pre-defined intervals between visits with frequencies varying from daily to monthly. The remaining five made a single request before a scheduled clinic visit. The number of items requested from patients ranged from 9-48 per session. We identified three different clinical workflows: Simple (data only used during consultation, n=5), moderate (real-time alerts for providers when severe symptoms were reported, n=4) and on-demand (patient-initiated visits, n=1). Benefits of symptom reporting from each of the studies were categorised as anticipated, realized quantitative, and realized qualitative. We present summarised counts of these benefits in Figure 1. The most common anticipated benefits were better communication, changes to patient management and improved health outcomes. Most common realized benefits were detecting unrecognised problems and changes to patient management.

Figure 1. Summarized counts of benefits from each included study assessed against Chen et al.'s 10 outcome indicators. Categorized in anticipated (orange), realized quantitative (light purple), and realized qualitative benefits (dark purple).

Conclusion: There is growing interest and urge for integrating symptom data in the EHR and clinical care. Yet, this review has illustrated that there are limited published efforts to learn from. The heterogeneity in approaches underpins the need for a common framework. There is growing evidence from qualitative work in support of remote symptom-reporting in enabling better and patient-centred care in LTCs. The next step will be for robust, quantitative studies to provide evidence of benefits.

References:

[1] Chen J, Ou L, Hollis SJ. A systematic review of the impact of routine collection of patient reported outcome measures on patients, providers and health organisations in an oncologic setting. *BMC Health Serv Res.* 2013 Jun 11;13:211.

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AB1155 WORK DISABILITY AND PREDICTORS OF POOR WORK OUTCOME IN PATIENTS WITH AXIAL SPONDYLOARTHRITIS

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Background: Axial spondyloarthritis (axSpA) is a chronic inflammatory disease which may lead substantial functional limitation. The disease more commonly affects men in their third decade of life. For patients with chronic disease participation in paid work may be the result of series factors like disease severity, effectiveness of the health care, availability and the type of work. Previously it was reported that ankylosing spondylitis may cause adverse work outcome.

Objectives: To understand the impact of axSpA on work disability and the factors associated with poor work outcome.

Methods: A cross-sectional survey was performed among 323 patients with axSpA according to ASAS classification criteria from one tertiary center. In total 219 (67.8%) patients were working age at the time study. The others were student, housewife or retired. Demographic, social and disease related characteristics were collected. Characteristic that might be associated with premature work loss were evaluated by univariable and multivariable logistic regression analysis.

Results: Out of 219 axSpA patients (155 [71%] r-axSpA and 64 nr-axSpA, 69% HLA-B27 positive) who have a work at least once 47 (22%) was either withdrawn from work (n=35) or retired due to disability (n=12) during median (IQR) 12 (12) years symptom duration. Demographic and disease related characteristics of the patients with or without work disability were summarized in the table. In univariate analysis gender, smoking, education levels, the presence of peripheral arthritis, BASMI score and radiographically presence of syndesmophyte and hip involvement were found to be associated with poor work outcome. However poor work outcome were similar between r- and nr-axSpA patients. In regression analysis low education level (HR:3.4 [95%CI:1.4-8.6], P=0.007), peripheral arthritis (HR:2.7[95%CI:1.07-6.8], P=0.035), and ever smoking (HR:4.9 [95%CI:1.3-18.0], P=0.02) were independent predictors of work disability.

Conclusion: Our results suggest that there is still remarkable poor work outcome among axSpA patients and work disability might be similar in r- and nr-axSpA. Patients who are smoker, with low education levels, and peripheral arthritis seem to be at risk for premature work loss.

Table. Demographics and diseases related characteristics of study population

Variables	All population (n=219)	No work disability (n=172)	Work disability (n= 47)
Male, n (%)	161 (73.5)	122 (70.9)	39 (83)
Age, years*		41.5 (9.4)	43.1 (12.4)
Ever smoking, n (%)	155 (71.4)	115/171 (67.3)	40/46 (87)
Education duration ≤8 years, n (%)	82/212 (61.3)	53/165 (32.1)	29/47 (61.7)
Disease duration, years	6.7 (8.3)	5.5 (6.3)	10.7 (12.6)
BASDAI*	4.3 (2.4)	4 (2.3)	5.3 (2.6)
BASFI*	3.4 (2.8)	2.9 (2.5)	5.4 (3.0)
ASDAS-CRP*	2.8 (1.2)	2.7 (1.1)	3.3 (1.4)
BASMI*	2.3(2.0)	2 (1.8)	3.5 (2.4)
ASQOL*	9 (5.5)	8 (5.3)	12 (4.9)
Peripheral arthritis, n (%)	81/207 (39.1)	54/163 (33.1)	27/44 (61.4)
Hip arthritis, n (%)	39/205 (19)	26/163 (16)	13/42 (31)
Presence of syndesmophyte, n (%)	92/164 (56.1)	63/125 (50.4)	29/39 (74.4)

* Variables presented as mean (SD).

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AB1156 OVERVIEW OF INFLAMMATORY RHEUMATIC DISEASES AT THE EMERGENCY DEPARTMENT

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Background: Patients with rheumatological diseases can also apply to the emergency room due to acute attacks or complications. Especially in recent years, more patients, due to the increased use of immunosuppressant drugs in treatment, have applied to emergency services due to infection. On the other hand, data on applications to emergency services for rheumatological reasons are very few.

Objectives: In this study, applications to emergency departments for inflammatory rheumatic diseases were investigated.

Methods: 2715 patients from Atatürk Training and Research Hospital Rheumatology Clinic who were followed-up with the diagnosis of inflammatory rheumatic diseases between 2014 and 2018 were included in this study. The clinical and laboratory information of the patients were achieved from the hospital file records and the hospital data bank. The patients were classified according to the 5-stage triage system (T1: resuscitation, T2: critical, T3: urgent, T4: less urgent, T5: non-urgent).

Results: 21.3% (577) of 2715 patients applied to the emergency department. Among the emergency admissions, the first three diseases were; rheumatoid arthritis 19.7%, ankylosing spondylitis 19.2%, and familial Mediterranean fever 15.9% [Vasculitis 8.8%, Behcet's disease 7.6%, Gout 5.7%, Systemic lupus erythematosus 3.9%, Sjogren's Syndrome 3.6%, Scleroderma 3.2%, Still Disease 1.5%, Polymyalgia rheumatica 0.6%, others 9%]. 343 patients (59.5%) were discharged from the emergency department. 36.8% (212) of the patients were hospitalized in services and 3.6% (21) of them in intensive care. The first three reasons of the applications to the emergency department were: fever, malaise and fatigue in 1. 150 patients (25.9%), musculoskeletal system complaints in 2. 124 patients (21.4%) and abdominal pain in 3. 89 patients (15.4%), respectively. Vasculitis was the most common cause of hospitalization in the service in 38 patients (17.9%), whereas scleroderma was the most common cause of hospitalization in intensive care in 7 patients (33.3%) (table). 16 (76.1%) of the patients followed in intensive care unit were hospitalized with the diagnosis of respiratory system diseases. Death was observed in 10 (1.7%) of 577 patients. Five (50%) of the ex-patients had scleroderma (table). 8 (80%) of the deaths were related