According to ICD-10 codes, 9 deaths were reported, so the YLL were 124. The YLDs were 264,658. Finally, the DALYs were 264,782 for a rate of 808.82 per 100,000, which is higher than the GBD 2016 results (647 per 100,000).

Conclusion: The main cause of burden disease of rheumatic disease in Colombia is due to LBP. The burden is because of the YLD, related to the frequency of cases in people younger than 50 years of age. It is necessary for an early detection and development of intervention strategies.

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AB1205 BURDEN DISEASE OF OSTEOARTHRITIS IN COLOMBIA, 2015

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Background: Osteoarthritis (OA) is the most prevalent rheumatic disease in Colombia, as reported by the COPCORD 2015 study. The prevalence is 10.81% (IC 95, 9.68-12.06) (1).

Objectives: To estimate the disease burden of OA for 2015

Methods: A descriptive study was developed. The reference data of the population was taken by DANE (Departamento Administrativo Nacional de Estadística) and the WHO (World Health Organization). It was necessary to develop an algorithm to determine the distribution in percentages of severity levels, according to the GBD definitions. A Markov model was elaborated to calculate the years of life lost due to premature mortality (YLL), years lived with disability (YLD) and Disability-Adjusted Life Year (DALY).

Results: Figure 1 shows the distribution of cases by age of OA, with the highest frequency of cases over 50 years in both sexes.

Abstract AB1205 Figure 1. Distribution of cases by age and sex

Figure 2 describes the distribution of the severity levels of the disease, with most cases being moderately severe.

Abstract AB1205 Figure 2. Distribution of severity levels of rheumatoid arthritis

The YLLs were 781 and the YLDs were 245,626. Finally, the DALYs calculated were 246,408 for a rate of 752.69 per 100,000.

When compared with that reported data by the GBD 2016, the burden of disease for OA was 204 (IC95% 143-278). The results of the present study show that the burden of the disease is higher, and the conditional factor is the YLDs.

Conclusion: Osteoarthritis is a frequent and disabling rheumatic disease that confers a large burden of rheumatic disease affecting people over 50 years of age. The treatment of OA should be focused on reducing disability and holistic intervention strategies to promote good quality of life.

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AB1206 SELF-REPORT OF FRACTURE HISTORY COMPARED TO FRACTURE CODES FROM AN ELECTRONIC HEALTH RECORD DATASET

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Background: Self-reported fracture history data is frequently used in epidemiological studies of osteoporosis. Self-reported fracture data may differ from fracture history coded in electronic health records (EHR) due to imperfect patient recall, incomplete communication with clinicians, or lack of a universal EHR. Because both self-reported fracture history and EHR data can define phenotypes for clinical research studies, it is important to understand how these 2 data sources compare.

Objectives: To compare self-reported fracture history using survey data with fracture codes from an available EHR dataset.

Methods: Self-reported fracture data was derived from the Activating Patients at Risk for Osteoporosis (APROPOS) trial, which recruited participants from the Global Longitudinal study of Osteoporosis in Women (GLOW) cohort. Prior fracture data was collected using a survey deployed June - August 2015. Women were asked if they ever had a fracture and for each fracture type the date of the most recent one. Data on fractures recorded in the EHR September 2011 - June 2015 was obtained from Kaiser Permanente Washington Health Research Institute. We excluded skull, toes and fingers fractures. We defined concordance between the EHR and self-reported data if the location of a fracture was reported to be the same and if the reported dates were within 1 year of each other. Kappa (κ) statistic described the concordance between the 2 sources of fracture history. Descriptive statistics