

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<sup>1</sup>, M. Kuijper<sup>1</sup>, C. Appels<sup>2</sup>, A. Spoorenberg<sup>3</sup>, J. Hazes<sup>4</sup>, L. Van Hoesen<sup>4</sup>, D. Lopes Barreto<sup>1</sup>, A. Weel<sup>1,5</sup>. <sup>1</sup>Maasstadziekenhuis, Rotterdam, Netherlands; <sup>2</sup>Amphia Hospital, Breda, Netherlands; <sup>3</sup>University Medical Center Groningen, Groningen, Netherlands; <sup>4</sup>Erasmus Medical Center, Rotterdam, Netherlands; <sup>5</sup>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<sup>1</sup>. 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<sup>2-3</sup>.

**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.

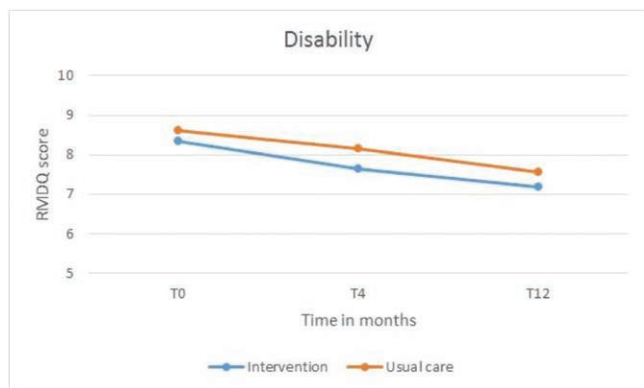
**Methods:** A clustered randomized controlled trial was performed in a primary care setting in the Netherlands. (ClinicalTrials.gov Identifier: NCT01944163). Each cluster contained the general practices from a single primary care practice and their included patients. Clusters were randomized to either 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 Hoesen 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

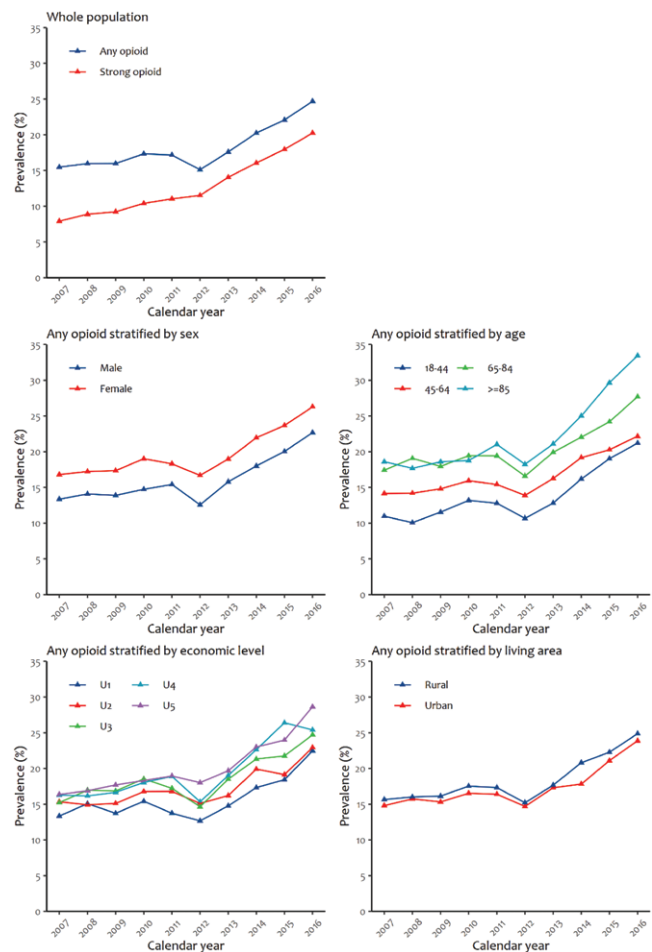
**OP0280 TEMPORAL TRENDS OF OPIOID USE AMONG INCIDENT OSTEOARTHRITIS PATIENTS IN CATALONIA, 2007-2016: A POPULATION-BASED COHORT STUDY**

J. Xie<sup>1</sup>, A. Turkiewicz<sup>2</sup>, G. Collins<sup>3</sup>, M. Englund<sup>4</sup>, V.Y. Strauss<sup>1</sup>, C. Reyes<sup>5</sup>, D. Prieto-Alhambra<sup>1</sup>. <sup>1</sup>University of Oxford, Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences, Oxford, United Kingdom; <sup>2</sup>Lund University, Department of Clinical Sciences Lund, Orthopaedics, Clinical Epidemiology Unit, Lund, Sweden; <sup>3</sup>University of Oxford, Center for Statistics in Medicine, NDORMS, Oxford, United Kingdom; <sup>4</sup>Lund University, Department of Clinical Sciences Lund, Orthopaedics, Clinical Epidemiology Unit Institution, Lund, Sweden; <sup>5</sup>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.

pharmacy dispensing data for 80 % of the population in Catalonia (~ 6 million people). All persons aged 18 or older at the beginning of each calendar year with an incident OA diagnosis (including both peripheral and central joints) in the study period were included. Index date was the date of first OA diagnosis, and the observation period of opioid use was 1-year after index date. Opioids considered included codeine, tramadol, fentanyl, and morphine, with the latter three classified as strong opioids. The period prevalence of any opioid use was estimated in whole and sub-population stratified by sex, age, socio-economic status (U1 – U5, higher values of the indicator equivalent to deprivation) and residence area (rural/urban).

**Results:** The 1-year prevalence of any opioid use among incident OA patients was around 15% from 2007 to 2012. After that, this figure grew by 10% approaching 25% in 2016. However, strong opioid use increased continuously to nearly triple, from 8% in 2007 to 20% in 2016. The different subgroups followed similar trends over time, with women 4% higher than men, oldest 10% higher than youngest, most deprived 6% higher than least deprived, and rural 1% higher than urban.

**Conclusion:** The use of opioids (and especially strong opioids) has substantially increased in recent years among newly diagnosed OA patients in Catalonia. Our findings call for urgent action for safe opioid prescribing to avoid opioid abuse in OA patients especially amongst older women living in deprived areas.

**Disclosure of Interests:** Junqing Xie: None declared, Aleksandra Turkiewicz: None declared, Gary Collins: None declared, Martin Englund Consultant of: Advisory Board 1 day (2019) Pfizer (Tanezumab), Victoria Y Strauss: None declared, Carlen Reyes: None declared, Daniel Prieto-Alhambra Grant/research support from: Professor Prieto-Alhambra has received research Grants from AMGEN, UCB Biopharma and Les Laboratoires Servier, Consultant of: DPA's department has received fees for consultancy services from UCB Biopharma, Speakers bureau: DPA's department has received fees for speaker and advisory board membership services from Amgen

DOI: 10.1136/annrheumdis-2020-eular.3070

#### OP0281 TWO-YEAR COST-EFFECTIVENESS BETWEEN TWO GRADUAL TAPERING STRATEGIES IN RHEUMATOID ARTHRITIS: COST-UTILITY ANALYSIS OF THE TARA TRIAL

E. Van Mulligen<sup>1</sup>, A. Weel<sup>2,3</sup>, M. Kuijper<sup>2</sup>, J. Hazes<sup>1</sup>, P. De Jong<sup>1</sup>. <sup>1</sup>Erasmus MC, Rotterdam, Netherlands; <sup>2</sup>Maasstad Hospital, Rotterdam, Netherlands; <sup>3</sup>Erasmus School of Health Policy & Management, Rotterdam, Netherlands

**Background:** Current guidelines recommend to consider tapering treatment in rheumatoid arthritis (RA) patients who are in sustained remission, but the optimal approach to de-escalate conventional synthetic and biological DMARDs (respectively csDMARDs and bDMARDs) remains unknown. The benefits of tapering are a decreased risk of long-term adverse events and a reduction of health care costs, especially when bDMARDs are tapered. However, tapering treatment may lead to more transient or persistent disease flares, which have a direct impact on patients' lives and societal costs.

**Objectives:** To evaluate the two year cost-utility ratio between tapering the csDMARD first followed by the TNF-inhibitor, and tapering the TNF-inhibitor first followed by the csDMARD.

**Methods:** The TARA trial is a multicenter single-blinded randomized controlled trial. RA patients that used a csDMARD(s) plus a TNF-inhibitor and who had a well-controlled disease for at least 3 months, defined as a DAS<sub>2.4</sub> and a swollen joint count (SJC)≤1, were included. Patients were randomized into gradual tapering their csDMARD followed by the TNF-inhibitor or vice versa. Medication was tapered in three steps over the course of 6 months. Gradual tapering was done by cutting the dosage into half, a quarter and thereafter it was stopped. Data on QALYs (measured with the Dutch EuroQol [EQ5D]), direct and indirect costs were used to calculate the Incremental Cost Effectiveness Ratio (ICER). The incremental cost-effectiveness ratio (ICER) and the incremental net monetary benefit (iNMB) were used to assess cost-effectiveness between both tapering strategies. Direct costs comprises costs for treatment and medical consumption, while indirect costs comprises costs due to loss of productivity (i.e. sick leave and unemployment).

**Results:** Of the 189 included patients, 94 started tapering their TNF-inhibitor first, while the other 95 tapered their csDMARD first. QALYs (sd) were, respectively, 1.64 (0.22) and 1.65 (0.22). Medication costs were significantly lower in the patients who tapered the TNF-inhibitor first, but indirect cost were higher due to more productivity loss. Therefore, total costs per QALY were similar for both tapering strategies (p=0.62). The ICER between tapering csDMARDs and the TNF-inhibitor was -€184534 (-€417314, €48245; 95% CI)(figure 1). The mean iNMB was €2831 at a willingness-to-pay (WTP) level of €80000. At all WTP levels the probability of being cost-effective was higher (62% vs. 28%) for tapering the TNF-inhibitor first (figure 2)

**Conclusion:** Medication costs are lower when the TNF-inhibitor is tapered first, but this is counterbalanced by higher indirect costs due to loss of productivity.

Therefore, overall cost savings are similar for both tapering strategies. However, tapering the TNF-inhibitor first has a higher chance of being cost-effective at all WTP thresholds. For this reason we advise to taper the TNF-inhibitor first when tapering medication is considered.

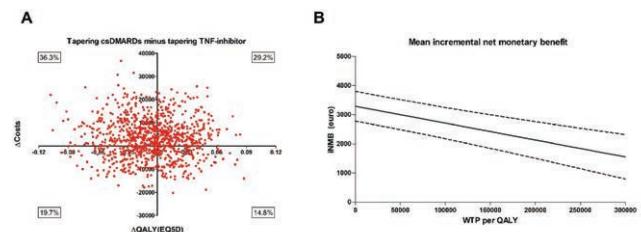


Figure 1 Summary of economic evaluation of tapering csDMARDs first minus tapering TNF-inhibitor first. (A) Results of 1000 bootstrapped replications, presented in a cost-effectiveness plane which represents uncertainty of the cost-effectiveness ratio. (B) Mean incremental net monetary benefit for tapering csDMARDs minus tapering TNF-inhibitors with 95% confidence intervals plotted against different levels of willingness to pay (WTP) per quality adjusted life year (QALY). csDMARDs: conventional synthetic DMARDs; iNMB: incremental net monetary benefit; QALY: quality adjusted life year; WTP: willingness to pay.

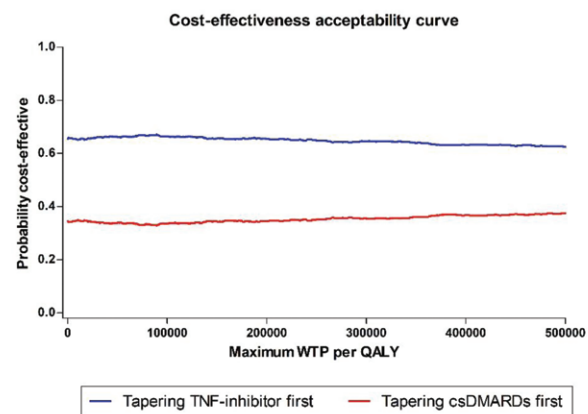


Figure 2 Cost effectiveness acceptability curve for tapering csDMARDs first versus tapering TNF-inhibitor first. Results of 1000 bootstrapped replication, presented for several levels of willingness to pay, indicated per quality adjusted life year (QALY). csDMARDs: conventional synthetic DMARDs; QALY: quality adjusted life year; WTP: willingness to pay.

**Disclosure of Interests:** None declared  
DOI: 10.1136/annrheumdis-2020-eular.740

#### OP0282 COST-EFFECTIVENESS ANALYSIS OF A CAFASPA REFERRAL MODEL FOR AXIAL SPONDYLOARTHRITIS

M.J. Abdelkadir<sup>1</sup>, M. Kuijper<sup>1</sup>, C. Appels<sup>2</sup>, A. Spoorenberg<sup>3</sup>, J. Hazes<sup>4</sup>, L. Van Hooen<sup>4</sup>, D. Lopes Barreto<sup>1</sup>, A. Weel<sup>1,5</sup>. <sup>1</sup>Maasstad Ziekenhuis, Rheumatology, Rotterdam, Netherlands; <sup>2</sup>Amphia Hospital, Breda, Netherlands; <sup>3</sup>University Medical Center Groningen, Groningen, Netherlands; <sup>4</sup>Erasmus Medical Center, Rotterdam, Netherlands; <sup>5</sup>Erasmus School Health Policy & Management, Rotterdam, Netherlands

**Background:** Chronic low back pain (CLBP) poses a significant individual and socio-economic burden. A substantial amount of patients with CLBP have axial spondyloarthritis (axSpA), but early recognition of these patients is difficult for general practitioners (GPs). Guidelines form primary care and secondary care differ in criteria for referral recommendation. The Dutch primary care guideline is restrictive in referring CLBP patients to secondary care whereas ASAS recommend to refer CLBP patients having at least 1 axSpA feature<sup>1</sup>. Therefore several referral models have been developed to assist GPs. Although the validated CaFaSpA referral model<sup>2</sup> is able to identify CLBP patients at risk for axSpA, its cost-effectiveness is yet unknown and essential before implementation in daily clinical practice.

**Objectives:** Primary objective to assess the cost-effectiveness of the CaFaSpA referral model for axSpA in primary care. Secondary objective to evaluate the costs made for screening by following the CaFaSpA vs ASAS referral model.

**Methods:** A clustered randomized controlled trial was performed with GPs as clusters. Clusters were randomized into the intervention (CaFaSpA referral, CS) or usual care (UC). Cost-effectiveness analysis from a societal perspective was performed to compare the CS and UC. Clinical outcomes were disability