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.

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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.

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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

obtain a baseline DEXA in any individual with anticipated long-term steroid use, primary prevention with calcium, and vitamin D initiation and medical therapy when appropriate based on fracture risk assessments.

Objectives: The objective of this study was to determine how successfully the ACR GIOP guidelines are implemented in daily rheumatologic practice. The study investigates the prevalence of osteoporosis screening, prevention, and treatment in patients with rheumatologic diseases over a 2 year period at a large medical centre.

Methods: A retrospective cohort study of patients who received rheumatology care between 2014 and 2015 at a large medical centre was performed. Patients were included if they were older than 18 years of age, had a diagnosis of rheumatoid arthritis, systemic lupus, vasculitis, polymyalgia rheumatica, or gout and were receiving ≥ 5 mg prednisone daily for ≥ 90 days. Electronic medical records were reviewed and medication history was evaluated. Screening was defined as bone mineral density testing with DEXA within one year of glucocorticoid initiation. Primary prevention and treatment were derived from ACR GIOP criteria and included the initiation of appropriate doses of calcium and vitamin D and initiation of medical therapy to prevent bone loss. The prevalence of screening and treatment was assessed and the relationships with age, gender, and ethnicity were evaluated using Chi Squared analyses and independent samples t-tests.

Results: Of the 600 patients reviewed, 61 met criteria of new long-term glucocorticoid initiations. Overall 61% received BMD testing and 48% received osteoporosis primary prevention. Of those who qualified for treatment by ACR GIOP criteria, only 19% received treatment. Patients who received a baseline DEXA were older than those who did not (65 ± 15 vs 57 ± 16 years, $p=0.046$). Age did not influence treatment. More women compared to men received screening DEXA (68% F vs 41% M, $p=0.053$) and primary prevention (55% F vs 29% M, $p=0.078$). Patients who received a longer duration of steroid treatment were more likely to receive primary prevention (16 ± 10 months vs 10 ± 8 months, $p=0.015$). There was no association between ethnicity or disease status on screening, prevention, or treatment.

Conclusions: Glucocorticoid-induced osteoporosis in the setting of a rheumatology practice is a common and manageable condition that should be screened, prevented, and treated. These results from one large academic medical centre in the United States suggest that rheumatologists may not be following ACR guidelines for the assessment and management of patients on chronic steroids. Quality improvement initiatives may be necessary in order provide optimal care for patients.

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THU0662

IMPACT OF THE INTERVENTION OF A MULTIDISCIPLINARY ADHERENCE TEAM IN CLINICAL OUTCOMES OF PATIENTS WITH RHEUMATOID ARTHRITIS AND SPONDYLOARTHROPATHIES IN COLOMBIA

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Background: The multidisciplinary adherence team (MAT) is a interprofessional health care group conformed by a general practitioner, a pharmaceutical chemist and a psychologist, which evaluate the patient to provide a simultaneous multidisciplinary approach focused on promoting strategies to improve adherence to treatment in patients with high disease activity of autoimmune or autoinflammatory pathologies

Objectives: To determine the impact of the MAT group intervention on the disease activity and therapeutic adherence of Colombian patients with rheumatoid arthritis (RA) and seronegative spondyloarthropathies (SpA).

Methods: A quasi-experimental analytical study was performed where 4.921 RA and 756 SpA patients were analysed, of which 395 and 90 respectively presented high persistent disease activity (from moderate to severe persistent), despite of conventional strategies implemented; therefore they underwent intervention by the MAT group between January and December of 2016. Clinical disease activity according to each disease (DAS28 and BASDAI measurements respectively) and adherence level (categories through the Morisky-Green test: no adherence, partial adherence, total adherence) were measured before and after the MAT intervention. The impact on disease activity and adherence level was determined through the McNemar test for independent samples

Results: A significant increase in the proportion of patients in total adherence level was found for both diseases when comparing the initial and final measurements after the intervention by the MAT (table 1). Furthermore, statistical significant differences in the disease activity level were found, identifying a reduction in the proportion of patients with moderate to severe disease activity (Graph 1, A and B) after the MAT intervention

Abstract THU0662 – Table 1. Impact in adherence in patients with RA and SpA underwent by the MAT group intervention

Treatment adherence (Morisky-Green test)						
	AR n=395			SpA n=90		
	Initial (%)	Final (%)	P-value	Initial (%)	Final (%)	P-value
No adherence	9,1	8,1	<0001	7,8	2,2	0002
Partial Adherence	40,8	32,9		37,8	40	
Total Adherence	50,1	59		54,4	57,8

Figure 1 A) Disease Activity in patients with RA (DAS28); B) Disease Activity in patients with SpA (BASDAI)

Conclusions: The intervention by the MAT interprofessional group is an efficient strategy impacting the disease activity and therapeutic adherence of RA and SpA patients, improving their clinical outcomes and the natural history of the disease. These findings are relevant and may highlight the potential benefits for the implementation of this approach in patients with devastating autoimmune diseases.

Disclosure of Interest: None declared

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THU0663

RHEUMATOLOGY ADOLESCENT AND YOUNG ADULT CARE: REAL WORLD CHALLENGES AND OPPORTUNITIES

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Background: Adolescents and young adults (AYA) form one sixth of the world's population and account for 6% of the world's global burden of disease. Those with chronic illness are particularly vulnerable. Globally, significant improvements in healthcare related morbidity and mortality have been seen, but not within the 10–24 year old group. Adolescence is a rapidly changing, formative phase of human development; opportunities exist to impact this through restructuring care pathways and patient empowerment.

Objectives: Establish awareness of current national guidance and identify unmet needs in existing rheumatology AYA systems.

Methods: Interested parties from South East England (South London, Kent, Surrey and Sussex) formed a multi-disciplinary, patient based, co-design initiative (RAYA collaborative) which included representatives from primary/secondary/tertiary care, allied health professionals and a youth worker/patient from the charity sector. Our discussions and an anonymous survey to hospitals in the region, formed the basis of a qualitative and quantitative analysis, which helped gain a holistic insight into the challenges and opportunities in delivering AYA care in our region.

Results: 15/20 centres, covering an 8 million population, responded; 4 tertiary care hospitals, 11 district general hospitals with 32 responses (19 consultants, 13 senior registrars).

31 (97%) of responders felt that AYA cohort (16–25 years old) required an approach different to that of older adults. 25 (78%) felt there was a need for dedicated AYA services. 23 (72%) and 17 (53%) were aware of UK national guidelines^{CQC 2014}/NICE NG43 2016 respectively) for transitional/integrated and coordinated care.

Barriers to developing dedicated AYA services (% of responders): Not a priority for NHS managers,³¹ other clinical priorities,³¹ insufficient patient numbers,²² not cost effective,¹⁹ unlikely to be commissioned,¹⁹ more research required,¹³ cohort by diagnosis,¹³ other ways to deliver care,¹³ only focus on transitioning patients from paediatrics¹³