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SAT0571 IDENTIFYING DETERMINANTS OF PRESENTEEISM IN WORKERS WITH INFLAMMATORY ARTHRITIS
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Background: Work disability (WD) and presenteeism (decreased at-work productivity) are often caused by arthritis, leading to major impact on individuals’ quality of life and cost to society.

Objectives: Our study objective was to identify the determinants of pre-senteemism in workers with inflammatory arthritis.

Methods: Baseline data from the randomized controlled trial of an employment intervention, the Making-it-Work TM program, were used. Participants were recruited from British Columbia, Alberta and Ontario. Inclusion criteria: diagnosis of inflammatory arthritis, currently employed, age 18-59, and having concerns about arthritis affecting ability to work. The primary outcome, presenteeism, was assessed using the % impaired while at work subscale of the Work Productivity and Activity Impairment scale for Specific Health Problem (WPAl-SHP). First, the association between potential explanatory variables and WPAI was assessed in bivariate analyses. Variables evaluated included: 1) sociodemographic variables: age, gender, ethnicity, marital status, education, children under age 19; 2) disease variables: IA diagnosis, disease duration, number of limiting comorbidities, global assessment of disease activity (VAS), joint pain (VAS), Disease activity [Rheumatoid Arthritis Disease Activity Index (RADAI)], physical function (HAQ II), Fatigue [VAS, Global Fatigue Index from the Multidimensional Assessment of Fatigue (MAFI)], Sleep quality [Insomnia Severity Index (ISI)]; Depression (Patient Health Questionnaire – PHQ-9); 3) work variables: physical demand, job autonomy, difficulty commuting to/from work, job spillover, job strain, psychosocial work characteristics [Job Content Questionnaire (JCO) decision latitude, physical and psychological job demands, social support at work], self-employment, family support of decision to work, importance of work. Variables correlated with WPAI-SHP at p < 0.20 were selected for inclusion in the multivariable linear regression analysis, using stepwise selection with alpha of 0.15.

Results: The sample included 565 participants [49% with RA, 17% PsA, 14% SLE, 20% AS] with median (IQR) arthritis duration of 7(3-15) years; mean (SD) age 45.6 (10) years; 43% were 50 years or older; 78% were females; 76% had completed post secondary education; 17% were self-employed. Multivariable linear regression analyses revealed that age < 30 (Var. adj. R2= 0.067; var. Rsq > 50, p=0.266), having more fatigue (GFI-MAF) (p=0.001), job strain (p=0.011), job spillover (p=0.002), disease activity (RADAI) (p<0.001), poor family support for working (p=0.049), poor physical function (HAQ II) (p=0.077) and commuting diffi-culty (p=0.081) were associated with greater impairment in work productivity.

Conclusion: This study identified important sociodemographic, disease and work-related factors associated with reduced productivity at work in people with inflammatory arthritis. These results provide useful information to health professionals counselling patients on dealing with employment issues.

REFERENCES

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SAT0572 ANTINUCLEAR ANTIBODIES IN PRIMARY CARE SETTING: IS IT WORTH IT?
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Background: Antinuclear antibodies (ANA) are the most frequently used screening tests for connective tissue diseases. However, their diagnostic value depends on the pre-test probability of such conditions.

Objectives: To evaluate the usefulness, clinical correlates and associated direct costs of ANA testing in the primary care setting in an Early Arthritis Clinic (EAC) referral cohort.

Methods: A retrospective study of consecutive patients referred to the EAC between 2011 and 2018 was conducted. Referral is based on the fulfillment of specific criteria: presence of arthritis or clinically suspected arthralgia beginning in the previous 12 months, plus suggestive laboratory abnormalities (rheumatoid factor, C-reactive protein or erythrocyte sedimentation rate). Many general practitioners also performed ANA testing (ANA-GP) and all patients underwent ANA testing, per protocol, in EAC (ANA-EAC). All patients having these 2 separated ANA results were determined.

Results: 207 patients were referred to the EAC Clinic during this period (63.4% female, aged 53.9 ± 18.2 years-old). Fifty eight percent of these patients (n=120) had their ANA previously determined in primary care setting. Of these, only 9.2% of cases (n=11) were positive, this being one of the main reasons for referral. Only 73% percent of positive (n=8) and 24% of negative ANA-GP were confirmed as such in our lab. Of the 8 patients testing positive in both settings, 2 had no rheumatic disease, 2 had an ARD and 4 had another type of inflammatory rheumatic disease.
Background: Systemic sclerosis-associated interstitial lung disease (SSc-ILD) places a substantial burden on patients and on healthcare services. Despite this, assessments of healthcare resource utilisation and costs incurred during the management of SSc-ILD are limited.

Objectives: To assess healthcare resource utilisation and costs among patients with SSc-ILD compared with SSc overall and patients with SSc and other organ involvement (SSc-OOI).

Methods: This was a population-based cohort study. Routinely collected healthcare data were extracted from medical records (dated 1 January 2005 to 31 March 2016) in the Clinical Practice Research Datalink (CPRD) and the Hospital Episode Statistics (HES) databases. Patients with SSc, with or without ILD and/or OOI, were identified from primary and secondary care records in combination with modified European League Against Rheumatism (EULAR) classification criteria. Patients were included in the OOI sub-cohort if their SSc affected cardiac, gastrointestinal, renal or oral function. Eligible patients were aged at least 18 years at first diagnosis, were diagnosed within the study period, and had at least 12 months of available data in CPRD/HES before and after diagnosis. All-cause healthcare resource utilisation (inpatient stays; A&E attendances; outpatient visits; general practitioner visits) and costs among patients with SSc, SSc-ILD and SSc-OOI were calculated to 2016 GBP.

Results: A total of 2656 citations were identified, of which 66 citations were excluded. For categorical outcomes, the number (#) of studies, median, interquartile range (IQR) and/or min-max range of values are reported; for continuous outcomes, the number (#) of studies, median, quartile range (IQR) are reported; for other measures, the number (#) of comparisons with significance (P<0.05) are reported.

Conclusion: The annual healthcare cost for a patient with SSc-ILD is substantial (£2,986–13,905), with inpatient stays the major cause of costs, and is much higher than for patients with SSc-OOI (without ILD). Healthcare costs are also higher among older SSc patients and those with more comorbidities. These results quantify the economic burden of SSc-ILD in a real-world setting, which will be useful when evaluating the cost-effectiveness of new treatment options for SSc-ILD. There is an unmet need for effective therapies for SSc-ILD.

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