previously associated with coronary artery disease, was genotyped by TaqMan probes. Results were adjusted by potential confounding factors (STATA® v.11.1).

**Results:** Serum and mRNA levels of omentin were lower in axSpA compared to controls (p<0.001). Low omentin serum levels were observed in obese patients, patients with inflammatory bowel disease (IBD) and in those with an atherosclerotic index indicative of dyslipidemia (p=0.002, 0.006 and 0.004, respectively). Interestingly, the C allele of rs12409609 (both when alleles and genotypes were considered) was associated with low mRNA levels of omentin in axSpA (p<0.001).

No association was observed between omentin and markers of subclinical atherosclerosis at the DNA, mRNA and protein level.

**Conclusion:** style="font-family: ’Times New Roman’,’serif’; font-size: 10.0pt; margin: 0cm; margin-bottom: 8.0pt; line-height: 106%; margin-left: 0cm; margin-right: 0cm; margin-top: 0cm; mso-style-name: Normal_0; text-align: justify;"; font-size="11.0" data-pos-index="11.0" class-name="serif">Omentin is linked to obesity and adverse lipid profiles in axSpA. Additionally, low serum levels of omentin are associated with the presence of IBD in axSpA. These data support a role of omentin as a CV risk biomarker in axSpA.

**REFERENCES:**


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and hospital organisation factors. Geographical Information Systems are used to display maps describing adjusted estimates of variation in outcomes across NHS CCG areas.

Variation in outcome of surgery across Clinical Commissioning Groups (2014-2016)

Results: 210,725 primary TKR/UKR were identified nested in 207 clinical commissioning group areas. 57% of patients were women, with an average age 70 years (SD ±9 years). Whilst we identified a number of factors that predicted outcomes of surgery (e.g. age, gender, co-morbidity, deprivation, baseline function, surgical volume, numbers of orthopaedic surgeons, beds, operating theatres), these factors did not explain the observed geographical variations in outcomes of surgery across CCGs. The absolute predicted change in OKS varied from 13.0 to 18.8, predicted 6-month complication rate from 2.9% to 5.8%, predicted revision from primary TKR/UKR undertaken in 2014-2016 0.7% to 1.8%, predicted mean length of stay 2.9 to 6.6 days, bed-day cost £4758 to £8693 (Figure).

Conclusion: We have identified potentially unwarranted variations in patient outcomes of knee replacement surgery. This variation cannot be explained by differences in patients case mix, surgical factors, or hospital organisational factors. This information is informative to patients in making a decision in where they have their surgery, and to commissioners in monitoring variations in outcomes of surgery.

REFERENCES:

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Background: Eumusc.net, a EULAR and EU supported initiative (which took place from 2008 to 2013) aimed to raise and harmonize quality of care for patients with rheumatic and musculoskeletal diseases across European countries. As part of Eumusc.net, 16 user-focused standards of care (SoC) for rheumatoid arthritis (RA) were developed.

Objectives: To evaluate gaps in quality of care using the Eumusc.net SoCs among patients and rheumatologists across Europe and to investigate the contribution of individual- and country-level characteristics to care gaps

Methods: Fifty RA patients and 50 rheumatologists from each of 34 countries were invited to participate in a survey. For each SoC, levels of importance and care were rated by patients or provided by rheumatologists on a scale from 0 to 10 (+best). Care gaps were calculated as difference from the maximum score for care received multiplied by the score for importance of care [0 (no gap) - 100], and defined as ‘problematic’ when the gap was >30 and importance >6. Individual- and country-level (GDP in tertiles) determinants of care gaps were analysed in multilevel logistic regression models, with patients clustered in country of residence. For patients, individual factors included gender, age, disease duration (years), level of education (low, high), work status (retired, disabled, working, not working), literacy, patient organisation membership and overall health (0-10). For rheumatologists, individual factors were gender, age, years of experience and work setting (university hospital and non-university hospital/private practice).

Results: In total, 1,422 patients from 27 and 1,044 rheumatologists from 33 European countries, respectively, were included. Patients had a mean (SD) age of 57.2 (13.2) years and 74% were female. For rheumatologists, the mean age was 47.7 (10.5) and 53% were female. After ranking the SoCs on percentage of problematic gap, the 7 SoCs in the top 10-ranks for both patients and rheumatologists (Table) were: diagnosis within 6 weeks, information about patient organisations, availability of treatment plan, receiving a schedule of regular assessment, vaccination-related information, information about adequate physical exercise and training on aids, devices and ergonomic principles. The least frequent problematic SoC for both patients and rheumatologists was adequate DMARD received (6% and 3%).

Multilevel analyses revealed large variation across countries for patients (all mod p<0.01) and for the majority of analyses for rheumatologists, despite adjustment for individual characteristics. In addition, patients with higher education and lower self-reported health experienced problematic gaps more frequently. Among rheumatologists, patterns in determinants across SoCs were less consistent. For about half of the SoCs, rheumatologists from lower GDP countries identified problematic gaps more often compared to those from medium or high GDP countries (see Table).

Table. Frequency and determinants of care gaps perceived by patients and rheumatologists (top-5 SoCs with highest % of respondents reporting a problematic gap)

<table>
<thead>
<tr>
<th>SoC Description</th>
<th>% of respondents indicating problematic care (-)</th>
<th>Gender: Female vs. male</th>
<th>Education: High vs. low</th>
<th>GDP: low vs. medium vs. high</th>
<th>Odd ratio from multilevel logistic regression (-) (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic delays within 6 weeks</td>
<td>Patient (10)</td>
<td>50% (51/102)</td>
<td>57% (59/103)</td>
<td>69% (77/112)</td>
<td>0.39 (0.25-0.61)</td>
</tr>
<tr>
<td>Information about relevant patient organisations and treated services</td>
<td>Patient (7)</td>
<td>38% (37/97)</td>
<td>44% (45/102)</td>
<td>57% (64/112)</td>
<td>0.77 (0.58-1.05)</td>
</tr>
<tr>
<td>Availability of a treatment plan</td>
<td>Patient (6)</td>
<td>50% (25/50)</td>
<td>68% (34/51)</td>
<td>57% (59/103)</td>
<td>0.89 (0.52-1.54)</td>
</tr>
<tr>
<td>Patients are informed about medication</td>
<td>Patient (6)</td>
<td>77% (46/59)</td>
<td>64% (38/60)</td>
<td>79% (72/91)</td>
<td>4.49 (2.14-9.42)</td>
</tr>
<tr>
<td>Schedules of regular assessment and consultations received</td>
<td>Patient (7)</td>
<td>55% (25/45)</td>
<td>63% (39/61)</td>
<td>48% (47/97)</td>
<td>1.57 (0.89-2.76)</td>
</tr>
<tr>
<td>Physical exercise</td>
<td>Patient (10)</td>
<td>58% (58/100)</td>
<td>63% (64/101)</td>
<td>53% (53/100)</td>
<td>0.70 (0.53-0.93)</td>
</tr>
<tr>
<td>Training on aids, devices and ergonomic principles</td>
<td>Patient (6)</td>
<td>31% (24/77)</td>
<td>35% (35/99)</td>
<td>29% (26/92)</td>
<td>1.67 (1.12-2.49)</td>
</tr>
</tbody>
</table>

SoC: Standard of Care; GDP: gross domestic product; rheum: rheumatologist; n/a: not significant; na: not applicable; * p-value<0.05; ** data presented for only complete pairs (i.e. when both importance and level of implementation were rated by the respondent).

Conclusion: For most SoCs, problematic gaps were identified in essential aspects of RA care, and substantial differences across countries were observed.