AB1215

CURRENT PRACTICE OF HYDROXYCHLOROQUINE PRESCRIPTION AND MONITORING IN INDIA - A NATIONAL SURVEY

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Background: Hydroxychloroquine was introduced as an antimalarial during World War 2 and since then has found numerous indications for usage as an immunomodulator. Research is ongoing for new uses of the drug. Hydroxychloroquine is generally considered to be safe and monitored less rigorously than other DMARDs that have strict bloods monitoring regimes. Emerging evidence of increased risk of retinal toxicity possibly due to widespread usage in a population with diverse co-morbidity has prompted updates to prescription and monitoring guidelines worldwide.

Objectives:

1. Evaluate current practice of Hydroxychloroquine prescription and monitoring in secondary care.
2. Understand awareness of cross specialty guidelines.
3. Explore barriers to evidence based monitoring.

Methods: Questionnaire based survey shared to practicing clinicians (consultant rheumatologists, Immunologists, postgraduate trainees, other clinicians with interest in rheumatology) who prescribe Hydroxychloroquine. Results analyzed through excel spreadsheet and charts.

Results: We received 61 responses from clinicians nationally. 88.5% were consultant rheumatologists, 6.6% consultant immunologists and others included clinicians with interest in rheumatology. Special interest was CTD for 47.5% and 36% inflammatory arthritis. All respondents worked in urban areas and average experience in specialty was 9 years. Majority saw in excess of 500 patients month.

61 clinicians saw in excess of 24,700 patients per month and on average started more than 2481 patients on Hydroxychloroquine. Approximate prescription rate was 41 patients per clinician per month. Indications included connective tissue disease and inflammatory arthritis mainly. Other indications include antiphospholipid syndrome, osteoarthritis, post viral arthropathy, dermatomyositis and diabetic arthropathy.

Pretreatment tests as per international guidelines were recommended by 35% clinicians only which includes baseline Optical coherence tomography 25% or eye evaluation by ophthalmologist 10%. 54% clinicians advised OCT after 5 years (47.5%) or formal ophthalmology monitoring (6.5%) in line with published international guidance. Barriers to following required pretreatment tests and monitoring we noted from this survey include lack of awareness or disagreement with guidelines (lack of conclusive data), doubtful cost effectiveness and nonadherence by patients due to cost implications.

Conclusion: There is need to improve awareness of existing evidence based guidelines on prescription and monitoring of Hydroxychloroquine by international ophthalmology and rheumatology organizations. There is more data needed to prove effectiveness of current guidelines beyond doubt. We also need to better counsel and educate patients on the drug so adherence can be improved.

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AB1216

CHECKING IN WITH IMMUNE CHECKPOINT INHIBITORS: RESULTS FROM A NEEDS ASSESSMENT SURVEY OF CANADIAN RHEUMATOLOGISTS

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Background: Immune checkpoint inhibitors (ICI) have revolutionized the treatment of cancer. However, enhanced immune activation from ICI has

been associated with immune-related adverse events (irAE), including autoimmune rheumatologic diseases such as inflammatory arthritis, spondyloarthritis, polymyalgia rheumatica-like syndrome and inflammatory myositis, among many others. This emerging field represents a challenge given that experience with these conditions is limited and evidence-based recommendations do not yet exist.

Objectives: The Canadian Research Group of Rheumatology in Immunology (CanRIO) is an emerging network of rheumatologists interested in rheumatic irAE (rh-irAE). CanRIO undertook a needs assessment survey to understand the need for education and recommendations for the management of rh-irAE in the rheumatology community in Canada. The primary objective was to recognize the knowledge gaps, if any, and understand current patterns of practice in this newly emerging area.

Methods: A 25-item electronic survey was developed by the CanRIO investigators. The survey, which was available in both French and English, was distributed via electronic mail to 574 members of the Canadian Rheumatology Association (CRA). Responses were collected over a period of 14 days. Results were summarized using descriptive statistics.

Results: Of the 574 CRA members who were invited to participate, 83 responded (response rate of 14.5%). Half of the respondents were adult rheumatologists from academic centres and 25% from the community. Over 25% of the respondents were not familiar with ICI and irAE. Half of the respondents had not seen or managed patients with irAE, and among the remaining, the majority had seen less than 5 patients with irAE. Inflammatory arthritis was the most common rh-irAE encountered. Other rh-irAE included sicca, myositis, sarcoid and vasculitis. Prednisone and methotrexate were the most common treatment strategies. Almost half of the respondents (43.6%) had been asked for advice from oncologists regarding discontinuation of ICI for irAE, and of these, almost half (48.7%) reported that they were either 'slightly confident' or 'not confident at all' in providing advice. Over half of the respondents had not yet been asked to provide advice concerning ICI for patients with pre-existing auto-immune diseases. The vast majority (87.2%) agreed that there was a need for clinical practice guidelines for the management of rh-irAE.

Conclusion: The survey highlighted the important knowledge gaps in the emerging field of rh-irAE. Given the increasing use of ICI in a growing number of cancer types and stages, referrals for rh-irAE are likely to increase. There is strong rationale to develop educational programs and clinical practice guidelines to support Canadian rheumatologists who will be increasingly responsible for managing rh-irAE.

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AB1217

WHY DO PATIENTS CLAIM? ANALYSIS OF THE CLAIMS MADE BY PATIENTS THROUGH CUSTOMER SERVICE

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Background: Analysis of the claims made by patients could be an indicator of quality and show strengths and aspects of improvement in the organization of a rheumatology department

Objectives: The aims of the present study are to evaluate these claims, describe the sociodemographic and clinical characteristics of claiming patients and to determine the association between medical history and types of complaints.

Methods: cross-sectional study. Claims made by patients treated by a Rheumatology department between 04/2016 and 12/2017 were analyzed. A descriptive analysis of these claims was carried out followed by a multivariate logistic regression model to determine the effect of the diagnosis of Fibromyalgia (FM)/Chronic Widespread Pain (CWP) on the type of claim and its association with clinical variables. A p <0.05 was considered significant.

Results: One hundred and nine patients (mean age 54.7 ± 18.5 years, 78% women and 50.5% residents in rural areas) made 113 claims. The main reasons for claiming were: "advance medical evaluation and/or tests" (45.1%), "request for evaluation by a specific physician" (24.8%) and "rejection of evaluation by specific physician" (13, 3%). 67% of the claims were satisfied. The least satisfied claims were "request for evaluation by specific doctor" (39.3%) while claims for "cancellation of evaluation" were satisfied in 88% of the cases.

Median time between claim and previous medical visit was 99 [34-203] days and between claim and the subsequent medical consultation was 44 [28-82] days. Patients whose claims were due to "unpleasant attendance" were the first to complaint (median 28 [2-72] days) but waited for the longest time to be attended (median 103 [46-147] days). "Cancellation of evaluation" was attended after a median of 31.5 [28-33] days.

The main reasons for medical evaluation were: inflammatory/systemic disease in 25 patients (22.15%), neck and low back pain in 23 patients (20.35%) and FM/CWP also in 20.35% of patients. As personal medical history, Psychiatric Disorders were present in 20.5% of patients and multiple comorbidities in 19.6% of patients. Twenty patients had no medical history of interest.

Regarding the type of claims, differences were observed related to the diagnosis and the patient's medical history. The logistic regression model (FM as dependent variable) adjusted for sex, age, rural area, time to/ after the claim and medical history showed that patients with FM/CWP requested more frequently to "be evaluated by other physician" (OR of 23.92 (95% CI, 1.4-409.06) and "reject to be evaluated by a specific physician" (OR of 8.48 (95% CI, 1.2-60.09) than rest of the patients and also presented more frequently with psychiatric history (OR of 22.39 (95% CI, 1.15-437.23).

Conclusion: the present study reflects main reasons for claiming of patients treated in a rheumatology department. Reasons of claiming and comorbidities of patients with FM/CWP differ from those of the rest of patients. These findings may be of interest for the organization of resources in rheumatology departments.

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AB1218

ANALYSIS OF REFERRAL TRENDS TO A SECONDARY CARE RHEUMATOLOGY SERVICE FROM GENERAL PRACTICE, OVER A TEN- YEAR PERIOD

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Background: The practice of Rheumatology in the UK has undergone significant change in the past decade. These have been driven by developments in our understanding of the diseases; early arthritis clinics; changing population demographics; changes in the health services (NHS) all of which have influenced referral patterns to rheumatology.

Objectives: To analyse referral data from primary care three time points of a month at a time, over a decade – from 2006 to 2016 to assess changing trends, if any, of patients attending Rheumatology.

Methods: We analysed referrals from the primary care in the months of Feb '06 (n=89), Aug'12 (n=50) and Feb'16 (n=100). We looked at the following: reason for referral and our response, referral to out-patient review interval; outcome and final diagnosis.

We also analysed between first appointment and DMARD initiation in inflammatory arthritis.

Results: Referrals were grouped as demonstrated in the table below.

Diagnostic category	2006 (n=89)	2010 (n=50)	2016 (n=100)
non inflammatory/inflammatory arthritis	82% (n=73)	68% (n=34)	73% (n=73)
Abnormal investigations results for opinion	2.5% (n=2)	6% (n=3)	10% (n=10)
Back pain	11.3% (n=10)	10% (n=5)	5% (n=5)
Myalgia	1.1% (n=1)	10% (n=5)	3% (n=3)
Suspected connective tissue disease	1.1% (n=1)	4% (n=2)	6% (n=6)
Soft tissue conditions/others	2.2% (n=2)	2% (n=1)	3% (n=3)

The mean interval from Referral to patient review was 11.5 weeks in Feb 2006, 7.15 weeks in August 2012 and 6.6 weeks in Feb 2016. In patients with the diagnosis of inflammatory arthritis we also looked at mean timeframe from 1st review to initiation of DMARDs which is demonstrated in the chart below.

Figure 1

Conclusion: • Mean interval between primary care referral to first outpatient review has improved significantly over the period of 10 years
• Mean interval for DMARD initiation in inflammatory arthritis patients has also improved in the 10 years' time

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AB1219

EFFECTS OF A WORKPLACE-CENTERED COUNSELING OF INDIVIDUALS WITH MUSCULOSKELETAL COMPLAINTS: A PROSPECTIVE COHORT STUDY

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Background: Employed people with musculoskeletal complaints often seek medical advice when symptoms are chronic and lead to loss of workability.

Objectives: A brief examination was offered in the workplace setting to detect and to counsel individuals with symptoms of Rheumatic and musculoskeletal diseases (RMDs).

Methods: Employees received a questionnaire regarding musculoskeletal problems. In case of a positive screening, consultation by RMD specialists was offered. If necessary, participants were referred to a clinic specialized in RMDs. Employees' work was categorized into physically-highly-demanding (HD) and less-demanding (LD).

Following data were acquired: demographics, known pre-existing RMD, pain intensity, affected region(s), current treatment, number of sick-leave-days due to musculoskeletal complaints, and out of pocket costs for treatments during the preceding year. General wellbeing and depression were measured by Euroqol-5d. Follow-up information about data mentioned above was collected by telephone-interview.

Results: 6170 employees were invited. 413 participated in the counselling program, 344 were enrolled in the study. 56.6% of the participants had no previously diagnosed RMD, after the specialists' assessment, this percentage decreased to 35.7%. Men with LD-workload had significantly higher wellbeing (EQ-5d scale) compared to women with both LD (p=0.034) and HD (p=0.001). LD and HD differed significantly regarding percentage with painful upper (p=0.006) and lower (p=0.016) limbs. Back pain was distributed equally among all groups. HD women reported significantly higher use of NSAIDs (p=0.001).

235 individuals participated in telephone follow-up. There was significant improvement in wellbeing (p=0.006) and in rating of RMD pain (p=0.001). Participants who were suspected to suffer from RMDs had significantly increased out of pocket costs after one year (p=0.026). Use of NSAIDs decreased significantly from 29.1 to 17.4% (p=0.02). Rates of use of physiotherapy (p=0.001), gymnastics (p=0.001), physical therapy (p=0.027) and complementary/alternative methods (p=0.003) were significantly increased.

Conclusion: We found most physical/psychological problems related to RMDs in HD-working women. After one year, participants reported improved quality of life, reduction of RMD pain, higher utilization of medical services and of gymnastics, less use of NSAIDs, and, if suspected to suffer from RMDs, higher out of pocket costs. Thus, this workplace-centered intervention appears to have beneficial effects on both subjective well-being and physical/physiological health.

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