treatment. BRASS Registry will be important to enhance research and to develop public health planning.

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THU0695 DIFFERENCES OF LIFESTYLE HABITS OF SMOKING, DRINKING ALCOHOL AND CAFFEINATED COFFEE CONSUMPTION BETWEEN RHEUMATOID ARTHRITIS PATIENTS AND HEALTHY CONTROL – TOMORROW STUDY-

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Background: Previous reports indicated the strong association between smoking and onset of rheumatoid arthritis (RA), and relation between some of lifestyle habit and disease activity of RA.

Objectives: In this study, we compared differences in habits of smoking, alcohol consumption, coffee and Japanese tea intake between RA patients and healthy volunteers (Vo) in the same study population.

Methods: This study was conducted based on baseline data from ongoing 10-years prospective cohort project TOMORROW study (UMIN000003876), which includes age and sex matched RA patients (n=208) and Vo (n=205). Data on smoking history and alcohol (Alc), coffee and Japanese tea intake were collected by self-reported questionnaires. Alc intake was categorized into 3 groups by calculating the amount per day using Alc unit (pure Alc 20 mg/Alc unit). We also categorized frequency of Alc intake per week into 3 groups, number of cups of coffee and Japanese tea intake per day into 4 groups each. The data of RA patients included anthropometric, blood test data, disease activity score28-ESR (DAS28-ESR), together with baseline characteristics. Using logistic multivariate regression lifestyle habits were compared between RA and Vo.

Results: We analyzed 191 Vo and 198 RA with complete data about lifestyle habits. Demographic data and lifestyle habits of RA and Vo were shown in the Table 1 and 2. In RA patients, the average disease activity score 28-ESR (DAS28-ESR) was 3.49±1.34 and disease duration was 13.9±11.8 years. In multivariate analysis, smoking history (OR 5.03, 95% CI 1.42-17.9; p=0.04), 2 - 6 unit of Alc intake per day (OR 0.20, 95%CI 0.04-0.96; p=0.04) and 0 - 1 cup of caffeinated coffee intake per day (OR 0.26, 95%CI 0.07-0.91; p=0.04) were significantly different between RA and Vo. However, there were no significant difference in Alc frequency, decaffeinated coffee and Japanese tea intake.

Conclusion: As shown in previous reports, the smoking history was significantly higher in RA patients with an odds ratio of 5.03. And moderate intake of Alc and caffeinated coffee seems to be low in RA patients.

Table 1. Demographic data of rheumatoid arthritis patients (RA) and healthy volunteer (Vo).

	RA (N=198)	Vo (N=191)	p.value*
Age	58.4±12.6	57.0±13.2	0.28
Sex female	167 (84.3)	158 (82.7)	0.68
BMI	22.7±3.64	22.6±3.20	0.72
Disease duration (year)	13.9±11.8		
ACPA positivity	166 (83.8)		
RF positivity	136 (68.7)		
DAS28-ESR	3.49±1.34		
mHAQ	0.47±0.59		
Methotrexate dose (mg/week)	6.54±3.76		
bDMARDs use	104 (54.5)		

Values are mean±SD, or n (%). *Student-T-test and Fisher's exact test for RA and Vo.

BMI, body mass index; Alc, alcohol; mHAQ, modified Health Assessment Questionnaire; bDMARDs, biologic disease modified anti-rheumatic-drugs.

Table 2. Lifestyle habits of rheumatoid arthritis patients (RA) and healthy volunteer (Vo).

	RA (N=198)	Vo (N=191)	p.value*
Smoking history	59 (29.8)	29 (15.2)	<0.01
Alc frequency (/week)			0.17
0	94 (47.5)	76 (39.8)	
1-5	77 (38.9)	77 (40.3)	
6-	27 (13.6)	38 (19.9)	
Alc (unit/day)			0.09
-2	147 (74.2)	125 (65.4)	
2-6	21 (10.6)	34 (17.8)	
6-	30 (15.2)	32 (16.8)	
Caffeinated coffee (cup/day)			0.19
0	45 (22.7)	27 (14.1)	
0-1	67 (33.8)	71 (37.2)	
1-4	69 (34.8)	75 (39.3)	
4-	17 (8.6)	18 (9.4)	
Decaffeinated coffee(cup/day)			0.14
0	188 (94.9)	188 (98.4)	
0-1	8 (4.0)	3 (1.6)	
1-4	2 (1.0)	0 (0.0)	
4-	0 (0.0)	0 (0.0)	
Japanese tea (cup/day)			0.43
0	18 (9.1)	17 (8.9)	
0-1	42 (21.2)	53 (27.7)	
1-4	66 (33.3)	63 (33.0)	
4-	72 (36.4)	58 (30.4)	

Values are n (%). *Fisher's exact test for RA and Vo.

Alc, alcohol.

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HPR Service developments, innovation and economics in healthcare

THU0696-HPR TRANSITION READINESS ASSESSMENT TOOLS (TRAT): A PRELIMINARY SINGLE-CENTRE PAEDIATRIC RHEUMATOLOGY TRANSITION PROGRAMME (PRTP) EXPERIENCE AND OUTCOMES IN SINGAPORE

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Background: Majority of childhood onset rheumatic diseases often continue into adulthood. Care for these youth especially during their transition from child centred to adult oriented healthcare system is crucial and challenging. The Paediatric Rheumatology Transition Programme at KK Women's and Children's Hospital (KKH) in Singapore was developed in 2016. In 2017, we have adopted the American College of Rheumatology Transition Readiness assessment tools (TRAT) with modification to assess the readiness of our paediatric rheumatology patient cohort.

Objectives: To assess factors contributing to the outcomes of Paediatric Rheumatology Transition Programme at our institute using the Transition Readiness Assessment Tools (TRAT)

Methods: The TRAT composed of 4 components – transition-importance, transition-confidence, medical knowledge/healthcare usage (MKHU-23 questions), transition-readiness assessment questionnaires (TRAQ, 5 domains – medicine management (MM), appointment management (AM), health issue tracking (HT), communications with providers (CP) and daily activity management (DAM)). Each component score was computed into 0-10 (scores >7 defined acceptable responses). Nonparametric statistics were used to describe and analyse the data.

Results: 106 patients (52.8% female) with SLE(42.5%) and JIA(50.0%) with median age of 20.0 (18.8-20.6) years were recruited. Median