and 1 with incomplete criteria for antiphospholipid syndrome), and 28 with an autoimmune rheumatic disease. A total of 41 pregnancies occurred (2 women with 2 pregnancies) and were chosen for the final analysis (Table).

Results: The mean gestational age at the first rheumatology visit was 16.8 ± 8.9 . The mean age at the end of pregnancy was 29.5 ± 5.7 years. Only nine pregnancies were planned (34.6%). Among the patients with a defined autoimmune disease the diagnoses were: systemic lupus erythematosus (SLE) (12), rheumatoid arthritis (RA) (5), antiphospholipid syndrome (APS) (2), autoimmune hemolytic anemia (AHA) (2), juvenile idiopathic arthritis (JIA) (2), overlap syndrome (OS) (3: 2 SLE/SSc; 1 SLE/Sjögren's) mixed connective tissue disease (MCTD) (1) and undifferentiated connective tissue disease (UCTD) (1). There were 8 pregnancies exposed to teratogenic drugs (MTX 5, LEF 1, MMF 1, CYC 1): 2 ended in fetal loss and 1 had a congenital pneumonia. There were 27 full-term births, 37-40 weeks (wk); 8 preterm births, 23-36 wk (4 twins); 1 stillbirth, 26 wk; and 3 abortions (2 in the same mother). Seven patients had an active disease before pregnancy, 13 during pregnancy (7 SLE, 3 RA, 2 AIHA, 1 MCTD) and 13 during the puerperium (7 SLE, 4 AR, 1 AIJ, 1 EMTD). No maternal deaths, neonatal lupus or congenital heart block were documented in this series. Four patients did not require any medication. One woman received treatment for pulmonary tuberculosis, and other was on anti-retroviral treatment for HIV infection. At the last follow-up, 2 patients were still pregnant.

Conclusion: The outcome of rheumatic disease during pregnancy remains variable. It seems that SLE patients tend to be more active and flare more commonly than other patients. The documented complications were similar to those reported in the literature.

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Table. Main clinical findings and outcomes

Variables	SLE (n=15)*	Non-SLE (n=13)**
Gestational age at first rheumatology follow up, mean (standard deviation, SD)	11,6 (5,9)	18 (9)
Treatment during pregnancy, n (%)		
Antimalarial	11 (73,3%)	6 (46,2%)
Steroids	10 (66,6%)	7 (53,8%)
Azathioprine	5 (33,3%)	1 (7,7%)
Laboratory findings, n (%)		
Anti-Ro antibodies	6/9 (66,7%)	0/9 (0%)
Lupus anticoagulant	1 (8,3%)	1 (14,3)
Anticardiolipin antibodies, IgM	1 (8,3%)	0
Anticardiolipin antibodies, IgG	1 (8,3%)	1 (14,3)
Relapses during pregnancy, n (%)	7 (46,7%)	8 (61,5%)
Maternal outcome, n (%)		
Preeclampsia	3 (20%)	1 (9,1)
HELLP syndrome	1 (6,7%)	0
Fetal outcome, n (%)		
Preterm newborn	6 (40%)	2 (18,2%)
Abortion	2 (13,3%)	0
Stillbirth	1 (6,7%)	0

SLE: systemic lupus erythematosus. * Two gemelar pregnancies ** Two patients with primary antiphospholipid syndrome.

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AB1196

A REVIEW OF ELECTRONIC RHEUMATOLOGY REFERRALS AT THE QUEEN ELIZABETH UNIVERSITY HOSPITAL (GLASGOW, UK) AND HOW THIS HAS LED TO SERVICE IMPROVEMENTS

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Background: Our department provides a service for inpatient Rheumatology reviews Monday to Friday, 9am to 4pm, with a guaranteed review timeframe of 48-72 hours. We work predominantly on the QEUEH site,

which comprises 1677 acute inpatient beds. We launched an electronic referral system for inpatient Rheumatology reviews in February 2018. Interspeciality referrals are an essential part of most inpatient stays. In a time of increasing service demand within the NHS it is important that we have an effective system to manage our time and resources^{1,2}. Electronic referrals allow us to audit our workload, our efficiency at reviewing patients and allow for accountability of both the referrer and reviewer, therefore improving patient safety³. Using a set proforma allows us to improve communication, the quality of the referral and triage effectively⁴.

Objectives: We performed a baseline review of the new system.

Methods: We reviewed all electronic referrals between 8.2.18 and 13.8.18. We collected data on demographics, timing, reasons for referral and outcomes.

Results: There were 346 referrals (58.4% female, mean age 64 years). Most (78%) were made from medical wards; the mean number of referrals per month was 49.4. Referrals were most frequently made on Fridays (23%). Most were in-hours (81%).

The most common reason for referral was: a request for review (212; 61.3%); phone advice (70; 20.2%); procedural requests (50; 14.5%). 207 referrals (59.8%) were made for new patients, 91 (26.3%) for patients known to Rheumatology prior to admission, and 48 (13.9%) for patients already seen during the current admission.

50% of procedures were performed on knees and 50% on other joints.

82% of patients were seen within 72 hours.

Acute hot swollen joint was the commonest reason for referral of new patients (38%), followed by vasculitis (6%). Questions regarding pre-existing disease management (59%) or DMARD questions (24%) predominated amongst referrals for patients known to Rheumatology prior to this admission.

Conclusion: The use of the electronic referrals system has made it simple to review the workload of our Rheumatology on-call service.

We have used the data on 'reason for referral' to guide the topics for our educational meetings to improve patient management.

We actively contribute to the procedural teaching on knee joint aspiration both in junior doctor's formal training sessions, and opportunistically on wards following referral. This is a core procedure required for training completion for medical trainees in the UK and should help reduce referrals and manage patients in a more time efficient and cost-effective manner.

We have also improved documentation by recording the time, date and name of the reviewer in our electronic entry

We intend to collect data in the same period this year, to assess changes in referral pattern in the 12 months since the system was initiated and the impact of our interventions.

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AB1197

EFFECTS AND SAFETY OF THE YELLOW FEVER VACCINE 17DD IN PATIENTS WITH IMMUNOMEDIATED RHEUMATIC DISEASES

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Background: The yellow fever is an acute infectious disease caused by the amarilic virus. It is present in tropical areas of South America and

Africa and is transmitted to humans through the bites of the infected female mosquitos, found in the endemic forest zones. The vaccine is produced with attenuated viruses and represents an essential prevention method. It confers prolonged immune protection and is considered to be safe in the general population. For the immunosuppressed condition under which many patients with immunomediated rheumatic diseases (IMRD) are submitted, little is known about its efficacy and safety in this group.

Objectives: The aim of this study is to analyse the effects of the vaccine in patients with IMRD.

Methods: The methodology of this research consisted of the application of a form-based interview, the analyses of the vaccine card and medical records, if existent. The requirement to take part as a volunteer was to be an IMRD patient that was vaccinated against yellow fever.

Results: 60 ambulatorial patients, unadvisedly vaccinated or not, were evaluated. Of those, 40 (66.7%) were female and 20 (33.3%) were male, with an age range varying from 8 to 48 years. It was observed that 52 (86.7%) presented no adverse effects from the vaccine, while 7 (11.7%) presented at least one side effect and 1 (1.7%) exhibited a severe reactivation of the underlying rheumatic disease. In the group of 7 patients that registered any side effects, it was described 1 case of bilateral optic neuritis with temporary vision loss, initiated three weeks after the vaccination. The other side effects registered were mild and included: 3 occurrences of headache and 1 record of each of the following: fever, local pain, arthralgia, myalgia, nausea, coryza and diarrhea.

Conclusion: Our data suggested that the vaccine exhibits a relative degree of safety in these patients. The benefits of the immunization should be evaluated by the rheumatologist, taking in account the risk of infection and lethality of yellow fever in patients who live or are visiting the endemic areas. The recommendations are that the vaccination in this group must always be planned, done under medical orientation and order. It should preferably be applied in patients under disease remission, without immunosuppression treatment or in those who, under immunosuppressors, it is possible to temporarily suspend this treatment in order to the vaccine to be administered.

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AB1198

EVALUATION OF THE WAITING TIME AND QUALITY OF RHEUMATOLOGY REFERRAL AT A TERTIARY CARE CENTER OF PORTO ALEGRE – RS, BRAZIL

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Background: To improve waiting time for a first consultation with a rheumatologist has become an important challenge in many countries [1, 2]. In 2008, a previous survey [3] evaluating the referrals to our Service, we observed long waiting times (median 3.8 months, interquartile range (IQR) =1.5-10.0, ranging from 3 days to 8 years) and that only 31% of consultations were related to hypothesis of systemic inflammatory rheumatic diseases (SIRD), which should be properly managed at a resourceful tertiary care center. In 2015, a new process of triage for referrals (based on a protocol recording relevant information and judgment by a rheumatologist) was introduced in our state health system aiming to improve quality of referrals and reduce waiting lists [4]. However, this system is applied only for patients from cities other than the capital (Porto Alegre, RS).

Objectives: To evaluate the waiting time and quality of referral for first Rheumatology consultations at a tertiary care center of South Brazil, comparing the present results with those obtained 10 years ago in a similar survey [3].

Methods: In a cross-sectional study, information regarding all first consultations at the Rheumatology Service of Hospital Nossa Senhora da Conceição were prospectively collected from Oct 2017 to Mar 2018. Referred patients were characterized in terms of demographic features, diagnostic

hypothesis formulated by the rheumatologist and time from initial referral. For analytical purposes, patients with adequate referrals were considered to be those that presented high probability of SIRD, needing assistance at secondary or tertiary level of care. The results were compared with data collected in the same way in 2008 [3]. Chi-square test was used for statistical analysis.

Results: Of 444 appointments for scheduled for new patients, 87 (19%) did not attend. The features of the remaining 357 patients were: female=85%, mean (SD) age= 53 (15) years. The waiting time for consultation ranged from 7 days to 63,8 months (median 12.7, IQR= 4.4-14.1). Diagnostic suspicion of SIRD occurred in 186 (52%). Among SIRD, rheumatoid arthritis (23,5%) was the most frequent, while among non-SIRD, osteoarthritis (21,0%) and fibromyalgia (20,7%) were the most common diagnostic hypotheses. A SIRD was the main hypothesis in 75/193 (38,9%) patients from the capital, comparing with 111/174 (67,7%) among those from other cities (P<0,001), indicating better selection of the latter group of patients. A reanalysis of data collected in 2008 revealed that, at that time, the prevalence of suspected SIRD was not significantly different between patients from capital (76/262, 29,0%) and those from other cities (74/225, 32,9%; P=0,354).

Conclusion: We observed improvement in the quality of referrals from other cities comparing to those from the capital of our state, suggesting a better selection process in the former [4]. Despite the efforts to reduce the waiting time for Rheumatology consultations, we observed an increase when compared to 2008. We believe that the delay is secondary to an increase of the demand without a proportional increase in the number of rheumatologist in the public health system. The elaboration of guidelines with standardized information required for referral and triage process seems to be promising to improve access to consultations in Rheumatology.

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AB1199

BARRIERS AND FACILITATORS TO THE IMPLEMENTATION OF A STRATIFIED MODEL OF CARE FOR LOW BACK PAIN PATIENTS IN PRIMARY CARE IN PORTUGAL

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Background: The results of a recent study have suggested that the current clinical practice is not in line with clinical guideline recommendations and may not be delivering the best outcomes to Low Back Pain (LBP) Portuguese patients. Since the stratified primary care approach has demonstrated clinical and cost-effectiveness in the UK and other countries, the SPLIT project aimed to introduce a similar approach that involves general practitioners (GPs) and physiotherapists (PTs) in the triage and targeted treatment for LBP patients, in Portugal. In order to facilitate the implementation of this project a training program for GPs and PTs was delivered by rheumatologists and PTs. Considering the specific organization of the Portuguese primary care, it was important to explore the perceptions of the GPs and PTs, who attended to the training, regarding the implementation of the SPLIT stratified model of care in the Portuguese context.

Objectives: Identify and understand the potential barriers and facilitators to the implementation of the SPLIT stratified model of care.

Methods: After obtaining ethical approval, two focus groups (one for each professional group) were carried out. The focus groups were based on a semi-structured interview schedule, audio-recorded and transcribed verbatim. A thematic analysis was conducted. Firstly, two researchers independently coded the transcripts. Secondly, these researchers discussed the codes and examined their scope and relevance. Thirdly, the researchers developed a coding scheme that included the main themes and sub-themes, as well as the connections among them.