rheumatoid arthritis. Understanding about the disease symptoms: 50.5% respondent answered they do not know RA symptoms; 29% correctly identified joint swelling; 17.4% correctly identified morning stiffness; 12.6% correctly recognized extreme fatigue as a symptom; and only 6.5% correctly identified that crunching and grinding of the joints is not a symptom. Understanding about disease risk factors: 49.4% of participants responded they do not know the risk factor for RA, only 7% correctly identified genetics as a factor; 17% knew that women are more vulnerable than men; only 3% correctly stated that smoking can increase the risk of developing RA; and 34% stated that undertaking exercise and obesity is also a risk factor and 23% identified sore throat can increase RA. Understanding about disease impacts: 21.1% correctly recognized that RA affects a person's ability to walk short distances; 55% did not know how RA affects person's quality of life, 40.3% correctly stated that RA affects a person's life expectancy; but only 11% knew that the disease affects the internal organs. In total, 12% of respondents saw information about the RA and 82% said public RA awareness needs to be improved.

Conclusion: In Mongolia, public awareness of rheumatoid arthritis was poor. Most of the participants responded to do not know. Other participants who have not responded to do not know that most of them misidentified disease symptoms, risk factors and impacts. The only good thing was most of the participants thought awareness of RA improvement certainly. A good awareness of RA can be one of the basic solutions for the early diagnosis of RA in Mongolia.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.7832

AB1342 TRANSLATION AND ADJUSTING THE PATIENT GUIDE FOR OSTEOARTHRITIS INTO DUTCH. LESSONS LEARNED FROM THE JIGSAW-E PROJECT

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Background: In the UK a guidebook was co-developed with UK patients during a OA research study (1). Within the JIGSAW-E (Joint Implementation of Guidelines for Osteoarthritis in Western Europe) project the guidebook is disseminated and implemented in clinical practice in 5 countries: UK, The Netherlands, Norway, Denmark and Portugal. We translated and adapted the English guidebook for use in the Netherlands.

Objectives: To describe the process of translating and adjusting the guidebook into Dutch, and to summarize the key lessons learned.

Methods: Starting point was a paid translated version of the guidebook. The translation was reviewed by an interdisciplinary working group and distributed among stakeholder organizations. Data collections took place by reports of working group meetings, written feedback from stakeholder organizations and patients' interviews focusing on their information needs. Along the way a logbook of adaptations was kept. After triangulation of findings, adaptations were clustered in six preliminary categories and, together with lessons learned, agreed upon in a consensus meeting with the working group.

Results: The working group convened fifteen times. Ten patients were interviewed about the readability and usefulness of the OA guidebook. Eight out of thirteen stakeholder organizations provided feedback on the draft guidebook. Advice for adaptations related to the following preliminary categories: language; patients' needs; cross-cultural differences; health care system; scientific evidence; structure and layout (see Table 1 for examples). Lessons learned related to the low quality of the initial translation, selection of representative working group members, selection of stakeholder organizations, and required time for thorough deliberation during meetings.

Conclusion: Important ingredients for a successful translation and cross-cultural adaption of a guidebook (or other patient material) are: time, a professional translation (sufficient budget), relevant stakeholders, and patients who can be critical. Patients who were interviewed about the guidebook added valuable patients' information needs, relevant to the cross-cultural adaptation. A draft framework of categories for cross-cultural adaptation is proposed.

REFERENCES

[1] Osteoarthritis Cartilage. 2018;26:43-53

Categories	Examples
Language	Joint pain, osteoarthritis (OA) and arthritis are used interchangeably; explanation in Dutch is needed (gewrichtspijn, artrose, reuma, ontstekings); Translation of English expressions, such as 'no pain, no gain'
Patients' need	More practical tips for specific OA type (hand, knee, hip); 'people with OA' is preferred over 'patients'
Cross-cultural differences	Compared to what there is already in the Netherlands, the tone in the guidebook is much better, less paternalistic; Photographs of people cycling are needed
Health care system	The central role of the nurse in primary care OA management in the UK versus that of the physiotherapist in the Netherlands
Scientific evidence	Due to new scientific insights we deleted the part on insoles
Structure and layout	Photographs should be of younger people and other cultural backgrounds in the Netherlands; Shorter sentences and more sub-headings

Acknowledgement: We thank all stakeholder organizations, patients and the JIGSAW-E team for their efforts.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2019-eular.5516

AB1343 EFFECTIVENESS OF A RHEUMATOLOGY EDUCATIONAL PROGRAM TO IMPROVE METHOTREXATE PRESCRIBING PRACTICES FOR RHEUMATOID ARTHRITIS IN THE SOLE PUBLIC ADULT RHEUMATOLOGY CLINIC IN ETHIOPIA

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Background: Treatment of recent onset Rheumatoid Arthritis (RA) is key to preventing deformities. Initial treatment with methotrexate (MTX) is standard of care. RA treatment in resource-limited countries is complicated by competing health priorities and a lack of rheumatologists. The sole public adult rheumatology clinic in Ethiopia, is at Tikur Anbessa Specialty hospital (TASH) (Addis Ababa). Due to the lack of rheumatologists, care is provided by internists with limited rheumatology training.

Objectives: To evaluate changes in RA management practice patterns following a series of educational activities provided by visiting rheumatologists.

Methods: With local faculty support, visiting rheumatologists conducted educational activities at TASH between July 2016 and December 2018 (2 continuing medical education workshops; 4 clinical preceptorships lasting 2-4 weeks each). Clinical charts of a convenience sample of RA patients seen in the TASH rheumatology clinic were reviewed in September 2016 (n=48) by a team of rheumatologists and a second set in December 2018 (n=78) by an internist. Socio-demographics, arthritis features, treatment patterns and drug safety monitoring were recorded when documented. Practice patterns were compared between 2016 and 2018 using univariate statistics.

Results: The patients were mainly female (90%) with a mean (standard deviation) age of 36(13) years, resided in Addis Ababa (61%) and received government funded health care (57%). When documented, (95/117; 81%) had polyarthritis and (42/55; 76%) clinical joint deformity (2016 vs 2018 p=NS). More patients were seropositive in 2016 compared to 2018 (32/43 vs 14/75 p<0.001) and more had radiographic damage (erosions, joint space narrowing, periarticular osteopenia) (21/27 vs 39/71 p<0.05). Between 2016 and 2018, prednisolone use remained common (92% in 2016 vs 99% in 2018 p=0.05) often in high doses (last visit daily dose 7.5mg (0-100) vs 5mg (0-100); p=NS; maximum daily dose 7.5 (0-100) vs 20 (0-100) p=NS) with continued documentation of steroid toxicity (45% vs 20%). The only available DMARDs prescribed were MTX (112/127; 97%) and chloroquine (50/125; 40%). Median prescribed weekly MTX dose increased between 2016 and 2018 (starting dose 5 vs 7.5 mg/week p=0.01; maximum dose 7.5 vs 12.5 mg/week p<0.0001) and was co-prescribed with folate by 84% in 2016 vs 93% in 2018 (p=NS). Documentation of drug safety for those prescribed MTX improved with