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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