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)

A. Beltagy¹, N. Eshak², M. Morsy¹, S. Shoela³, F. Fayed⁴, S. Aly⁵, A. Emam⁶, A. El-Girby⁷. ¹Alexandria University, Faculty of Medicine, Internal Medicine, Rheumatology Department, Alexandria, Egypt; ²Texas Tech University Health Sciences Center, Internal medicine, Lubbock, United States of America; ³Alexandria University, Faculty of Medicine, Internal Medicine, Rheumatology Department, Alexandria, Egypt; ⁴Alexandria University, Alexandria Students Hospital, Internal Medicine, Rheumatology, Alexandria, Egypt; ⁵Alexandria University, Alexandria, Egypt; ⁶Alexandria University, Obstetric and Gynecology, Alexandria, Egypt; ⁷Alexandria University, Internal Medicine, Rheumatology, Alexandria, Egypt

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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AB1147

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

K. Benesova¹, V. Lion¹, O. Hansen¹, H. M. Lorenz¹. ¹University Hospital Heidelberg, Department of Medicine V, Hematology, Oncology and Rheumatology, Heidelberg, Germany

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.

Methods: The screening consultation model has been launched in two phases: in the first phase (02/2016 - 01/2018), a screening clinic open to all patients without previous rheumatologic evaluation with appointments according to the registration order has been established through rearrangement of available capacities. In contrast to regular appointments, the screening clinic took place in shorter consultation time frames and without additional diagnostic procedures. In the second phase (02/2018 - 01/2020), in order to manage and prioritize access to rheumatologic care at our division more efficiently, prior to appointment allocation (not only) to the screening clinic all new patient registrations became subject to a preselection procedure based on the evaluation of an anamnesis questionnaire, medical reports and laboratory findings by an experienced rheumatologist. Furthermore, SCREENED project has been launched for scientific evaluation of both phases of the consultation model.

Results: The screening consultation model achieved a significant reduction in waiting times to few weeks compared to six months for a regular appointment. In the first phase, the screening clinic had a high sensitivity of 94.3% and an improvable specificity of 31.1%. In the retrospective cohort, high remission rates have been observed over all RMD entities (120/206 = 58.3% patients based on physicians' assessment in the follow-up after screening clinic) and in rheumatoid arthritis (RA) in particular (38/61 = 62.3% and 33/55 = 60% patients with DAS28 score < 2.6 after 12 and 24 months respectively). Remission was usually reached within a year after the first appointment (9.5 ± 6.7 months), however, a trend to higher remission rates in patients with shorter illness duration was obvious. In RA patients, csDMARDs have been initiated in a third of patients immediately at diagnosis in the screening clinic and in another third within six months after the first appointment. After 12 months, > 80% have received csDMARDs, while only 14.2% needed b/tsDMARDs in the follow-up over 24 months.

Conclusion: High sensitivity and significant reduction in waiting times for initial rheumatologic evaluation in the screening clinic pave the way for early recognition and treatment of RMDs. Subsequently, high remission rates in the follow-up were reached. In RA, a high proportion of patients only required csDMARDs to achieve sustained remission. A correspondingly small proportion of patients necessitating b/tsDMARD in the follow-up points towards a significant health economic benefit of the early rheumatologic intervention in the screening consultation model.

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AB1148

ECONOMIC BENEFIT FROM IMPROVEMENTS IN HEALTH-RELATED QUALITY OF LIFE WITH UPADACITINIB AND COMPARISONS WITH TOFACITINIB AND METHOTREXATE IN PATIENTS WITH MODERATELY TO SEVERELY ACTIVE RHEUMATOID ARTHRITIS

A. Bensimon¹, M. Yang¹, E. Orvis¹, J. Clewell², N. Tundia². ¹Analysis Group, Inc., Boston, United States of America; ²Abbvie Inc., North Chicago, United States of America

Background: Rheumatoid arthritis (RA) is a chronic, debilitating autoimmune disease and is associated with high direct medical costs. Treatment of RA with disease-modifying anti-rheumatic drugs (DMARDs) can improve patients' health-related quality of life (HRQOL) and has the potential to reduce direct medical costs associated with RA. Treatment with janus kinase inhibitors, such as upadacitinib (UPA), has shown improvements in HRQOL in patients with RA [1].

Objectives: To estimate the economic benefit from improvements in HRQOL and to compare estimated direct medical costs between: (1) UPA and tofacitinib (TOFA) and (2) UPA monotherapy and methotrexate (MTX) monotherapy in patients with RA.

Methods: This economic analysis used individual patient-level data from 2 randomized clinical trials (RCTs) of UPA (SELECT-NEXT and SELECT-MONO) and published aggregate data from 1 RCT of TOFA (ORAL-Standard) in patients with moderate to severe RA that collected repeated measurements of HRQOL based on the Short Form 36 Health Survey (SF-36). Estimated direct medical costs per patient per month (PPPM) for UPA 15mg once daily (QD) and MTX were estimated based on observed SF-36 Physical (PCS) and Mental Component Summary (MCS) scores in the SELECT RCTs using a published regression algorithm [2]. Direct medical costs PPPM for TOFA 5mg twice daily (BID) were estimated from Rendas-Baum, et al [3], which applied the same regression algorithm to SF-36 PCS and MCS scores observed in the ORAL-Standard RCT. Resulting estimates of direct medical costs PPPM in the short-term (12–14 weeks) and long-term (48 weeks) were compared between UPA and TOFA and between UPA and MTX. Costs were inflation-adjusted to 2018 US dollars. Bootstrapping was used to generate 95% confidence intervals (CI).

Results: Over 12 weeks, estimated direct medical costs PPPM were \$186 lower (95% CI: \$21, \$364) in patients treated with UPA compared with those treated with TOFA. Estimated long-term medical costs PPPM at Weeks 24 and 48 (Figure 1) and cumulative costs over the entire 48-week period (difference: \$1,452; 95% CI: \$906, \$2,086; Table) were significantly lower for UPA than for TOFA. Over 14 weeks, estimated direct medical costs PPPM were \$370 lower (95% CI: \$147, \$575) in patients treated with UPA monotherapy compared with those treated with MTX alone. Estimated long-term direct medical costs at Week 48 (Figure 2) and cumulative costs over the entire 48-week period (difference: \$2,120; 95% CI: \$1,398, \$2,861; Table) were significantly lower for UPA monotherapy compared with MTX alone.

Conclusion: Based on improvements in HRQOL in the short-term and long-term, UPA 15mg QD was associated with significantly lower direct medical costs than TOFA 5mg BID in patients with active RA. UPA 15mg QD monotherapy was associated with significantly lower direct medical costs than MTX monotherapy in patients with active RA. These results provide evidence of the economic benefits of UPA as a novel treatment for moderate to severe RA.

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Table. Cumulative cost savings over 48 weeks with UPA vs TOFA and UPA vs MTX

Treatment	Total 48-week medical costs (\$)	Difference (95% CI)
UPA vs TOFA		
TOFA 5mg BID	8,964	
UPA 15mg QD	7,511	1,452 (906, 2,086)
UPA vs MTX		
MTX	9,833	
UPA 15mg QD	7,713	2,120 (1,398, 2,861)

Figure 1. Estimated long-term direct medical costs per patient per month (PPPM) with UPA vs TOFA