treat analysis at 52 weeks was 40.8% for the voclosporin arm and 22.5% for the control arm (OR: 2.65; 95% CI: 1.64, 4.27; p< 0.001); therefore, AURORA met its primary endpoint. These findings were consistent with those observed in the previously completed pivotal AURA-LV study. Ethnicity subgroup analysis of RR at 52 weeks noted benefit of VCS in both Hispanic/Latino (VCS 38.6% and control 18.6%, p=0.0062, OR 3.45) and non-Hispanic/Latino patients (VCS 41.8% and control 24.6%, p=0.0045, OR 2.29). The benefits of VCS were also seen for all pre-specified hierarchical secondary endpoints: RR at 24 weeks, partial renal response (PRR) at 24 and 52 weeks, time to achieve UPCR ≤ 0.5, and time to 50% reduction in UPCR. Furthermore, all pre-specified subgroup analyses (age, sex, race, biopsy class, region, and prior MMF use) favored VCS. VCS was well tolerated with no unexpected safety signals. The overall incidence of SAEs were similar in both groups (VCS 20.8% and control 21.3%); with infection most commonly reported (VCS 10.1% and control 11.2%). Overall mortality in the trial was low, with one death in the voclosporin arm and five in the control arm. Additionally, the VCS arm showed no significant decrease at week 52 in eGFR or increase in BP, lipids, or glucose.

Conclusion: The AURORA study met its primary endpoint and VCS was efficacious in Hispanic/Latino ethnicity patients, a difficult to treat group.

Disclosure of Interests: Cristina Arriens Grant/research support from: - BMS: Investigator Initiated Trial Research Funding, GSK: Investigator Initiated Trial Research Funding, Exagen: Research Grant, Consultant of: AstraZeneca (Sci Ad Board Dec 2017), GSK (Sci Ad Board Oct 2018), BMS (Sci Ad Board April 2019), Svetlana Polyakova: None declared, Igor Adzerikho: None declared, Simrat Randhawa Shareholder of: Aurinia Pharmaceuticals, Inc. stock, Employee of: Aurinia Pharmaceuticals, Inc., Neil Solomons Shareholder of: Aurinia Pharmaceuticals, Inc. stock, Employee of: Aurinia Pharmaceuticals.

DOI: 10.1136/annrheumdis-2020-eular.5010

Public health, health services, and health economics in RMDs

OP0278

IDENTIFICATION OF PARAMETERS ASSOCIATED WITH A DIAGNOSTIC DELAY IN AXIAL SPONDYLOARTHRITIS: RESULTS FROM THE EUROPEAN MAP OF AXIAL SPONDYLOARTHRITIS (EMAS)

M. Garrido-Cumbrera[1,2], V. Navarro-Compán[3], C. Bundy[4], R. Mahapatra[5], S. Makri[6], J. Correa-Fernández[1], L. Christen[7], C. J. Delgado-Domínguez[1], D. Poddubnyy[8,9]on behalf of EMAS Working Group. *[1]Health & Territory Research (HTR), Universidad de Sevilla, Sevilla, Spain; [2]Spanish Federation of Spondyloarthritis Associations (CEADE), Madrid, Spain; [3]University Hospital La Paz, IdiPAZ, Madrid, Spain; [4]Cardiff University, Cardiff, United Kingdom; [5]Axial Spondyloarthritis International Federation (ASIF), London, United Kingdom; [6]Cyprus League Against Rheumatism, Nicosia, Cyprus; [7]Novartis Pharma AG, Basel, Switzerland; [8]Charité-Universitätsmedizin Berlin, Berlin, Germany; [9]German Rheumatism Research Centre, Berlin, Germany*

Background: Early diagnosis of Axial Spondyloarthritis (axSpA) is crucial for timely access to specialist care and effective treatment.

Objectives: To assess the current diagnostic delay in axSpA and identify the parameters associated with increased diagnostic delay in a European sample.

Methods: Data from unselected patients participating in the European Map of Axial Spondyloarthritis (EMAS) study through an online survey (2017- 2018) across 13 countries were analysed. Mean differences in diagnostic delay were analysed using Mann-Whitney and Kruskal-Wallis tests, among sociodemographic and disease-related factors. A multivariate linear regression analysis was carried out to identify the relative weight of the associated parameters in determining diagnostic delay.

Results: 2,846 patients participated in EMAS. Mean age was 43.9 years, 61.3% were female, 48.1% had a university degree, and 53.9% were employed. Of the 2846 participants, 2652 provided information for calculating diagnostic delay. Mean age at symptom onset was 26.6 ± 11.1, mean age at diagnosis was 33.7 ± 11.5, and mean diagnostic delay was 7.4 ± 8.4 (Fig. 1). The following variables were associated with longer diagnostic delay in the bivariate analysis: older age, female gender, being diagnosed by a rheumatologist (Table 1). In the multivariate regression analysis younger age at symptom onset, number of HCPs seen before were associated with diagnostic delay (Table 2).

Table 1. Associations between sociodemographic and disease-related variables and diagnostic delay (N: 2,652)

Variable		Diagnostic Delay (years) Mean ± SD	P-value
Age categories	18-34	4.4 ± 5.5	**<0.001**
	35-51	7.9 ± 8.2	
	52-68	9.5 ± 10.2	
	>68	7.3 ± 9.7	
Gender	Male	6.1 ± 7.4	**<0.001**
	Female	8.2 ± 8.9	
Education level	No school completed	8.0 ± 10.7	0.397
	Primary school	7.6 ± 8.9	
	High school	7.6 ± 8.4	
	University	7.3 ± 8.3	
Occupation	Manual worker	6.7 ± 8.3	0.163
	Non-manual worker	7.3 ± 8.4	
Diagnosed by rheumatologist	Yes	7.9 ± 8.7	**<0.001**
	No	5.7 ± 7.3	
HLA-B27	Positive	8.3 ± 8.3	0.775
	Negative	8.7 ± 9.0	
Uveitis (ever)	Yes	8.0 ± 8.3	0.098
	No	7.6 ± 8.4	
IBD (ever)	Yes	7.7 ± 8.7	0.944
	No	7.5 ± 8.5	

Table 2. Regression analysis between sociodemographic and clinical variables in relation to diagnostic delay

Variable	Univariable linear regression		Multivariable stepwise linear regression	
	B	95% CI	B	95% CI
Age at symptoms onset	**-0.289**	**-0.316, -0.262**	**-0.321**	**-0.390, -0.253**
Female gender	**2.099**	**1.442, 2.755**	NA	NA
Employed, Manual worker	-0.604	-1.953, 0.746	NA	NA
Educational status, University	-0.343	-0.986, 0.299	NA	NA
Diagnosed by rheumatologist, Yes	**2.117**	**1.321, 2.913**	NA	NA
Number of HCPs seen before diagnosis	**1.723**	**1.486, 1.960**	**1.258**	**0.739, 1.776**
HLA-B27, Positive	-0.471	-1.347, 0.404	NA	NA
Uveitis (ever), Yes	0.463	-0.392, 1.319	NA	NA
IBD (ever), Yes	0.123	-0.971, 1.217	NA	NA

Conclusion: In this large sample of axSpA patients from 13 different European countries, the average diagnostic delay was more than seven years. The fact that one of the most strongly associated parameters to diagnostic delay was number of HCPs seen before diagnosis suggests the need for urgent action to reduce incorrect referrals to shorten the patient journey to diagnosis across Europe.

Acknowledgments: Funded by Novartis Pharma AG

Disclosure of Interests: Marco Garrido-Cumbrera: None declared, Victoria Navarro-Compán Consultant of: Abbvie, Lilly, Novartis, Pfizer, UCB, Speakers bureau: AbbVie, MSD, Lilly, Novartis, Pfizer, UCB, Christine Bundy Grant/research support from: Has received unrelated honoraria from Abbvie, Celgene, Janssen, Lilly, Novartis, and Pfizer., Raj Mahapatra: None declared, Souzi Makri: None declared, José Correa-Fernández: None declared, Laura Christen: None declared, Carlos

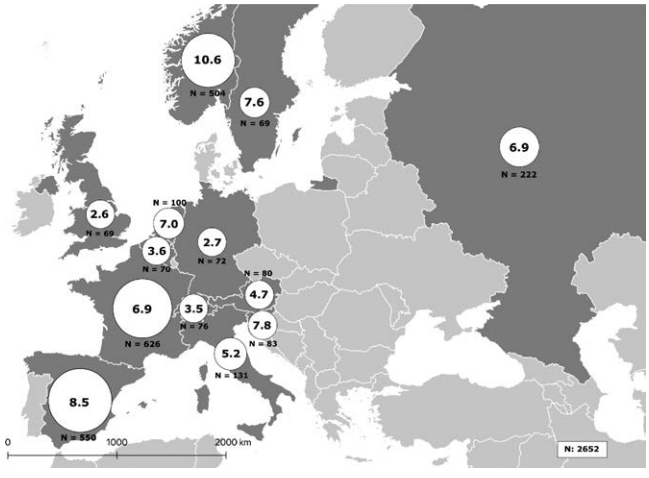

Figure 1. Average years of diagnostic delay across EMAS countries (N: 2,652)

Jesús Delgado-Domínguez: None declared, Denis Poddubnyy Grant/research support from: AbbVie, MSD, Novartis, and Pfizer, Consultant of: AbbVie, Bristol-Myers Squibb, Eli Lilly, MSD, Novartis, Pfizer, Roche, UCB, Speakers bureau: AbbVie, Bristol-Myers Squibb, Eli Lilly, MSD, Novartis, Pfizer, Roche, UCB
DOI: 10.1136/annrheumdis-2020-eular.4221

OP0279 THE IMPACT OF A REFERRAL STRATEGY FOR AXIAL SPONDYLOARTHRITIS: 12 MONTHS FOLLOW-UP OF PATIENT REPORTED OUTCOMES

M. J. Abdelkadir[1], M. Kuijper[1], C. Appels[2], A. Spoorenberg[3], J. Hazes[4], L. Van Hoeven[4], D. Lopes Barreto[1], A. Weel[1,5]. *[1]Maasstadziekenhuis, Rotterdam, Netherlands; [2]Amphia Hospital, Breda, Netherlands; [3]University Medical Center Groningen, Groningen, Netherlands; [4] Erasmus Medical Center, Rotterdam, Netherlands; [5]Erasmus School of Health Policy & Management (ESHPM), Rotterdam, Netherlands*

Background: Early recognition of axial spondyloarthritis (axSpA) patients is difficult for general practitioners within the large amount of chronic low back pain (CLBP) patients[1]. As a result, several referral strategies have been developed to help physicians identify patients at risk for axSpA. Most referral strategies were developed in secondary care patients with no available data on their impact. The only referral strategy that was developed and validated in primary CLBP patients is the Case Finding Axial Spondyloarthritis (CaFaSpA) strategy, but required an impact analysis before implementation in daily clinical practice[2-3].
Objectives: The purpose of this study was to assess the impact of using the CaFaSpA referral strategy on patient reported outcome outcomes (PROs) in primary care patients with CLBP at risk for axSpA.
Methods: A clustered randomized controlled trial was performed in a primary care setting in the Netherlands. (ClinicalTrials.gov Identifier: NCT01944163). Each cluster contained the general practices from a single primary care practice and their included patients. Clusters were randomized to either the intervention (use of CaFaSpA referral strategy) or the control group (usual care). Primary outcome was disability after 12 months. Secondary outcome was quality of life, pain and fatigue after 12 months. A linear mixed-effects model was used to explore the effects over time according to intention to treat analysis.
Results: In total 679 patients were included within 93 GP clusters. Sixty-four percent of our study population were female and mean age was 36 (7.5) years. Overall RMDQ reduced over time both in the intervention and control group (figure 1). The difference in decrease was not statically significant between the groups (p-value 0.81).
EQ-5D increased by 0.03 after 12 months within the intervention group and 0.01 in the control group (not significant) (table 1). The decrease in pain and fatigue did not differ significantly between the intervention and control group.

Table 1. Mean change in PROs after 12 months in the intervention and control group

PROs	Intervention			Usual care		
	Baseline	12 months	p-value	Baseline	12 months	p-value
EQ-5D mean (SD)	0.69 (0.26)	0.72 (0.27)	0.14	0.72 (0.24)	0.73 (0.25)	0.53
VAS-pain mean (SD)	5.03 (2.42)	4.68 (2.69)	0.07	4.96 (2.42)	4.55 (2.69)	0.02
VAS-fatigue mean (SD)	5.19 (2.50)	5.01 (0.21)	0.35	5.23 (2.45)	4.86 (2.73)	0.04

Figure 1. Estimated mean RMDQ scores over time for the overall intervention and usual care group.

Conclusion: Although the functional disability due to pain reduces over time, there was no positive effect by referring based on the CaFaSPA model. Further data on PROMs for the axSpA patients are under investigation.
References:
[1] Jois RN et al. Rheumatology (Oxford) 2008;47:1364-1366.
[2] van Hoeven L et al. PLoS One 2015; 22;10(7):e0131963.
[2] Moons KG et al. Heart 2012;98(9):691-8.
Disclosure of Interests: None declared
DOI: 10.1136/annrheumdis-2020-eular.6090

OP0280 TEMPORAL TRENDS OF OPIOID USE AMONG INCIDENT OSTEOARTHRITIS PATIENTS IN CATALONIA, 2007-2016: A POPULATION-BASED COHORT STUDY

J. Xie[1], A. Turkiewicz[2], G. Collins[3], M. Englund[4], V.Y. Strauss[1], C. Reyes[5], D. Prieto-Alhambra[1]. *[1]University of Oxford, Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences, Oxford, United Kingdom; [2]Lund University, Department of Clinical Sciences Lund, Orthopaedics, Clinical Epidemiology Unit, Lund, Sweden; [3]University of Oxford, Center for Statistics in Medicine, NDORMS, Oxford, United Kingdom; [4] Lund University, Department of Clinical Sciences Lund, Orthopaedics, Clinical Epidemiology Unit Institution, Lund, Sweden; [5]IDIAP Jordi Gol, GREMPAL, Barcelona, Spain*

Background: Opioids are not recommended as first-line treatments for chronic pain management in osteoarthritis (OA), but recent data suggest they are commonly used in routine practice in North America and northern Europe.
Objectives: To characterise the secular trends of opioid and strong opioids use in patients with incident OA from 2007 to 2016, and to explore the impact of patient characteristics on the use of opioid/s for OA.
Methods: Data was obtained from the SIDIAP (The System for the Development of Research in Primary Care) database, which contains primary care records and

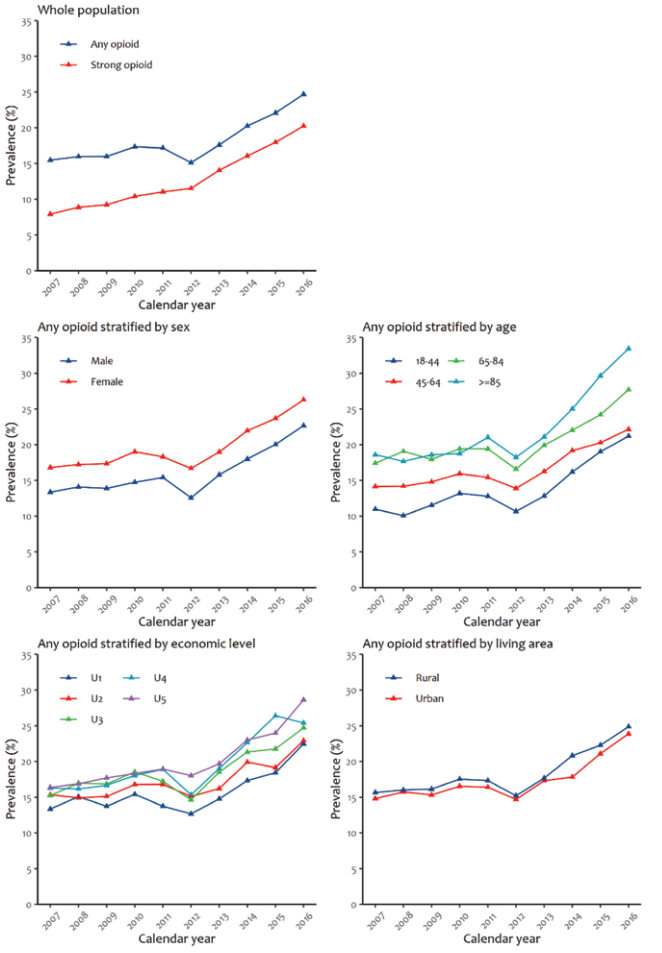

Figure 1. Trends of 1-year prevalence of opioid/s use among incident OA patients, whole and subgroup population.