

THU0661

OSTEOPOROSIS SCREENING, PRIMARY PREVENTION, AND TREATMENT IN GLUCOCORTICOID TREATED INDIVIDUALS WITH RHEUMATOLOGIC DISEASE

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Background: Glucocorticoids are commonly used in a wide variety of inflammatory conditions treated by rheumatologists. Bone loss from glucocorticoids is known to occur early and with relatively small doses. The American College of Rheumatology outlines that Glucocorticoid-Induced Osteoporosis (GIOP) is under screened and undertreated. The ACR guidelines suggest standard clinical care to