mandatory pharmacovigilance by professionals and patients. As per law (2) and professional ethics, patient preference and right to informed consent must prevail.

- Self-assessment surveys, and patient reported outcomes using studies, should be encouraged. These are facilitated by new information technologies practices and devices.

Conclusion: The information tool will be proposed in the form of an information letter to be remitted by professionals to patient when biosimilar prescription or initiation is planned. The process includes:

- creation of document by expert patients
- user testing of tool (assessment about understandability and usefulness), in hospital departments, patient groups and on-line
- knowledge assessment and opinion gathering among patients about biosimilars.

REFERENCES:

- According to its current by-laws, AFLAR board consists of at least 2/3 of persons affected with/concerned by rheumatic diseases, and/or presidents of affiliated patient associations.
- Articles L1111-2 and L2002-303 Code de Santé Publique

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How to perform low-budget high-quality research

OP0014

NO ASSOCIATION BETWEEN THE PROPORTION OF ELDERLY PEOPLE AND TRIAL RETENTION IN RHEUMATOID ARTHRITIS AND OSTEOARTHRITIS TRIALS: A SYSTEMATIC REVIEW WITH META-REGRESSION ANALYSES

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Background: The elderly (defined by an age of ≥ 65 years) are underrepresented in current rheumatoid arthritis (RA) and osteoarthritis (OA) trials.¹ This is partly due to age-related exclusion criteria. Investigators might be reluctant to include more elderly people because they fear reduced trial retention.

Objectives: To evaluate whether the proportion of included elderly individuals (PE) is associated with trial retention in current RA and OA trials.

Methods: This study is registered with protocols.io (dx.doi.org/10.17504/protocols.io.uhaet2e). In our previous study,¹ two systematic searches in MEDLINE had yielded randomized controlled trials (RCTs) in rheumatoid arthritis (RA) and osteoarthritis (OA) on any intervention published in 2016 and 2017. Here we included all trials reporting data on retention. We either extracted the PE from the research manuscript or estimated it from an assumed (truncated) normal distribution. We coded retention into proportional effect sizes (logit-transformed for analysis and back-transformed for reporting). Subsequently, multiple mixed effects meta-regression models with several covariates assessed whether there is an association between the PE and trial retention. Sensitivity analyses evaluated whether associations were connected to attrition due to lack of efficacy (LoE) or adverse events (AE).

Results: 243 RCTs comprising 48,288 participants were deemed eligible, and 227 RCTs provided complete data on overall retention and all covariates. Pooled trial retention (random effects) was 88% (95%-CI 87% to 90%; $I^2 = 90\%$). The PE was not associated with trial retention in the unadjusted (slope $\beta = 0.0$ [-0.0 to 0.0]; $p = 0.97$; **Figure 1**), or any protocolized adjusted model (p -values depending on the adjustment: 0.14 to 0.90). Of all included covariates, only study duration (longer study duration being associated with inferior retention: $p < 0.001$) and the type of intervention (surgical interventions averaging the highest retention; psychological interventions averaging the lowest retention: $p < 0.001$) were associated with trial retention. Post hoc analyses allowing for interaction revealed a small statistically significant association between the PE and trial retention in pharmacological (retention increasing with the PE) and physical/physiotherapeutic (retention decreasing with the PE) interventions. Further sensitivity analyses showed no significant associations between attrition due to LoE or AE and the PE in any model.

Conclusion: Trial retention in RA and OA trials is very high, and unaffected by the proportion of elderly.

Figure 1. Bubble plot of trial retention against the proportion of elderly people. The size of each bubble is inversely proportional to the standard error.

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