successful cooperation with target institutions in Serbia in the next years. We would like to improve the cooperation with medical faculties and become a part educational program. And the PEP was the best way to achieve this aim

Objectives: The aims of this knowledge transfer programme were for us to:

1. Fundraising

- Learn how to gather more voluntary contributions of money and other resources. Following the knowledge transfer visits we will organise a seminar to disseminate information with the representatives of all our branches. After the seminar our activists will have been trained to collect money for different activities. Those activities will attract more members and provide better life for people with RMDs.

2. Patient Expert Program

- Implement the Patient Expert Program. The implementation of this program would strengthen the connections with medical institutions, provide first-hand knowledge for future doctors, provide better care for RMDs patients in the future. The PEP will allow the organization to collaborate closer with the universities, the doctors, researchers, health professionals.

3. Cooperation among sister organisations

Develop strong relationships with the sisters EULAR organisations.

Methods: From 4th September – 8th September 2018 we visited Swedish Rheumatism Association in Stockholm in order to gain insight into the structure and activities of their association.

From 14th October-16th October 2019 Swedish delegation (president, two trainers and secretary) visited Serbian association for rheumatic diseases. It was organized the two-days PEP training as well as the visits to relevant institutions.

From 23th January-26th January 2020 two trainers from Sweden came to Serbia in order to hold the exams.

Results: Association of Rheumatic Diseases Patients of the Republic of Serbia now has six Patient Experts for RA. They will be involved in the education of future doctors through the lectures within the subject Intern Medicine.

ORS improved cooperation with Faculty of Medicine in Belgrade, as well as, with Ministry of Health.

Conclusion:

- We achieve to have six Patient Experts. Unofficially right now we have confirmation how they will be included in the education of future doctors through the lectures within the subject Intern Medicine in next school year at the Belgrade University
- We reduced contribution of the pharmaceutical companies of our income for 10% to our budget.
- We increased donations from personal donors In past year.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.4864

OP0261-PARE BIOSIMILAR SWITCHING PROCESS - UK PATIENTS' EXPERIENCE STUDY

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Background: The introduction of 4 adalimumab biosimilars was challenging for the health service and patients alike. A group of patient organisations representing rheumatology, dermatology and gastroenterology patients worked with NHS England in producing materials for disseminating information to prescribers and patients to ensure smooth and appropriate transition to biosimilar products from the originator product as appropriate. These patient groups wanted to know how the 'switch' process was implemented and if shared decision making was practiced.

Objectives: To gather patient feedback on biosimilar switch process and report findings back to NHS England as well as provide the patient organisations information to develop any future resources to help improve patient and physician shared decision making.

Methods: A working group of the 4 organisations collaborated on designing an online survey asking questions around how the individual was communicated with regarding their treatment being switched to a biosimilar; was there any choice or perceived input into the decision making process; how queries or issues were handled and overall satisfaction on how the individual felt their personal preferences/needs were met.

Results: 899 useable responses were gathered representing 52% Rheumatology patients; 42% Gastroenterology patients and 5% Dermatology patients with remaining 1% more complex specialties. More than half of patients were not asked for their consent before their treatment was switched to a biosimilar of adalimumab with only 40% giving consent 7% couldn't remember or were unsure if consent was given. 75% were not at all satisfied or not satisfied with the ability to decline being switched with only 12% feeling that they had been given an option to decline being switched.

Conclusion: Shared Decision Making (SDM) needs to be put into action not just words. There is a clear majority that are dissatisfied with the communication they had prior to the switch and are very dissatisfied with the lack of patient engagement in the decision-making process. NRAS, NASS, Crohn's & Colitis UK and the Psoriasis Association will continue to collaborate with NHS England and other stakeholders as appropriate to make Shared Decision Making a reality not just rhetoric.

Acknowledgments: National Axial Spondyloarthritis Society UK; Crohns' & Colitis UK;

Psoriasis Association, UK; National Rheumatoid Arthritis Society

Disclosure of Interests: Clare Jacklin Grant/research support from: NRAS has received grants from pharmaceutical companies to carry out a number of projects. Consultant of: I have been paid a speakers fee to participate in advisory boards, in house training of staff and health professional training opportunities, Speakers bureau: Various pharma companies, Ailsa Bosworth Speakers bureau: a number of pharmaceutical companies for reasons of inhouse training, advisory boards etc.

DOI: 10.1136/annrheumdis-2020-eular.2362

Disease consequences

OP0262-HPR COST OF ILLNESS IN PATIENTS WITH PSORIASIS AND PSORIATIC ARTHRITIS. COEPSO STUDY

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Background: Psoriasis (Ps) and psoriatic arthritis (PsA) have a major impact on patients' health-related quality of life. Cost of illness of patients with Ps, PsA and both diseases (PsA+Ps) is an important subject as they are associated with a substantial economic impact, with implications from a health management perspective.

Objectives: To describe the economic burden of direct non-healthcare and indirect resources of patients with Ps, PsA and PsA+Ps in Spain.

Methods: COEPSO ("Evaluation of Costs in patients with Psoriatic Disease") was an observational, retrospective, cross-sectional study performed in 22 Spanish centers (17 Dermatology and 14 Rheumatology Services), from February 2017 to February 2018, including moderate to severe Ps and PsA patients (with or without Ps), naive to biologics. Direct non-healthcare (social services, home care, physical adaptations, private health and non-health professionals, non-reimbursed and non-pharmaceutical therapies), indirect (loss of productivity) and total costs (direct non-healthcare and indirect costs) related to the disease during the previous year to the study were obtained. Unitary costs (€, 2018) were calculated: out-of-pocket costs were specified directly by patients and loss of productivity costs by means of average salaries based on occupation specified by patients. The information was collected through a case report form filled out by the investigators and a telephone survey administered to the patients.

Results: A total of 318 patients were included (196 Ps; 43 PsA and 79 PsA+Ps), mean age 48.7 years and 51.3% males. Metabolic syndrome was the most frequent comorbidity in all groups. The average annual total cost per patient was 1,042.71€ (SD 3,817.55), 1,137.84€ (SD 3,070.39) and 1,830.26€ (SD 5,835.81) for Ps, PsA and PsA+Ps, respectively. The average annual direct non-healthcare cost per patient was 749.57€ (SD 2,393.77), 750.50€ (SD 1,641.82) and 1,247.56€ (SD 4,467.19) for Ps, PsA and PsA+Ps, respectively. The average annual indirect cost per patient was 293.14€ (SD 2,855.27), 387.35€ (SD 2,409.63) and 582.71€ (SD 3,842.12) for Ps, PsA and PsA+Ps, respectively. Patients with combined PsA+Ps had higher annual total cost (direct non-healthcare and indirect costs) than patients with only one of these manifestations separately (75.5% and 60.9% above patients with Ps and PsA, respectively). Total costs in patients with Ps and PsA were similar. Direct non-healthcare costs represent between 66.0% (patients with PsA) to 71.9% (patients with Ps) of total cost. Indirect costs represent between 28.1% (patients with Ps) to 34.0% (patients with PsA) of total cost.

Conclusion: PsA and Ps have proved to be diseases with a high economic burden, and the total costs were mainly driven by direct non-healthcare costs. Moreover, although annual total costs in patients with PsA were similar to those of Ps patients, the combination of both manifestations yielded the highest costs suggesting the importance of the increased disease load.

Disclosure of Interests: Santos Castañeda: None declared, Esther Vicente Speakers bureau: BMS, Roche., Mar Llamas Velasco: None declared, Javier Sanchez Perez: None declared, José Pardo: None declared, Rita Cabeza-Martínez: None declared, Mercedes Miranda-Fontes: None declared, Juan Márquez: None declared, Jaime Calvo Grant/research support from: Lilly, UCB, Consultant of: Abbvie, Janssen, Celgene, susana armesto: None declared, Isabel Belinchón: None declared, Alejandro Gómez: None declared, María Dolores Miranda: None declared, Silvia Martínez Pardo: None declared, Leticia Merino-Meléndez: None declared, Miguel Angel Casado Consultant of: UCB Pharma, María Yébenes: None declared, Araceli Casado: None declared

DOI: 10.1136/annrheumdis-2020-eular.3298

OP0263-HPR MAJOR STRESSORS IN THE YEAR PRIOR TO RA DIAGNOSIS: IMPACT ON PATIENT-REPORTED OUTCOMES ONE YEAR LATER

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Background: Stress is implicated in RA onset and poorer prognoses through changes in neuro-endocrine and autoimmune function. Although many people with RA link disease onset to recent stressful life events, results from retrospective studies are unclear.

Objectives: To describe the incidence of major stressors (+STRESS) in year prior to diagnosis and compare characteristics and patient-reported outcomes (PROs) of newly diagnosed RA patients with and without +STRESS at 0 and 12 months.

Methods: Data were from early RA patients (symptoms <1 yr) enrolled in the Canadian Early Arthritis Cohort (CATCH) from 2007-17 who met 1987/2010 ACR/EULAR criteria and had ≥12 months of follow-up. Patients reported major psychological (death, divorce/separation, family, financial, other) and physical (motor vehicle accident, surgery, major illness/infection, other) stressors in previous year. We used independent t-tests and chi square to compare characteristics by stressors at baseline, and multivariable regression to examine the impact of +STRESS on disease activity and PROs at 1 year, adjusting for age, sex, education, fibromyalgia, and SJC.

Results: The 1933 adults were mostly female (72%), with a mean (SD) age of 55 (15) years. 52% reported 1+ stressors in previous year; family (48%), financial stress (36%), death (35%), surgery (28%), and major illness (26%) were the most common stressors. Patients with +STRESS were more likely to be women, younger, have more comorbidities including fibromyalgia, and higher mean DAS28. Patients with +STRESS also had significantly higher mean pain, fatigue, depression, sleep disturbance, patient global, and HAQ scores at baseline. At 1 year, SJC and the proportion in DAS28 REM was similar between groups. However, PROs (pain, HAQ, Fatigue, Pt Global, Depression, Poor Sleep) remained higher in +STRESS, with evidence of an additive effect for number of stressors and having both physical and psychological stressors (Table). The greatest impacts were on mood, sleep disturbance, and fatigue.

Conclusion: In this pan-Canadian early RA cohort, more than half reported 1+ stressful life events in the year prior to diagnosis. Individuals reporting major stressors had significantly worse pain, patient global, disability, depression, fatigue, and sleep disturbance at diagnosis; 1 year later, though disease activity was similar between groups, the effects of +STRESS on PROs persisted. Early RA patients with recent major stressors may benefit from emotional support and stress reduction to optimize how they feel and function.

Mean (SD) or N (%)	No Stress (N=928; 48%)	Physical (N=131; 7%)	Psychological (N=658; 34%)	Both (N=216; 11%)
Age	56 (15)	56 (15)	53 (14)	52 (15)
Women	622 (67%)	82 (63%)	512 (78%)	174 (81%)
College Education	464 (50%)	76 (58%)	345 (52%)	126 (58%)
Rheum Dis Comorbid Index	1.1 (1.2)	1.4 (1.4)	1.1 (1.3)	1.4 (1.3)
OA or Spinal pain	168 (18%)	35 (27%)	117 (18%)	55 (25%)
Fibromyalgia diagnosis	15 (2%)	2 (2%)	13 (2%)	11 (5%)
Symptom duration (months)	5.6 (3.0)	5.7 (3.0)	5.9 (3.0)	5.9 (3.0)

Mean (SD) or N (%)	No Stress (N=928; 48%)	Physical (N=131; 7%)	Psychological (N=658; 34%)	Both (N=216; 11%)
DAS28 – mean	5.0 (1.4)	5.1 (1.5)	5.0 (1.5)	5.2 (1.4)
MTX ±csDMARDs	679 (73%)	100 (76%)	489 (74%)	166 (77%)
Oral Steroids	295 (32%)	40 (31%)	215 (33%)	55 (25%)
Pain (0-10)	5.3 (2.8)	5.5 (2.9)	5.7 (2.8)	6.2 (2.8)
HAQ-DI	1.0 (0.7)	1.2 (0.7)	1.1 (0.7)	1.3 (0.7)
Fatigue (0-10)	4.7 (3.1)	5.0 (3.0)	5.7 (2.9)	5.9 (2.9)
Patient Global (0-10)	5.6 (2.9)	6.0 (2.9)	6.0 (2.9)	6.4 (3.0)
Depression (SF12 MCS < 45.6)	329 (35%)	54 (41%)	356 (54%)	123 (57%)
Poor sleep (0-10)	4.5 (3.4)	4.8 (3.3)	5.3 (3.2)	6.0 (3.1)

Effect of stress in year prior to diagnosis on outcomes at 12 months (N=1933).*

	Pain	Fatigue	Patient Global	Depression	Poor Sleep	HAQ-DI	DAS28 REM	Swollen Joints
Any Stress	0.27 (0.02, 0.53)	0.39 (0.12, 0.66)	0.25 (-0.01, 0.51)	1.55 (1.24, 1.95)	0.49 (0.21, 0.76)	0.05 (-0.01, 0.11)	1.02 (0.82, 1.27)	0.12 (-0.19, 0.42)
Total stressors	0.24 (0.12, 0.37)	0.32 (0.18, 0.45)	0.24 (0.11, 0.37)	1.30 (1.17, 1.45)	0.37 (0.24, 0.51)	0.05 (0.02, 0.08)	1.00 (0.90, 1.12)	0.05 (-0.10, 0.20)
1 (n=928, 48%)	REF	REF	REF	REF	REF	REF	REF	REF
2 (n=575, 30%)	-0.02 (-0.31, 0.28)	0.14 (-0.17, 0.46)	-0.04 (-0.34, 0.26)	1.31 (1.00, 1.71)	0.18 (-0.14, 0.50)	0.00 (-0.07, 0.06)	1.12 (0.87, 1.43)	0.05 (-0.29, 0.42)
3 (n=295, 15%)	0.54 (0.17, 0.92)	0.59 (0.19, 0.99)	0.54 (0.16, 0.92)	1.79 (1.29, 2.48)	0.80 (0.40, 1.20)	0.10 (0.02, 0.18)	0.99 (0.72, 1.35)	0.20 (-0.25, 0.65)
4 (n=88, 5%)	1.06 (0.45, 1.66)	0.73 (0.08, 1.39)	0.81 (0.19, 1.44)	3.10 (1.15, 3.16)	0.72 (0.06, 1.38)	0.18 (0.04, 0.32)	0.90 (0.53, 1.52)	0.23 (-0.50, 0.96)
4+ (n=47, 2%)	0.75 (-0.11, 1.61)	1.78 (0.84, 2.72)	1.02 (0.12, 1.91)	3.45 (1.70, 6.99)	2.10 (1.16, 3.04)	0.19 (0.00, 0.38)	0.46 (0.21, 1.03)	0.03 (-0.99, 1.05)

*Multivariable linear regression coefficient adjusted for age, sex, education, baseline fibromyalgia diagnosis and swollen joints.

Disclosure of Interests: Nicole Andersen: None declared, Orit Schieir: None declared, Marie-France Valois: None declared, Gilles Boire Grant/research support from: Merck Canada (Registry of biologics, Improvement of comorbidity surveillance)

Amgen Canada (CATCH, clinical nurse)

Abbvie (CATCH, clinical nurse)

Pfizer (CATCH, Registry of biologics, Clinical nurse)

Hoffman-LaRoche (CATCH)

UCB Canada (CATCH, Clinical nurse)

BMS (CATCH, Clinical nurse, Observational Study Protocol IM101664. SERO-POSITIVITY IN A LARGE CANADIAN OBSERVATIONAL COHORT)

Janssen (CATCH)

Celgene (Clinical nurse)

Eli Lilly (Registry of biologics, Clinical nurse), Consultant of: Eli Lilly, Janssen, Novartis, Pfizer, Speakers bureau: Merck, BMS, Pfizer, Janet Pope Grant/research support from: AbbVie, Bristol-Myers Squibb, Eli Lilly & Company, Merck, Roche, Seattle Genetics, UCB, Consultant of: AbbVie, Actelion, Amgen, Bayer, Boehringer Ingelheim, Bristol-Myers Squibb, Eicos Sciences, Eli Lilly & Company, Emerald, Gilead Sciences, Inc., Janssen, Merck, Novartis, Pfizer, Roche, Sandoz, Sanofi, UCB, Speakers bureau: UCB, Glen Hazlewood: None declared, Louis Bessette Grant/research support from: AbbVie, Amgen, Bristol-Myers Squibb, Celgene, Eli Lilly, Janssen, Merck, Novartis, Pfizer, Roche, Sanofi, UCB Pharma, Consultant of: AbbVie, Amgen, Bristol-Myers Squibb, Celgene, Eli Lilly, Janssen, Merck, Novartis, Pfizer, Sanofi, Carol Hitchon Grant/research support from: UCB Canada; Pfizer Canada, Diane Tin: None declared, Carter Thorne Consultant of: AbbVie, Centocor, Janssen, Lilly, Medexus/Medac, Pfizer

Speakers bureau: Medexus/Medac, Edward Keystone Grant/research support from: AbbVie, Amgen, Bristol-Myers Squibb, F. Hoffmann-La Roche Inc, Gilead, Janssen Inc, Lilly Pharmaceuticals, Pfizer Pharmaceuticals, Sanofi-Aventis, Consultant of: AbbVie, Amgen, AstraZeneca Pharma, Biotech, Bristol-Myers Squibb Company, Celltrion, Crescendo Bioscience, F. Hoffmann-La Roche Inc, Genentech Inc, Gilead, Janssen Inc, Lilly

Pharmaceuticals, Merck, Pfizer Pharmaceuticals, Sandoz, UCB., Speakers bureau: Amgen, AbbVie, Bristol-Myers Squibb Canada, F. Hoffmann-La Roche Inc., Janssen Inc., Merck, Pfizer Pharmaceuticals, Sanofi Genzyme, UCB, Vivian Bykerk: None declared, Susan J. Bartlett Consultant of: Pfizer, UCB, Lilly, Novartis, Merck, Janssen, AbbVie, Speakers bureau: Pfizer, UCB, Lilly, Novartis, Merck, Janssen, AbbVie

DOI: 10.1136/annrheumdis-2020-eular.4826

OP0264-HPR PERSPECTIVES ON APPROACHES TO PREDICT THE DEVELOPMENT OF RHEUMATOID ARTHRITIS: A QUANTITATIVE ASSESSMENT OF PATIENTS AND THEIR FIRST DEGREE RELATIVES

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Background: There is considerable interest within the medical research community in the identification of individuals at risk of developing rheumatoid arthritis