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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AB1220 DISTRIBUTION OF RHEUMATOLOGISTS AND YOUNG RHEUMATOLOGISTS' ORGANIZATIONS ACROSS THE WORLD: STILL ROOM FOR IMPROVEMENT

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Background: Rheumatology is a rapidly advancing specialty. The increasing understanding of autoimmune mechanisms and advanced therapies have improved care for patients with chronic inflammatory conditions immensely. National and international collaborations are growing and are key to scientific developments. Still, the number and geographical distribution of rheumatology organizations globally, is not known.

Objectives: To gain further insights into the distribution of established and young rheumatologists' organizations beyond Europe. Furthermore, we intended to explore correlations between presence of rheumatology organizations and demographic and socio-economic parameters.

Methods: A systematic online search was performed independently by three investigators (AN, SS, JS). Keywords used in the search related to three main themes (i) Rheumatology (rheumatology or rheumatologist(s) or rheumatism), (ii) Organizations (associations or young organization or society or group or association or league or federation) and (iii) country's name. All identified rheumatology organizations worldwide were reported. Countries were grouped in eight regions according to their geographic location. General demographic information (including population, area, pop. density, net migration, infant mortality, GDP, literacy, phones, arable, crops, climate, birth-rate, death rate) was retrieved from World Bank Open Data by one extractor (SS). Descriptive statistics and quartile distribution for each analysed variable were performed using Excel^R (Microsoft Office) and SPSSR software^R, using the total number of countries per region as the denominator.

Figure 1. Overview of the percentage of national rheumatology societies

Figure 1

Results: Four international societies and three junior international organizations (EMEUNET, PANLAR joven, ALPAR Young rheumatologists) were identified. Out of the 227 countries assessed, 89 national rheumatology societies (39%) and seven junior national organizations were identified (n=4, 2%). Rheumatology societies were more frequent in Eastern Europe (n=18/27, 67%), Middle east (n=10/15, 67%) and Western Europe (n=19/29, 66%) (Figure 1). Rheumatology societies were more frequently found

in countries in the upper quartiles (Q1) of population density, gross domestic product and literacy when compared to Q2-4 (as assessed for each variable, $p < 0.05$). Conversely, it was significantly less frequent in countries with high migration and infant mortality (Q1 Vs Q2-3, $p = 0.043$ and $p = 0.039$, respectively).

Conclusion: National rheumatology societies were identified in less than half the countries across the globe and were unequally distributed. We only found 7 national young organizations. Such organizations are needed, as trainees can highly benefit from educational and networking offers. Further steps will include the exploration of the impact and the reasons for lack of such establishments in some countries.

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AB1221 VIEWS OF PRIMARY CARE PHYSICIANS AND RHEUMATOLOGISTS REGARDING SCREENING FOR HYPERLIPIDEMIA AMONG PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Screening of hyperlipidemia in rheumatoid arthritis (RA) is suboptimal, despite RA patients' high risk for cardiovascular disease (CVD) mortality.

Objectives: To identify barriers to screening for hyperlipidemia among patients with RA from the viewpoint of primary care physicians (PCPs) and rheumatologists.

Methods: We recruited rheumatologists and PCPs nationally to participate in separate moderated structured group teleconference discussions using the nominal group technique. Participants in each group generated lists of barriers to screening for hyperlipidemia in patients with RA, then each selected the three most important barriers from this list.

Results: Twenty-six rheumatologists participated in 3 groups and 20 PCPs participated in groups. The resulting barriers were organized into physician-, patient- and system-level barriers. Rheumatologists prioritized physician level barriers (e.g. 'ownership' of hyperlipidemia screening), whereas PCPs prioritized patient-level barriers (e.g. complexity of RA itself). See table 1 for details.

Conclusion: These rheumatologists were conflicted about whether screening of CVD risk among patients with RA should fall within the role of the rheumatologist or PCPs. On the other hand, participating PCPs were concerned about the overall effect of RA and RA treatments in the context of screening hyperlipidemia.

Table 1221. Screening for hyperlipidemia: List of themes and sub-themes of barriers for rheumatologists and primary care physicians (PCPs) to screen patients with RA, with their respective priority votes

Category	Subcategory	Rheumatologist (% votes) Total Votes N=162	PCP (% votes) Total Votes N=120
Physician Level	Total Votes	83.0	42.5
	Lack of time	34.0	1.7
	Conflict regarding ownership of hyperlipidemia screening	25.9	10.8
	Lack of training and knowledge of hyperlipidemia guidelines or RA itself	17.9	20.0
	Focus only in RA	4.9	—
Patient Level	Physician prioritization of RA symptomatology over preventive measures	—	10.0
	Total Votes	7.5	44.2
	Effect of RA and its treatment	2.5	9.2
	Patient prioritization of RA symptomatology over preventive measures	2.5	9.2
	Patient expectations	1.9	—
	Patient already on multiple medications	0.6	0.0
	Multiple blood draws	0.0	8.3
	Side effects of statins and drug interactions with statins	0.0	5.0
	Poor patient compliance with medical care	0.0	9.2