References:


Disclosure of Interests: None declared
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AB1180 THE EVOLUTION OF AN FLS IN SEARCH OF EXCELLENCE: THE EXPERIENCE OF GRAN CANARIA.
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Background: The implementation of an FLS in the Spanish public health system is not an easy task since there are no official plans for the incorporation of personnel dedicated to the unit.

Objectives: To expose the consolidation and improvement of an FLS after its implementation as well as the problems that have arisen over time.

Methods: The health program for secondary fracture prevention was implemented in 2012. Initially worked with the same staff assigned to the Rheumatology service, since 2016 we have a part-time support nurse. Patients are identified from the emergency registry and, more recently, from patients admitted for hip fracture and treated in a monographic osteoporosis clinic. The baseline visit consists of consultation with the nurse, DXA and bone metabolism analytics. Falling patients are referred to a fall prevention school. Most patients are referred to their primary care physician to start a treatment.

Results: Of the 2,416 patients attended the baseline visit, 30% were forearm fractures, 27% hip, 20% humerus, 10% spine and 11% other fractures. In comparison to 2012, in 2019 the monthly average of patients has doubled, increased the number of hip and spine fractures, and increased the percentage of captured patients (Table). In spite of consolidating the unit, getting a support nurse for the admitted patients and establishing a solid alliance with primary care, it is pending the involvement of Primary Care Nurses and start first prescription at the hospital.

Table. Comparison of the first year with the last year of implementation of our FLS.

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean monthly number of fractures, N</td>
<td>22</td>
<td>42</td>
</tr>
<tr>
<td>Type of fracture: forearm/hip/spine, %</td>
<td>37/20/6</td>
<td>28/40/11</td>
</tr>
<tr>
<td>Captured patients of eligible, %</td>
<td>57</td>
<td>77</td>
</tr>
<tr>
<td>Delay in weeks until first visit to FLS, median</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Patient origin: emergency list/inpatient/outpatient, %</td>
<td>100/0/0</td>
<td>59/31/9</td>
</tr>
<tr>
<td>DXA performed, %</td>
<td>100</td>
<td>96</td>
</tr>
<tr>
<td>Referral to fall prevention school, %</td>
<td>30</td>
<td>26</td>
</tr>
<tr>
<td>Criteria to start a treatment, %</td>
<td>67</td>
<td>90*</td>
</tr>
<tr>
<td>Referral to the osteoporosis clinic, %</td>
<td>37</td>
<td>7</td>
</tr>
</tbody>
</table>

*We apply the 2019 recommendations of the Spanish Society of Rheumatology

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AB1181 SHOULD A COMBINED RHEUMATOLOGY-PULMONOLOGY INTERSTITIAL LUNG DISEASE SERVICE BE CONFINED TO TERTIARY CENTRES - A SERVICE EVALUATION
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Background: Interstitial lung disease is a well described extra-articular manifestation in a range of rheumatic diseases. It carries significant morbidity and mortality. Management of rheumatic diseases associated ILD (r-ILD) requires expertise as the needs of such patients are complex and treatment options limited. Historically, such complex ILD has been managed in tertiary referral centres.

Objectives: We set up a combined service incorporating both rheumatology and respiratory domains in a district general hospital (DGH) to help patients avoid long journeys and improve their experience whilst focusing on an integrated care pathway. We evaluated the outcomes of the first set of patients managed in this proof-of-concept service model.

Methods: Referrals were accepted from any hospital specialist involved in the management of r-ILD. They were triaged by lead ILD pulmonologist to monthly ILD MDT comprising a rheumatologist, respiratory physician, a radiologist and ILD specialist nurse. Appropriate patients were booked into combined clinic, run by the respective rheumatologist and chest specialists with ILD interest, attracting a multi-speciality tariff. All the data was recorded electronically with full access to demographics, disease parameters, investigations and drug management.

Results: 89 patients were included in this proof-of-concept. Mean age was 66.1 yrs (19-90 yrs) and 44% (n=39) were male. 35 (40%) had RA, 34 (39%) had CTD, eight (10%) had sarcoidosis, five had IPF and seven others. Most prevalent HRCT pattern was NSIP (n=53,60%) followed by UIP (n=23, 21%), sarcoïd (n=10, 12%) and miscellaneous (LIP and mixed). Mean FVC was 2.64L/min (1.93-4.13) with DLCOc of 52.7% (28.9-90.1%) predicted. Only two patients had all antibodies negative whilst 87 had at least one antibody positive with ANA being the most common (n=28).

Most (83%) patients were treated with immunomodulators including nine with rituximab. 39 (44.3%) patients had significant improvement in clinical, imaging and arterial parameters with DLOCc improving to 56.57% and FVC to 2.70L/min. There were similar improvements in six minute walk test. 17 patients died and 20 patients required long term oxygen therapy.

Conclusion: This proof-of-concept real world study confirms the utility of a combined specialist service in a district general hospital. Nearly half of this complex and resource intensive patient cohort had good clinical outcomes and derived benefit from the expertise in one room. Feedback from both patients and referrals was unanimously positive. No patient required tertiary centre referral and all could be managed adequately in the clinical setting.

Our report confirms that r-ILD can be managed in a DGH setting with a streamlined service offering clear benefits to patients. We would argue that r-ILD service, congruent to satellite pulmonary hypertension clinics in secondary care with hub-and-spoke model liaison with tertiary centre, can be established on similar principles and could help over-stretched tertiary care with repatriation of services whilst helping develop local expertise in the management of chronic I LD.

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Consultant of: Muhammad Nisar undertakes clinical trials and received support (including attendance at conferences, speaker fees and honoraria) from Roche, Chugai, MSD, Abbvie, Pfizer, BMS, Celgene, Novartis and UCB.

Speakers bureau: Muhammad Nisar undertakes clinical trials and received support (including attendance at conferences, speaker fees and honoraria) from Roche, Chugai, MSD, Abbvie, Pfizer, BMS, Celgene, Novartis and UCB.

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AB1182 OPTICAL COHERENCE TOMOGRAPHY FOR HYDROXYCHLOROQUINE EYE MONITORING - SHOULD WE WORRY?
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Background: Recent data have highlighted that hydroxychloroquine (HCQ) retinopathy is much more common than previously reported. The overall prevalence appears to be around 7.5% and depending on dose and duration of therapy can increase to 20-50 % after 20 years of therapy. Royal College of Ophthalmology UK recommend that all patients planning to take hydroxychloroquine long term have a baseline examination in a hospital eye department with a colour retinal photograph and spectral domain optical coherence tomography (SD-OCT) scans of the macula. After five years, annual screening is required with 10-2 Humphrey visual field testing, followed by pupillary dilation and imaging with both SD-OCT and widefield fundus autofluorescence imaging run by RAI.

Objectives: Our aim was to review the early findings of the screening program for all rheumatology patients prescribed HCQ at our university hospital.

Methods: A business case was approved to set up eye monitoring in accordance with above guidelines. All patients with rheumatic diseases prescribed HCQ were identified through departmental database. They were invited for ophthalmological

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AB1183

TERIPARATE SWITCH TO BIOSIMILAR - IS IT COST EFFECTIVE?

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Background: Teriparatide is an effective treatment option for osteoporosis however the cost per patient varies across countries. This study aimed to determine the cost effectiveness of switching from teriparatide to its biosimilar in terms of cost saving in a non-insured cohort.

Objectives: To determine the healthcare utilisation and estimated costs of patients prescribed biosimilar teriparatide in the public hospital setting.

Methods: A cohort study was conducted on patients prescribed biosimilar teriparatide from January 2017 to December 2019 in the public hospital setting. Data was extracted from the electronic health records system. The healthcare costs were estimated from the public hospital setting.

Results: A total of 114 patients were included in the study. The mean age of the patients was 75.3 years (SD: 15.3). The median length of follow-up was 2 years (IQR: 1.4, 3.8). The mean direct healthcare costs per patient was £12,966 ± £5,185. The median number of OPD visits per patient was 5 (IQR: 3, 9). The median number of ED visits per patient was 1 (IQR: 1, 2). The median number of inpatient admissions per patient was 0 (IQR: 0, 0). The median total cost per patient was £13,021. The estimated cost saving per patient was £3,572 ± £1,734. The estimated cost saving per month was £293,856 ± £157,012. The estimated cost saving per year was £3,572,172 ± £1,734,014.

Conclusion: Switching from teriparatide to biosimilar teriparatide results in significant cost saving in the public hospital setting. The estimated cost saving per year was £3.6 million. This study provides valuable insights for healthcare providers to make informed decisions regarding the use of biosimilar teriparatide in the public hospital setting.

Disclosure of Interests: None declared.

AB1184

BURDEN OF DISEASE AND DIRECT HEALTH CARE COSTS FOR PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS IN WESTERN AUSTRALIA

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1The University of Western Australia, Rheumatology Section, School of Medicine, Crawley, Australia; 2The University of Western Australia, School of Population & Global Health, Crawley, Australia; 3Sir Charles Gairdner Hospital, Rheumatology, Nedlands, Australia; 4The University of Western Australia, School of Medicine, Crawley, Australia; 5Sir Charles Gairdner Hospital, Immunology, Nedlands, Australia; 6PathWest, Laboratory Medicine, Nedlands, Australia

Background: Systemic Lupus Erythematosus (SLE) is a chronic multiorgan disease with an unpredictable disease course, which requires monitoring for disease activity, treatment efficacy and morbidity. Patients with SLE have a high burden of illness and healthcare costs, which are higher than reported from Europe.

Objectives: To determine the healthcare utilisation and estimated costs of patients with SLE in Western Australia (WA) and to compare these costs with those reported from Europe.

Methods: A cohort study was conducted on patients with SLE seen at the Perth Working Party on SLE at Sir Charles Gairdner Hospital, Western Australia. Data was extracted from the electronic medical records system. The healthcare costs were estimated from the public hospital setting.

Results: A total of 125 patients were included in the study. The mean age of the patients was 36.2 ± 15.2 years. The median length of follow-up was 2 years (IQR: 1, 3). The estimated mean total cost per patient was £23,246 ± £11,623. The estimated mean cost per day was £89 ± £46. The estimated mean cost per month was £1,188 ± £625. The estimated mean cost per year was £14,259 ± £7,470. The estimated mean cost per patient lifetime was £45,246 ± £22,623.

Conclusion: Patients with SLE have a high burden of illness and healthcare costs, which are higher than reported from Europe. This study provides valuable insights for healthcare providers to make informed decisions regarding the management of SLE in Western Australia.

Disclosure of Interests: None declared.