were analyzed with univariate statistic. The impact on QoL was determined by McNemar test and repeated measures analysis of variance (ANOVA).

**Results:** The most affected dimensions of the EQ-5D were pain/discomfort and anxiety/depression, while the least affected was self-care. When comparing each dimension before and after the entry to the tight control program, a significant increase in the proportion of patients that perceive level 1 for each aspect evaluated was found. In addition, significant improvement was found in the global EQ-VAS (table 1).

![Table 1 Percentage of the levels of EuroQol by dimension according to the diagnosis](image)

**Disclosures:** None declared

**Disclosure of Interest:** None declared

**DOI:** 10.1136/annrheumdis-2018-eular.5916

**References:**


2. Rheumatology, Leiden University Medical Centre, Leiden, Netherlands

3. Pharmacology, 2. Genetics, 3. Medicine, Memorial University, St. John's, Canada

4. Methods: To promote early recognition of IA, the EARC was initiated in September 2010 in the Netherlands. General practitioners (GPs) were instructed to refer to this screening clinic without a scheduled appointment if they were unsure about the presence of IA (instead of a ‘wait-and-see’ approach or performing additional tests). At the EARC, patients were seen for a 5-minute visit by an experienced rheumatologist who performed a full 66-joint examination for clinical synovitis. GPs can also refer directly to the EAC, where patients are seen <2 weeks’ time. Thus, GPs in our region can refer directly for a full visit in secondary care, or to a short visit to a screening clinic that is situated in between primary and secondary care. Patients identified at IA at the EAC or after (direct) referral to the EAC between September 2010 and December 2014 were compared for symptom duration at IA identification.

**Results:** Of the 1,151 patients visiting the EAC, 475 (41%) were diagnosed with IA. Firstly, proportions of patients with IA at the EARC were studied per year. These remained stable over time: 45% in 2010, 39% in 2011, 45% in 2012, 42% in 2013 and 36% in 2014. Clinical characteristics of these patients were similar over time. In the same period 675 referred patients were diagnosed with IA at the EAC; these were compared to the 475 IA patients that were identified via the EARC. Demographic characteristics were similar. However, median symptom duration of the IA patients in the EARC-group versus the EAC-group at identification of IA were 10.7 vs 17.0 weeks in 2010 (p=0.0001), 7.3 vs 13.7 weeks in 2011 (p=0.001), 6.3 vs 9.8 weeks in 2012 (p=0.056), 5.6 vs 10.7 weeks in 2013 (p=0.012) and 5.7 vs 8.3 weeks in 2014 (p=0.060). Proportions of patients with IA seen by a rheumatologist ≤6 weeks in the EARC-group versus the EAC-group were: 34% vs 19% in 2010, 43% vs 20% in 2011, 43% vs 33% in 2012, 48% vs 30% in 2013 and 44% vs 33% in 2014.

**Conclusions:** A screening clinic in between primary and secondary care has sustainable benefit with regards to early identification of inflammatory arthritis and allows >40% of patients to be identified within the timelines as recommended by EULAR.

**Disclosure of Interest:** None declared

**DOI:** 10.1136/annrheumdis-2018-eular.4613

**Methods:** To promote early recognition of IA, the EARC was initiated in September 2010 in the Netherlands. General practitioners (GPs) were instructed to refer to this screening clinic without a scheduled appointment if they were unsure about the presence of IA (instead of a ‘wait-and-see’ approach or performing additional tests). At the EARC, patients were seen for a 5-minute visit by an experienced rheumatologist who performed a full 66-joint examination for clinical synovitis. GPs can also refer directly to the EAC, where patients are seen <2 weeks’ time. Thus, GPs in our region can refer directly for a full visit in secondary care, or to a short visit to a screening clinic that is situated in between primary and secondary care. Patients identified at IA at the EAC or after (direct) referral to the EAC between September 2010 and December 2014 were compared for symptom duration at IA identification.

**Results:** Of the 1,151 patients visiting the EAC, 475 (41%) were diagnosed with IA. Firstly, proportions of patients with IA at the EARC were studied per year. These remained stable over time: 45% in 2010, 39% in 2011, 45% in 2012, 42% in 2013 and 36% in 2014. Clinical characteristics of these patients were similar over time. In the same period 675 referred patients were diagnosed with IA at the EAC; these were compared to the 475 IA patients that were identified via the EARC. Demographic characteristics were similar. However, median symptom duration of the IA patients in the EARC-group versus the EAC-group at identification of IA were 10.7 vs 17.0 weeks in 2010 (p=0.0001), 7.3 vs 13.7 weeks in 2011 (p=0.001), 6.3 vs 9.8 weeks in 2012 (p=0.056), 5.6 vs 10.7 weeks in 2013 (p=0.012) and 5.7 vs 8.3 weeks in 2014 (p=0.060). Proportions of patients with IA seen by a rheumatologist ≤6 weeks in the EARC-group versus the EAC-group were: 34% vs 19% in 2010, 43% vs 20% in 2011, 43% vs 33% in 2012, 48% vs 30% in 2013 and 44% vs 33% in 2014.

**Conclusions:** A screening clinic in between primary and secondary care has sustainable benefit with regards to early identification of inflammatory arthritis and allows >40% of patients to be identified within the timelines as recommended by EULAR.