(MDHAQ) 60-symptom checklist may recognize most adverse events of medications.

Objectives: To document recognition of adverse events using a remote weekly electronic MDHAQ completed by patients at home, as a cost-effective approach to reduce their morbidity, costs, and mortality.

Methods: The MDHAQ includes 0-10 scales for physical function, pain, and patient global assessment, compiled into a 0-30 RAPID3, fatigue and painful joint count, to assess treatment efficacy. The MDHAQ also includes a 60-symptom checklist to recognize comorbidities, review of systems, and symptom reduction; this checklist also recognizes adverse events associated with medications. Weekly remote completion of an electronic MDHAQ at home can monitor both efficacy and adverse events.

Results: A flowsheet from a patient with pulmonary fibrosis monitored over 2018 illustrates remote electronic MDHAQ use. At a first visit of 19 Jan, a routine clinic-based MDHAQ indicated RAPID3 of 14/30, fatigue 6/10, and 10 symptoms (Flowsheet). Treatment with low-dose methotrexate and prednisone led to clinical improvement from 19 Jan to 2 Aug, RAPID3 to 3.5, fatigue 2, and 6 symptoms. On 15 Aug, a pulmonologist discontinued prednisone and methotrexate and prescribed pirfenidone, an anti-fibrosis agent. A telephone call from the patient on 24 Sep indicated an increase of RAPID3 to 4.2, fatigue to 1.0, and resolution of pirfenidone-specific symptoms (7 symptoms - 7 not reported on 2 Aug were among 16 adverse events listed for pirfenidone. Discontinuation of pirfenidone and resumption of prednisone and methotrexate led to improvement of RAPID3 to 4.2; fatigue to 1.0, and resolution of pirfenidone-specific symptoms by 24 Dec, documented with weekly remote electronic MDHAQ (Flowsheet). A brief retraill of pirfenidone indicated an increase of RAPID3 to 6.0, which was discontinued in a timely manner.

78-year-old man monitored over 2018–all data from self-report on MDHAQ – pirfenidone highlighted (many entries deleted for space considerations)

Conclusion: Weekly remote electronic MDHAQ monitoring of a high-risk medication for treatment response and adverse events may provide a cost-effective approach to reduce the morbidity and mortality of adverse events, involving about 10 minutes/weekly or 2 hours of patient time over 12 weeks.


**AB1226**

ONE YEAR’S RESULTS OF A PROTOCOLIZED HIGH RESOLUTION RHEUMATOLOGY CLINIC

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Background: Mechanical musculoskeletal pathologies put high demands on the Public Health Service, as they affect a significant percentage of the population, and cause both temporary and permanent disabilities. The specialised High Resolution Rheumatology Clinic (CAR) in Spanish at our centre started up in October 2017, and focuses on the diagnosis and treatment of pathologies which are fundamentally of a mechanical ethology. The centre covers a population of approximately 328,868 inhabitants (Alava 2018 census).

The aim of our study, carried out at the unit over one year, is to determine the patients’ epidemiological features.

Objectives: • To provide the Primary Care Centres with a “fast–track” and immediate care system in order to guide, diagnose, and treat patients who have worsening acute or chronic mechanical affictions to the musculoskeletal system.

• Diagnosis confirmation, request for non-accessible tests, adaptation of treatments mainly for the primary care doctor.

• To speed up and reduce waiting lists, for both inflammatory rheumatic pathologies and mechanical rheumatic pathologies, by establishing new referral guidelines.

• To draw up protocols in agreement with primary care doctors and related specialists.

• To act as a support for other medical services.

Methods: The main services available are those offered mainly to primary care level. There are 3 clinics a week, attending to approximately 30 new patients per week. 1330 patients are included in the study, seen at the High Resolution Rheumatology Clinic (CAR) over 12 consecutive months (November 2017 – 2018), with non-complex regional pathologies and/or soft tissue rheumatism, which are able to be resolved with one or two visits.

Results: 1330 patients were seen, with an average age of 58 ±15.6 years, 64.84% female and 35.36% male, mainly for musculoskeletal ailments. In order of frequency, the visits were for shoulder (25.79%), hip (16.10%), axial skeleton (15.13%), ankle/foot (13.06%), wrist/hand (12.08%), knee (11.21%), and elbow (6.63%).

61.95% of the patients were discharged after the first visit, and one year later, this figure rose to 90.15% of all the patients discharged; only 2.78% made a return visit after being discharged. 22.26% were referred to other services, mainly Traumatology and Orthopaedics (10.53%); Rehabilitation and Physiotherapy (9.72%); and the Pain Management Unit (1.65%). The 3.68% were referred to the usual Rheumatology department. For 52.33% of the patients seen, there was no need to request more than one diagnostic tests, even though 12.41% visited for reasons other than the main one. Moreover, 63.08% received some kind of infiltration injection. The negative point was that 7.89% of the referrals had been made from Primary Care to several specialists at the same time; and 7.98% were consultations regarding traumatic injuries.

Conclusion: Systematising a clinic for mechanical musculoskeletal pathologies which have a high chance of being resolved in the short term, means that the quality of the care given, the waiting times, and the demand on the health service can be improved. Developing these can have important repercussions on waiting lists for other related services, and even for the Rheumatology service itself, allowing more serious cases to be seen earlier. Creating multi-disciplinary units should be encouraged, in order to improve care quality and prevent the various medical services involved from all carrying out fragmented courses of action. New guidelines could be considered, to optimise the care and management of new resources and/or links to other services, as the most prevalent pathologies can be identified. Most of the patients seen represent the economically active part of the population; there are therefore, repercussions as far as sick leave, disability leave, etc. is concerned.