References:

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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 average number 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>
<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>59/3/19</td>
</tr>
<tr>
<td>DXA performed, %</td>
<td>100</td>
<td>69</td>
</tr>
<tr>
<td>Referral to fall prevention school, %</td>
<td>0</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

Conclusion: We present the achievements made by our FLS along 8 years and the difficulties within the Spanish public health system.

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AB1181 SHOULDN’T 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 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 rheumatology 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 IAPF and seven others. Most pre-dominant HRCT pattern was NSIP (n=53, 60%); followed by UIP (n=23, 21%), sarcoid (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 pulmonary parameters with DLCOc improving to 56.57% and FVC to 2.70/ 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 referring rheumatologists 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 ILD.

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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, Pfister, 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 (WFAF).

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
examination and those with drug exposure >5 yrs were prioritised. An MDT path-
way was established to manage anyone with signs of HCoC toxicity.

Results: 2,132 patients are prescribed HCoC in our county with population of 660,000. 237 patients fell under our unit’s remit. 196 patients (92% women) have been screened with mean age of 58 yrs (24-84y), 65 (48%) have RA and remaining
with connective tissue diseases. Median disease duration is 10 yr (0.75-30 yrs) and median drug exposure is 10 yr (0.4-27yr). Three doses of HCoC are prescribed: 200mg daily (53%), 300mg daily (13%) and 400mg daily (34%). Ten (73%) patients were found to have abnormal results. Three were consistent with HCoC toxicity pattern and one with likely toxicity. Two of them had already developed severe sight loss. HCoC was discontinued in all these cases. Six had other incidental anomalies requiring further input.

Conclusion: Hydroxychloroquine is used increasingly in the treatment of auto-
immune diseases with emerging role in oncology. It has a favourable safety and
tolerability profile with survival benefit demonstrated in SLE. In the UK, it’s a dop-
ation has been particularly high owing to the requirement of trialling two DMARDs
prior to being eligible for biologic therapy in RA and PsA. In the absence of
modern retinal imaging techniques, HCoC toxicity was perhaps underestimated
and hence older guidelines did not emphasise strict monitoring practice. Our
preliminary data, in line with published evidence, represents a greater public
health problem than previously estimated. It is clear that implementing the
new guidelines not only recognises hitherto undiagnosed drug toxicity but also
teaches incidental significant eye pathology which puts pressure on health-
care resources and needs robust service planning. Rheumatologists need to
be aware of the potential impact requiring informed discussion with patients
and perhaps a fundamental shift in prescribing behaviour to avoid this rapidly
developing health concern.

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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.

Background: Systemic Lupus Erythematosus (SLE) is a chronic multorgan disease with an unpredictable disease course, which requires monitoring for
disease activity, treatment efficacy and comorbidity. Data on the healthcare utili-
zation and cost of SLE, especially from Australia are scarce.

Objectives: To determine the healthcare utilisation and estimated costs of inpa-
tient admissions (IP), emergency (ED) and outpatient (OPD) hospital visits and
investigations for SLE patients in Western Australia (WA).

Methods: This is a longitudinal cohort study of SLE patients seen at a metropol-
itan public hospital, with ≥6 months of follow-up (n=179, 95% female; baseline
age 36.2 ± 15.2 years). Electronic medical records provided data on OPD, ED and IP visits, and investigations conducted at public hospitals from January 2000 - December 2019. Direct healthcare costs were estimated from public hospital expenditure aggregates in FY2018/19.

Results: During a median observation period of 11.0 years (IQR 7.4, 13.5), SLE
patients required 13,320 OPD visits for a median of 5.3 (IQR 3.0, 9.3) appoint-
ments per annum. The majority of OPD visits were with Rheumatology (n=1,986,14.9%), Immunology (n=1,527,11.5%), and allied health services (n=1,952,14.7%), followed by Ophthalmology (n=1,385,10.4%), maternal & fetal health (n=873.6.6%) and Renal medicine (n=844,6.3%). In total 143 patients (79.3%) attended ED on average of 3 times (IQR 2; 7; ED visit rate 4.00 (95%CI 4.01 4.70) per 100 person years. Overall, 125 patients (69.8%) were hospitalised at average times (IQR 2; 6), with a mean LOS of 5 days (IQR 3; 12) for an IP rate of 378 per 100 patient years (95%CI 34.8, 40.5); Only 12.8% of patients did not attend ED or IP in the public health care system. A total of 367,087 labora-
utory investigations were performed (median n= of tests per patient 205 (±290)
per year) across fields of haematology/biochemistry (89%), immunology (5%),
microbiology (4.5%) and histopathology (<1%). Minimum estimates for direct
health care cost during the study period were 25.4 million AUD (IP 11m, OPD
6.3m, ED 0.9m and investigations 9.1m) for a crude annual cost of 14,088 AUD
per patient.

Conclusion: SLE patients have extensive healthcare utilization across a range
of outpatient and inpatient services. The main direct costs for this multi-discipli-
ary health care provision are for disease monitoring and in-hospital treatment.
Based on these conservative cost estimates to which medicare cost need to
be added, total costs for SLE care in WA are projected to be significantly higher
than reported from Europe.

This is in line with recent meta-analysis of real life teriparatide use in complex
osteoporosis with multimorbidity. Our study should enhance clinicians’ confi-
dence in its prescribing. It’s notable that the use is higher than current esti-
mates based on NICE cost effectiveness analysis. Instead of annual predicted use of 4.8/100,000 population, it was prescribed to 6.4/100,000. This could potentially have a cost impact however the introduction of a generic version would mitigate against it. We calculated our savings to be over £125,000 if all patients were switched. These savings at national level would hopefully improve access to a wider patient cohort and perhaps allow earlier use in the treatment paradigm.

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