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THU0650

COMPLEMENTARY AND ALTERNATIVE MEDICINE IN RHEUMATOLOGY: A SURVEY OF ITS USE FOR COMMON RHEUMATOLOGICAL CONDITIONS AMONG MULTI-ETHNIC PATIENTS IN LEICESTERSHIRE

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Background: The use of complementary and alternative medicine (CAM) is common in patients with chronic disease.¹ However, the usage of CAMs among patients with rheumatological conditions has been understudied. A significant proportion of primary care trusts are now providing therapies such as acupuncture and osteopathy to some of the 9 million users of CAMs in the United Kingdom (UK).² As the NHS serves a varied patient populace, it is important to appreciate the perceptions and utilisation of CAM amongst multi-ethnic groups.

Objectives:

1. To identify the different types CAMs utilised by Rheumatology patients.
2. To identify Rheumatology patients' views towards the role and use of CAMs in managing their condition(s).
3. To identify locations where patients receive CAM and to determine patient's spending practices.

Methods: A cross-sectional survey on CAMs, and its use for common rheumatological conditions was conducted among multi-ethnic patients in Leicestershire, UK, through convenience sampling. The initial questionnaire was created by a multi-disciplinary input, with a patient-centred focus. Thereafter 10 questionnaires were piloted and revised accordingly. The data subsequently underwent statistical analyses.

Results: A total of 107 patients completed the survey over a 3-month period with a response rate of 90%. Most of the respondents (91.8%) were over the age of 35 (age range 19 to 78 years, mean age 50.512.8SD). Among the respondents, 66% were women and 34% were men. 72.9% were of white British or European ethnicity and 20.6% of South Asian ethnicity (17.8% Indian and 2.8% Pakistani). Majority of the patients (66.4%) had rheumatoid arthritis (RA), followed by psoriatic arthritis (11.2%) and ankylosing spondylitis (4.7%). The respondent demographics were consistent with known epidemiology of common rheumatological conditions, with a higher prevalence among women than in men (female-to-male ratio of 3:1 in RA).

31.8% used CAM for managing symptoms related to their condition(s). Almost half of these respondents (41.2%) used CAM products and/or practices daily, with up to 64.7% spending between £10- £100. The majority of respondents (82.4%) received CAM therapy within the UK, followed by India (17.6%). Commonly used CAM products include: ginger (35.3%), fish oil supplements (32.4%), turmeric (32.4%) and cannabidiol (CBD) oil (23.5%). The most common CAM therapies were acupuncture (44.1%), yoga (14.7%), chiropractic (14.7%), meditation (2.9%) and stretch-fit (2.9%). Many respondents (64.7%) used more than one product and/or practice. 60% of the respondents that used CAMs had RA. 9 out of 34 (26.5%) respondents found CAM therapies to be beneficial for their condition(s), with seven (20.6%) finding it to be useful for pain control/relief. Up to 17.8% of all respondents, including those with no prior experience of CAM, perceived potential benefits. However, 65.4% reported neutral views towards CAM.

Conclusion: In our local multi-ethnic population, it is evident that a notable proportion of patients have utilised CAM to supplement the management of their condition. Healthcare professionals need to be aware of the CAMs available, particularly when informing and treating their patients. Effective communication is required in this area to maintain patient's confidence and safety. Further qualitative research should consider the reasons for the use of CAMs.

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THU0651

AN INDIVIDUALIZED DECISION-AID FOR DIVERSE WOMEN WITH LUPUS NEPHRITIS (IDEA-WON): A RANDOMIZED CONTROLLED TRIAL

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Background: Medication decision-making is challenging in lupus. No validated, effective decision-aids are available to assist patients with medication decision-making.

Objectives: Our objective was to assess the effectiveness of an individualized, culturally-tailored, computerized decision-aid for immunosuppressive medications for lupus nephritis.

Methods: In a multicenter, randomized controlled trial, diverse adult women with lupus nephritis, largely racial/ethnic minorities with low socioeconomic status, were randomized to decision-aid vs. American College of Rheumatology lupus pamphlet (1:1 ratio). Co-primary outcomes were change in decisional conflict and informed choice regarding immunosuppressive medications.

Results: Of 301 randomized women, 47% were African-American, 26% were Hispanic, and 15% White. Mean age (standard deviation [SD]) was 37 (12) years, 57% had annual income of <\$40,000, and 36% had a high-school education or less. Compared to the pamphlet (n=147), participants randomized to the decision-aid (n=151) had: (1) a clinically meaningful and statistically significant larger decrease in decisional conflict, 21.8 (standard error [SE], 2.5) vs. 12.7 (SE, 2.0; p=0.005); and (2) a clinically meaningful difference in informed choice, statistically non-significant in the main analysis, 41% vs. 31% (p=0.08), but significant in sensitivity analysis (net values for immunosuppressives positive [in favor] vs. negative [against]), 50% vs 35% (p = 0.006). Respectively, unresolved decisional conflict post-intervention was significantly lower, 22% vs. 44% (p<0.001). Significantly more patients in decision-aid vs. pamphlet group rated information to be excellent for understanding lupus nephritis (49% vs. 33%), risk factors (43% vs. 27%), medication options (50% vs. 33%; p≤0.003 for all); and the ease of use of materials higher (51% vs. 38%; p=0.006).

Conclusion: An individualized decision-aid was effective in reducing decisional conflict for immunosuppressive medications in diverse women with lupus nephritis.

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THU0652

THE ECONOMIC BURDEN OF ANCA-ASSOCIATED VASCULITIS IN GERMANY – A CLAIMS DATA STUDY

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Background: ANCA-associated vasculitis AAV is a rare systemic disease, characterized by recurrent episodes of systemic inflammation. It is a severe disease associated with hospitalization, risk of renal failure and a therapy inducing serious side effects. The economic impact of AAV to the German health care system is currently not well understood.

Objectives: The aim of this study was to better understand and quantify the economic burden of AAV in Germany. Therefore, selected aspects, such as prevalence and incidence, frequency of hospitalization, frequency of intensive care unit (ICU) stays and treatments costs, were systematically assessed in a claims data study.

Methods: Longitudinal data from years 2013 to 2016, provided by German statutory health insurance (SHI) companies from the InGef database have been analyzed representing an age- and gender stratified cohort of approx. 4 million insured persons representative for the German population.

Results: Prevalence and incidence data show that, in accordance with the previously published literature (1, 2), Granulomatosis with Polyangiitis (GPA) was more frequent than Microscopic Polyangiitis (MPA). On average, a combined prevalence of 256 : 1 000 000 (210 : 1 000 000 for GPA and 46 : 1 000 000 for MPA) was identified within the data set over the observed time period of 4 years (2013-2016). Incidence rates were found to be 46 : 1 000 000 (34 : 1 000 000 for GPA and 13 : 1 000 000 for MPA) within the same time period. Over the observed time period, prevalence and incidence rates remained stable.

The majority of AAV (GPA and MPA) diagnoses were made in hospitals (61%), another 24% were diagnosed in the outpatient sector and 15% were diagnosed in both within one quarter. In total, 97% of newly diagnosed patients (GPA and MPA) were hospitalized within 4 years post diagnosis. Especially during the induction period (quarter of diagnosis and the following 2 quarters) 91% (GPA) to 95% (MPA) of the patients were hospitalized. Of these patients, approx. 60% were hospitalized due to GPA and MPA disease, showing the high rate of severe co-morbidities. Patients diagnosed with GPA and MPA were frequently treated at ICUs (in average 1 stay per quarter); in particular severe infections and renal involvements increased the likelihood of ICU stays.

Treatment costs were highest during the induction period; within this period hospitalization represented the largest cost factor. Severe kidney disease, which occurred in 11,6% of GPA and 24,3% of MPA patients, induced total costs ranging between 131.521€ (GPA) to 145.472 € (MPA) over four years post diagnosis, with the induction period being most expensive (approx. 58.826 € to 50.339 € for GPA and MPA during the induction period). In the following years total treatment and hospital costs decreased, however remained high.

Conclusion: AAV represents an underestimated financial burden to the German healthcare system, especially during induction therapy. The high level of hospitalizations amongst AAV patients also represents a high usage of healthcare resources. Thus, AAV represents an underestimated cost factor for the German health care system, and better treatment options are desperately needed.

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THU0653

SOCIOECONOMIC ANALYSIS OF GOLIMUMAB TREATMENT IN PATIENTS WITH RA, PSA, AND AS – NON-INTERVENTIONAL STUDY GO-NICE

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Background: Rheumatic diseases are associated with pain, loss of functionality, fatigue, hospitalization, sick leave, and work disability. This results in high economic burden for patients and society.

Objectives: Golimumab (GLM) is an effective but costly treatment option for patients (pts.) with moderate to severe, active rheumatic diseases. The aim of this analysis of the GO-NICE study was to investigate the direct and indirect costs of healthcare utilization and sick leave after starting a treatment with GLM.

Methods: Data of outpatients collected in the non-observational study GO-NICE in 1,483 pts. with RA (n = 474), PsA (n=501), and AS (n=483) in 158 sites (2010-2015) in Germany were analysed. Details on the study design, pts. characteristics, the clinical and patient-reported outcomes, and safety data have been reported earlier [1,2].

Direct medical and indirect costs per patient and year were calculated for consultations, physiotherapy, massages, hospitalisations and inpatient rehabilitation, medication (DMARDs, Glucocorticoids, NSAIDs, and biologics) as well as sick leave days. Findings were shown for RA-, PsA- and AS-pts. and categorised by biological-naïve pts. and pts. with a pre-treatment with a biologic. The 6-month periods prior baseline (BL)/start of a GLM therapy vs. month 24 (M24) were compared.

For this calculation the standardized evaluation rates were used (Bock et al. (2015), AG MEG of the DGSM (2005). Costs for prescribed and documented medication were calculated by the mean cost per defined daily dose (based 2010-2015). Indirect costs were estimated through the human capital approach (HCA).

Results: Data of 758 biologic-naïve pts. (n = 265 RA, 247 PsA and 246 AS) and 694 pts. with biologics as pre-therapy (n = 208 RA, 252 PsA and 234 AS) were included in the analysis.

Direct medical costs (excl. medication) decreased in all 6 groups, min. 765€ (PsA pre-treatment group) and max. 2,426€ (AS pre-treatment) as well as the costs due to work disability/absenteeism, min. 855€ (PsA pre-treatment) and max. 2,564€ (RA pre-treatment, table). Total costs in biological-naïve pts. increased due to the additional expense of the biologic agent.

Absolute changes in costs totalled 15,665€ (RA-, table), 15,799€ (PsA-) and 14,764€ (AS-patients) per patient and year when comparing the BL vs. M24 periods.

Total savings of 6,289€ (RA-, table), 2,617€ (PsA-), and 5,555€ (AS-patients) per patient and year were generated in the group of biologic-pre-treated patients.

	RA pts. biologic-naïve (n=265)			RA pts. with biologics as pre-treatment (n=208)		
	Baseline	Month 24	Changes	Baseline	Month 24	Changes
Consultation fees/€	354	168	- 186	369	178	- 191
Physiotherapy, massages etc./€	162	59	- 103	144	91	- 53
Hospitalisation/€	939	99	- 840	1,163	423	- 740
Rehabilitation measures/€	163	55	- 109	148	0	- 148
(in- and outpatients)						