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THU0643 ARE PSORIATIC ARTHRITIS OUTCOMES BETTER IN EARLY ARTHRITIS SERVICE? STUDY FROM A NATIONAL AWARD WINNING CENTRE

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Background: There is good evidence that dedicated early arthritis clinics (EACs) improve referral lag time and reduce delay in establishing disease-modifying therapy. However it remains arguable whether such clinics improve outcomes especially for arthritides other than RA. In the UK, only 57% of units have dedicated EACs. Our early arthritis service won national best practice commendation award for achieving high standards.

Objectives: We analysed our psoriatic arthritis (PsA) population data to ascertain whether this cohort benefits from EACs.

Methods: The department set up an early arthritis service with introduction of six clinics (EACs) every week. An agreed treatment protocol incorporating ultrasound was developed to ensure standardised approach to early initiation of treatment, drug education and timely review. This is a retrospective study of all patients with PsA presenting to the service in the first year

Results: Our catchment area covers a population of 350,000 with 40% ethnic minorities. Of 1884 patients referred, 482 (25.5%) were triaged into EACs based on set criteria. All were reviewed within 3 weeks. 247 (51%) were confirmed to have early inflammatory arthritis (EIA). Mean age was 52.4 years (17-86y). 157 (63.5%) were women. 177 (71.6%) were White, 58 (23.5%) of Asian and twelve of other background. 159 (64.3%) had RA, 55 (22%) with PsA and 33 had other inflammatory arthritides. There was median 26 weeks delay (0.4-1043 weeks) from symptom onset to GP presentation. Median time for GP referral to the department was 4.0 days (0-84 days).

All PsA patients had regular PsARC assessment. Mean tender (TJ) and swollen joint (SJ) counts at first visit were 8.2 (1-35) and 3.5 (0-14) respectively [n=55]. The patient (PtGA) and physician (PhGA) global assessments mean were 3.0 and 2.9 (1-5).

95% commenced their DMARDs within 3 week of initial review. Other 5% who missed the target was owing to patient factors. Target [TJ & SJ ≤2] was achieved for 38 patients (69%) and good PsARC response for a further four (7%). Median time to achieve the target or good response was 22 weeks (0-48 weeks). Of 55, only four (7%) patients required escalation to biologic therapy. Final TJ and SJ mean was significantly better at 1.2 (0-4) and 0.3 (0-2) [p <.0001] with similar improvement in PtGA [mean 1.8 (1-4)] and PhGA [mean 1.6 (1-3)]. Only six (11%) patients were true non-responders as the remaining seven declined therapy.

Conclusion: Dedicated EACs help achieve good clinical outcomes in majority of PsA patients. Nearly 76% of our cohort attained the target or good PsARC response in less than six months. This was despite a significant delay in patients presenting to their GPs and moderately-high disease activity. 100% of our patients were treated to target facilitated by protocol driven escalation of therapy in these clinics. This is in contrast to the national audit findings whereby only 68% of patients were treated with disease modifying drugs within 6 weeks of referral and 89% had treatment to target.

This study shows that the establishment of dedicated EACs improve the prognosis of psoriatic arthritis in terms of primary clinical outcomes compared to patients managed outside of EACs.

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THU0644 PATIENTS' PERCEPTION AND USE OF MEDICAL MARIJUANA

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Background: Though the introduction of biologics has resulted in significant improvements in their quality of life, people living with rheumatic and musculoskeletal disease (RMD) often seek alternative treatments, such as marijuana (THC) and cannabidiol (CBD). As these substances become more widely available, and legal in some jurisdictions, health care providers (HCP) need to understand patients' THC/CBD perceptions, use and information needs.

Objectives: To examine patient behavior and information needs regarding THC/CBD medical use.

Methods: A 77-item survey was developed in partnership with RMD patient partners and administered online via CreakyJoints and the ArthritisPower research registry. Participants (pts) were eligible if they were ≥19 years of age, resided in the US and reported physician-diagnosed RMD. Pts reported current health status (NIH PROMIS Global Health), use and perceptions of THC/CBD, and related information needs.

Results: To date, 189 pts completed the survey. A majority of pts were female (87%) and white (93%), with mean age of 55(11). More than half of all pts (62%) reported a diagnosis of rheumatoid arthritis. Most pts (78%) reported fair/poor health (PROMIS Global Physical Health <43). Only 30% of all pts were satisfied with their current treatment, and more than half (63%) had been on their current treatment for >1 year. Of those surveyed, a majority of pts (n=168, 89%) reported trying THC and/or CBD for a purpose they perceived as medical and offered various reasons for initiating its use (Table). Half of all pts (n=98, 52%) reported ever using CBD and a third (n=70, 37%) ever using THC "for medical reasons," fifty-one (73%) of whom currently use THC. More than half (53%) of those currently using THC reported using it at least once daily. Top reasons for stopping among the 19 who previously used THC were cost (26%) and illegality (26%). Most pts who had ever used THC reported that THC improved their symptoms (83%) and/or their condition (71%). Pain (100%) and sleep disturbance (73%) were the main symptoms pts sought to relieve with THC. Many pts had used THC in lieu of prescribed (56%) or OTC (73%) medications. Two thirds (67%) reported telling their HCP about their THC use, most of whom (64%) reported that their HCP did not consider it when making treatment changes nor offer advice about mode of administration or dosage. When acquiring THC, 39% of pts used a medical marijuana card issued by the state; the main reason given for not using a card was that THC was not legal for medical use where the pt lived (44%). Whether they had used THC for medical reasons or not, nearly all pts wanted information about THC, including its effectiveness (37%) and its interaction with other medications (34%); a majority preferred to receive information from HCPs (55%) or online educational resources (34%). Two thirds (60%) of all pts expressed interest in THC/CBD trial participation.

Table: Participants' Reasons for Initiating THC/CBD Use (N=168)

Reasons (not mutually exclusive)	n (%)
To address symptoms (e.g. pain) experienced despite taking medication	74 (44)
To address symptoms with less or no medication	50 (30)
Nothing else worked to treat condition or symptoms	33 (20)
Friend suggested it	30 (18)
Saw information online	28 (17)
Had used marijuana recreationally and wanted to try it for medical reasons	25 (15)
Medical marijuana became legal in state	24 (14)
To address side effect(s) from medication	19 (11)
Physician suggested it	17 (10)
Relative suggested it	17 (10)

Conclusion: Though many pts have used or currently use THC/CBD to substitute for or augment their prescribed treatment, pts lack adequate information to guide its use for medical reasons.

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**VIRTUAL VISITS IS THE FUTURE COMING?
TELERHEUMATOLOGY. PILOT PROJECT: REVIR
PROGRAM, RHEUMATOLOGY SERVICE. BARCELONA,
SPAIN**

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Background: The prevalence of rheumatic diseases in the Spanish population is estimated at 22.6% according to the EPISER 2000 study. A new epidemiological study is currently underway, EPISER 2016 and its preliminary results point towards a higher prevalence. Within the national health system, primary care is the first level of access to the health system and is provided at primary care centers (CAP). The rheumatology at primary care centers at Spain has been a pioneer in the application from the team at Parc de Salut Mar (Hospital del Mar), with the physical presence of rheumatologists in the 14 centers belonging to the CAP network of the SAP Litoral. The high prevalence of the medical pathology of the musculoskeletal system and the aging of the population, can condition an increase in visit requests in rheumatology, and with it, the increase in the waiting lists of patients.

Objectives: The main objective of this study is to know the resolutive possibility of virtualization, measured in the number of visits resolved telematically, as well as its impact on the resolution capacity of the primary care physician and the reduction of the waiting list of first face-to-face visits.

Methods: Prospective experimental study, started on December 1, 2017 and ended on May 31, 2018. Four primary care centers were selected according to population and waiting list: Sant Martí Nord, Sant Martí Sud, Ramón Turró and Villa Olímpica. The REVIR program proposes the creation of a circuit for the assessment of referrals to rheumatology from primary care physicians (MAP).

Results: 726 first visit requests were received during the REVIR program. The most common categorized pathology was mechanical pathology, representing about 70% of the first visits requested. Metabolic bone disease ranked second with 16%, and inflammatory pathology ranked third (SLE, RA, SA, SPA, PsA). Chronic musculoskeletal pain ranked fourth (including fibromyalgia) and lastly soft tissue pathology. The number of first visit requests was multiplied by two in all the participating primary care centers of the project. Despite this increase, the telematic resolution of the visits created was stable, with a value greater than 40%.

Conclusion: The implementation of a system of assessment of the first visits in rheumatology requested from Primary Care is effective in decreasing the waiting list to make face-to-face visits, as well as to detect early serious pathology that requires hospital control. It has been achieved, therefore, that the patient is treated at the level of attention that corresponds to him. Guaranteeing the adequate use of hospital resources and reducing the waiting list for a first in-person visit in rheumatology in primary care is one of the most important goals fulfilled, given that it is directly related to maintaining the accessibility and equity of the public health system.

REFERENCES:

[1] Kataria, S., & Ravindran, V. (2018). Digital health: a new dimension in rheumatology patient care. *Rheumatology International*. <https://doi.org/10.1007/s00296-018-4037->

Tabla 1: Resolution of the first virtual visits to 6 months of REVIR project

CAP	Total	First CAP	First Hospital	Virtual resolution
Ramón Turró	193 (26,4%)	94 (49%)	22 (11,3%)	77(40%)
Villa Olímpica	96 (13,2%)	36 (37,5%)	13(13,5%)	47(49%)
Sant Martí (1 y 2)	437 (60,2)	216 (49,5%)	53(12,1%)	168(38,4%)
Total	726 (100%)	346 (47,6%)	88(12,1%)	292(40,2%)

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**HIGH LEVELS OF DAMAGE IN INFLAMMATORY
RHEUMATIC DISEASES: A CLUE TO LOW RATES OF
REMISSION AND LOW DISEASE ACTIVITY**

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Background: Despite introduction of powerful biologic medications over the last 2 decades, rates of remission and low disease activity rates in RA remain less than 50%. One possible basis is that measures and indices such as disease activity score 28 (DAS28) and clinical disease activity index (CDAI), while sensitive primarily to disease activity in clinical trial patients selected for high inflammatory activity, may also reflect clinically important joint damage and patient distress in unselected patients in routine care. Similar considerations may pertain to systemic lupus erythematosus disease activity index (SLEDAI), Bath ankylosing spondylitis disease activity index (BASDAI), and other measures and indices initially designed to assess disease activity. Levels of organ damage and patient distress, as well as inflammation, may be quantitated according to 3 physician (0-10) visual analog scales (VAS), in addition to physician global assessment VAS (DOCGL), scored in fewer than 10 seconds in routine care.

Objectives: To test a hypothesis that damage and distress may be prominent in patients with inflammatory conditions, according to mean VAS for inflammation or reversible findings (DOCINF), damage or irreversible findings (DOCDAM), and distress (DOCSTR), e.g., fibromyalgia.

Methods: All patients at one site complete a multidimensional health assessment questionnaire (MDHAQ), which includes patient global VAS (PATGL), at each visit in routine care. Physicians complete four 0–10 (none-highest) VAS for DOCGL, DOCINF, DOCDAM, and DOCSTR, and a query to estimate the proportion of clinical decisions (total=100%) attributed to each of the 3 findings. Patients were classified into various diagnostic groups, in which scores were analyzed according to mean and standard deviation.

Results: Analyses included 563 patients (Table). Mean levels of DOCGL ranged from 3.2 to 5.2, and PATGL from 3.6 to 6.5, which might be interpreted to indicate high disease activity. Highest mean DOCINF scores were seen in patients with RA, SLE, vasculitis, polymyalgia rheumatica (PMR), spondyloarthropathy (SpA), and gout (2.2-2.8), while highest mean DOCDAM was seen in OA (4.9) and DOCSTR in FM (6.2) (Table). However, in RA, mean DOCDAM was 3.7 vs 2.4 for DOCINF. DOCDAM also was almost as high or higher than DOCINF in SLE, SpA, vasculitis, and gout. Mean estimates of distress were also ≥ 1.5 in patients with all inflammatory diagnoses.

Diagnosis (per ICD code)	N (%)	Global Estimates (0-10)				
		PATGL	DOCGL	DOCINF	DOCDAM	DOCSTR
RA	64	4.9 (2.9)	4.5 (2.4)	2.4 (2.2)	3.7 (2.8)	1.9 (2.7)
SLE	47	4.1 (3.1)	3.7 (2.8)	2.2 (2.4)	1.5 (1.7)	1.8 (2.5)
SpA and psoriatic arthritis	34	4.1 (2.9)	3.9 (2.4)	2.4 (2.5)	2.7 (2.3)	1.9 (2.8)
Vasculitis and PMR	23	3.6 (2.6)	3.4 (3.0)	2.6 (1.8)	2.3 (2.2)	1.7 (2.6)
Gout	21	4.4 (2.9)	4.2 (2.7)	2.8 (2.5)	3.2 (2.8)	1.5 (1.9)
Osteoarthritis	135	5.8 (2.9)	4.9 (2.2)	1.2 (1.9)	4.9 (2.5)	2.2 (2.7)
Fibromyalgia	84	6.5 (2.6)	5.2 (2.2)	0.9 (1.2)	1.7 (2.0)	6.2 (2.6)
Other diagnosis	155	4.0 (3.0)	3.2 (2.2)	1.6 (2.0)	2.4 (2.3)	1.6 (2.1)
TOTAL	563	4.8 (3.0)	3.9 (2.4)	1.6 (2.0)	2.9 (2.5)	2.4 (2.9)

Conclusion: Rheumatologists estimated high levels of damage in patients with RA and other inflammatory rheumatic diseases, similar or higher than inflammation, as well as recognizable distress which may elevate measures such as tender joint count and PATGL. These findings may explain in part low rates of remission and low disease activity noted in RA and other inflammatory diseases, as index scores used to document improvement are not affected by anti-inflammatory therapy. Most rheumatology clinical quantitative measurement is directed to inflammatory activity. However, an estimate of damage and distress may clarify why many patients may appear to have suboptimal control of inflammatory activity despite aggressive treatment, including treat to target in RA.

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