FRI0609

EUROPEAN MEDICINES AGENCY'S GUIDELINE ON THE CLINICAL INVESTIGATION OF MEDICINAL PRODUCTS FOR THE TREATMENT OF RHEUMATOID ARTHRITIS

D. Da Silva¹, E. Rook², N. Semis-Costa¹, J. Mueller-Berghaus³, R. Vesely¹ on behalf of The Rheumatology and Immunology Working Party of the Committee for Medicinal Products for Human Use from the European Medicines Agency.

¹European Medicines Agency, London, United Kingdom, ²Medicine Evaluation Board, Utrecht, Netherlands, ³Paul-Ehrlich-Institut, Langen, Germany

Background: The European Medicines Agency (EMA) in consultation with regulatory authorities in the EU Member States prepares scientific guidelines, to help drug developers prepare marketing authorisation applications. The scope of the rheumatoid arthritis (RA) guideline is to provide a European common position on the clinical evaluation of new medicinal products.

Objectives: The EMA guideline is an update of the Points to Consider adopted in 2003. A revision of the guideline was required as the pharmacological therapy of RA has advanced. Treat-to-target strategies are now employed, and the optimum treatment goal is remission, or at least low disease activity (LDA). New classification criteria for RA have been developed and validated by the ACR-EULAR, which allows for earlier DMARD use. Increasing knowledge of the risk associated with DMARDs has been gained from trials and registries.

Methods: The guideline has been prepared by the Rheumatology-Immunology Working Party of the EMA. The guideline was revised based on literature, and recent trial and safety data from regulatory dossiers of RA products. External experts, investigators, industry and patient representatives were consulted ("Public consultation"), and in person during a Targeted consultation meeting in 2016.

Results: New primary endpoints (PE) were defined, reflecting treatment targets LDA or remission, in place of the previous PE of ACR20. Different validated scales may be used (either DAS28-ESR, DAS28-CRP, SDAI, or CDAI). The PE of choice should be corroborated by other outcomes as secondary endpoints. E.g if DAS28-CRP is chosen, more stringent outcomes like SDAI and DAS-ESR, or CDAI, which is independent of biomarkers CRP or ESR, should point at the same direction.

A distinction is made between study populations of DMARD naïve patients, where remission at 3 months is considered as a realistic target and methotrexate a suitable comparator; and patients irresponsive (or insufficiently responsive) to prior DMARDs, where LDA at 3–6 months is considered as an acceptable endpoint. For patients with long-standing disease irresponsive to multiple DMARDs, including two biologic DMARDs of different classes, ACR20 is still acceptable. Long-term safety data of 12 months should be available before marketing authorisation.

The ultimate goal of RA treatment is the prevention of structural joint damage. However, showing an effect on structural damage has become increasingly challenging, since the placebo control should be kept short, and milder or more controlled patients may be eligible for studies of new DMARDs. Therefore, maintenance of remission and LDA could serve indirectly as an indicator for the prevention of structural damage, provided that these clinical outcomes are compelling, and routine monitoring by X-ray does not indicate a deviating trend as compared to an established comparator.

Conclusions: The EMA guideline on the development of products in the treatment of RA has undergone major revisions regarding the choice of endpoints and study design. The revision comes into force in July 2018.

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FRI0610

PATIENT NON-ATTENDANCE CHARACTERISTICS AT RHEUMATOLOGY OUTPATIENT CLINICS WITHIN A LARGE MULTI-ETHNIC REGION

A. Takvi¹, K. Sunmboye². ¹Rheumatology, University of Leicester, ²University of Leicester Hospital, Leicester, United Kingdom

Background: Patient non-attendance for outpatient appointments is increasingly becoming more important in an era where resources have to be used in the most cost effective way. The Leicestershire region of the United Kingdom has a very diverse multi-ethnic population of just over 1 million people. Across 3 large hospital sites the University Hospitals of Leicester, United Kingdom caters for the rheumatology needs of this diverse population.

Objectives: The aim of our observational study was to identify the patient characteristics of the non-attenders and investigate if ethnicity and socioeconomic class contribute to the non-attendance rate.

Methods: The study was based on patient appointments scheduled at a busy rheumatology outpatient clinic across three large hospital sites from January 2017 to June 2017. Extensive data on various outcomes such as cancellation on the part of the patients and non-attendance from the patients without giving formal notice were collected from the main electronic administrative systems of three hospitals in the region. The data for the appointment characteristics were also collected. Logistic regression was used for statistical analysis.

Results: Of the 22,011 appointments scheduled over the study period. The non-attendance rate of 3.5% was recorded for this study period without the patients giving notice. The age range of the study population was 16 to 95 years. The median age was 50 years. Majority (24%) of non-attenders were in the 45–54 year age bracket. The 85–95 year age group had the lowest non-attendance rate at 2%. When the data was analysed for ethnicity, the percentage of patients who did not attend in the black Asian and minority ethnic group (BAME) was 44%. Only 33% of the study population were recorded on the hospital database as employed. The reminder included retirees (29%), students (4%) whilst the remaining 34% were either unemployed or we had no formal recording of their employment status.

Conclusions: The cost implications of missed appointments is so significant that even small percentage reductions in non-attendance rates could lead to significant savings. Various studies have identified many contributory factors such as age and ease of access to hospital facilities.

Few studies have looked at the role of ethnicity and socioeconomic class. From our data there was a significant (P value <0.05) difference between the employed and unemployed group. The working class group also had a significant non-attendance rate which suggests that more can be done at looking at the appointment scheduling by the health service provider.

Patient factors are likely to play a role in the BAME group not attending hospital appointments. The existing letter and text reminder service might need to explore several language options as this may play a contributory role in non-attendance rates. Addressing these issues may go a long way in ensuring that existing resources are not wasted due to non-attendance.

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FRI0611

ENGLISH LANGUAGE PROFICIENCY AND TOTAL KNEE/ HIP REPLACEMENT OUTCOMES: IS THERE A RELATIONSHIP?

B. Mehta^{1,2,3}, J. Szymonifka⁴, S. A. Dey¹, I. Y. Navarro-Millan^{1,2}, S. V. Grassia⁴, L. A. Mandl^{1,2}, A. R. Bass^{1,2}, L. A. Russell^{1,2}, M. L. Parks^{5,6}, M. P. Figgie^{5,6}, Y.-Y. Lee⁴, J. T. Nguyen⁴, S. M. Goodman^{1,2}. ¹Rheumatology, Hospital for Special Surgery, ²Rheumatology, Weill Cornell Medicine, ³Columbia Mailman School of Public Health, ⁴Biostatistics, ⁵Orthopaedics, Hospital for Special Surgery, ⁶Orthopaedics, Weill Cornell Medicine, New York, United States

Background: Health care disparities are recognized for medical and surgical outcomes in patients with Limited English Proficiency (LEP) (1).

Objectives: The purpose of this study is to assess the association of LEP on Total Knee Replacement (TKR) and Total Hip Replacement (THR) outcomes.

Methods: Individual patient-level variables were obtained from a single institution TKR and THR registry between 5/1/07 and 2/1/11. Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) pain and function scores at baseline and 2 years after elective TKR and THR were collected and retrospectively analyzed. We used census tract LEP-“Less than very well” as recommended for screening individuals, since individual LEP data is not collected in most cohorts. We obtained census level data using patients’ geocodable addresses (2). Only patients from closest states (NY, NJ and CT) were included. Data was analyzed using univariate and multivariable linear mixed effects models, with census tracts variables treated as random effects.

Results: Table 1 describes the characteristics of the patients with THR (n=4009) and TKR (n=3898). In univariable analyses, for every percent increase in LEP, the WOMAC scores at baseline and 2 year were universally decreased and are statistically significant (p value <0.001). However in the multivariable model when adjusted for neighborhood poverty age, BMI, sex, comorbidities, and the Gini