postmenopausal women (PMW) and age-matched men. Evaluate DA in WoCBA comparing to the aforementioned groups.

Methods: Observational transversal study, using data from the portuguese registry of rheumatic diseases (Reuma.pt) from 3 portuguese centers. Adult patients (pts) with the diagnosis of RA, PsA, AS or JIA were allocated to the following groups: WoCBA (aged 18–44y), young men (YM) (18–44y), PMW ($\geq 45y$) and matched men ($\geq 45y$). Demographic and clinical variables are described as means or frequencies. Differences between groups regarding therapy and DA were assessed with Chi-square and ANOVA tests. Linear and logistic regression models were used to find predictors of DA and prescription patterns.

Results: 2133 pts were included, 69.9% female with a mean age of 55.96 ± 15.85 y. 1437 pts were diagnosed with RA, 305 with PsA, 254 with AS and 137 with JIA. Patterns of prescription are detailed in table 1. WoCBA were less likely to be treated with glucocorticoids than PMW (OR 0.66 95%CI 0.44-0.99). WoCBA were 1.76 times more likely to be treated with MTX than YM (95%CI 1.04-2.97). Certolizumab was specially prescribed in WoCBA (OR 13.8, 95%CI 1.4-132.8). WoCBA had significantly higher DA scores than YM (DAS28 3.03 ± 1.39 vs 2.32 ± 1.18 and BASDAI 3.55 ± 2.0 vs 2.43 ± 1.66).

Table 1. Prescription patterns

Medications, n (%)	A -WoCBA (N=256)	B - Young Men (N=161)	C - Post menopausal Women (N=927)	D - Men N=340	Chi-square test
NSAIDs	143 (55.9)	111 (68.9)	472 (50.9)	169 (49.7)	$p < 0.001$
Glucocorticoids	106 (41.4)	31 (19.3)	625 (67.4)	154 (45.3)	$p < 0.001$
csDMARDs					
- Methotrexate	149 (58.2)	60 (37.3)	663 (71.5)	197 (57.9)	$p < 0.001$
- Leflunomide	12 (4.7)	4 (2.5)	45 (4.9)	2 (0.6)	$p = 0.003$
- Sulfasalazine	9 (3.5)	5 (3.1)	39 (4.2)	9 (2.7)	NS
- Hydroxychloroquine	36 (14.1)	4 (2.5)	117 (12.6)	18 (5.3)	$p < 0.001$
bDMARDs					
- Etanercept	48 (18.8)	29 (18.0)	140 (15.1)	66 (19.4)	NS
- Infliximab	9 (3.5)	11 (6.8)	36 (3.9)	30 (8.8)	$p = 0.002$
- Adalimumab	17 (6.6)	15 (9.3)	47 (5.1)	27 (7.9)	NS
- Golimumab	15 (5.9)	18 (11.2)	37 (4.0)	30 (8.8)	$p < 0.001$
- Certolizumab	10 (3.9)	0 (0)	2 (0.3)	2 (0.6)	$p < 0.001$
- Tocilizumab	12 (4.7)	2 (1.2)	71 (7.7)	10 (2.9)	$p < 0.001$
- Rituximab	5 (1.9)	0 (0)	50 (5.4)	4 (1.2)	$p < 0.001$
- Abatacept	0 (0)	0 (0)	9 (1)	0 (0)	NS
- Secukinumab	1 (0.4)	4 (3.5)	8 (0.9)	2 (0.6)	NS
- Ustekinumab	1 (0.4)	3 (1.9)	5 (0.5)	0 (0)	NS
tsDMARDs	4 (1.6)	1 (0.6)	9 (0.9)	0 (0)	NS

bDMARDs – biologic disease modifying antirheumatic drugs, csDMARDs – conventional synthetic disease modifying antirheumatic drugs, NSAIDs – non-steroidal anti-inflammatory drugs, tsDMARD – targeted synthetic disease modifying antirheumatic drugs, WoCBA – women of childbearing age

Conclusion: Certolizumab was prescribed preferentially in WoCBA, who also received more MTX than YM. Nevertheless, DA in this group was not well controlled, which may influence future pregnancy outcomes. Ensuring tight DA control in WoCBA through proper and ideally no teratogenic medication remains an unmet clinical need.

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AB1146

REAL-LIFE PRACTICES IN MANAGEMENT OF REPRODUCTIVE HEALTH IN SLE AND APS BY OBSTETRICIANS AND RHEUMATOLOGISTS IN EGYPT. (AN ONLINE-BASED QUESTIONNAIRE)

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Background: Systemic lupus erythematosus (SLE) is an auto-immune disease that affect women in their reproductive age. Antiphospholipid syndrome (APS) is a hypercoagulable immune disease that occur as a primary condition or in association with SLE.

The reproductive aspects as contraception, fertility, pregnancy are crucial to consider for proper management of SLE/APS.

Addressing these issues require collaboration between rheumatologists and obstetricians, improving their knowledge and ensuring that both are acquainted with the updated guidelines.

Objectives: To assess the knowledge and practice of Egyptian obstetricians and rheumatologists in management of reproductive health issues in SLE and APS, and to detect common misconceptions.

Methods: This research was conducted via google form online survey based on points discussed in EULAR recommendations for women's health and the management of family planning, assisted reproduction, pregnancy and menopause in patients with SLE and/or APS.¹ It was sent to target obstetricians and rheumatologists by internet clouds like (Facebook, twitter, LinkedIn) from August to November 2019. It included five domains; demographic data, general knowledge and attitudes about pregnancy in SLE and APS, contraception, drugs, and assisted reproductive techniques (ART) After submitting answers, respondents were shown a link directing them to the 2016 EULAR recommendations.¹

Results: This study was conducted on 254 physicians, 62% obstetricians and 38% rheumatologists. 64.6% were between the ages of 30-35 years.

For general knowledge, 52% of Obstetricians considered pregnancy in inactive SLE to be risky. (79.4% vs 54.1%) of (rheumatologists and obstetricians) respectively test for aPL in SLE patients. More than 70% in both groups were well informed on the increased rate of fetal and maternal complications in both SLE and APS. For fetal surveillance, 87% and 90% of obstetricians performed first and second trimester U/S, and 79% performed second trimester Doppler.

For contraception, (57.7% vs 56.7%) discuss contraceptive choices with their patients. The majority considered it safe to use IUDs (73.9% vs 76%) and condoms (84.7% vs 85.4%) in both SLE and APS patients. On the other hand, for hormonal contraception- Levonorgestrel IUD, Depoprovera, COCP, and POP- only 14.6%, 22.9%, 26.1%, 24.8% of rheumatologists and 18.5%, 27.2%, 29.9%, 26.8% of obstetricians considered them unsafe to use in APS.

Concerning treatment, the majority considered low dose prednisone to be safe during pregnancy (94.8% vs 80%) and breastfeeding (87.6% vs 64.3%). The majority also agreed on avoidance of Methotrexate (94.8% vs 84.1%) and Cyclophosphamide (89.7% vs 66.2%). However, regarding Hydroxychloroquine and Azathioprine use in pregnancy there was a significant discrepancy between rheumatologists and obstetricians, (89.7% vs 42%) and (78.4% vs 36.9%) believed them safe to use in pregnancy. For Mycophenolate Mofetil, (80.4% vs 46.5%) said that it should be avoided in pregnancy. Regarding ART (45.4% vs 71%) considered it safe to use in stable SLE/APS.

Conclusion: The gaps in knowledge identified include the use of hormonal contraception in APS patients and the proper utilization of important medications to prevent and treat lupus flares. Initiation of shared Rheumatology/ obstetric clinics and focusing on the identified educational topics, would lessen the gap in knowledge and discrepancies in practice improve overall patient management.

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[1] Andreoli L et al. Ann Rheum Dis. 2017;76(3):476-85.

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AB1147

SCREENED – HIGH REMISSION RATES UNDERLINE THE BENEFIT OF SCREENING CONSULTATION MODELS FOR EARLY RECOGNITION AND TREATMENT OF RHEUMATIC AND MUSCULOSKELETAL DISEASES

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Background: Early recognition and treatment of rheumatic and musculoskeletal diseases (RMDs) is of critical importance for the individual outcome. However, nationwide health care structures in Germany do not facilitate early access to initial rheumatologic evaluation. Furthermore, waiting times of several months due to substantial capacity constraints in regional rheumatology care services compromise the prognostically relevant “window of opportunity” for subsequent sustained remission. To promote early detection of RMDs, the Division of Rheumatology at the University hospital Heidelberg, Germany has launched a unique screening consultation model that offers early access to rheumatologic evaluation on regional level.

Objectives: The registry-based study SCREENED (“Screen for early diagnosis”) has been initiated to monitor the outcome of patients that were diagnosed with an RMD at the screening clinic and to assess the costs and benefits of this consultation model for the regional quality of care.