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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.

	2012	2019
Mean monthly number of fractures, N	22	42
Type of fracture: forearm/hip/spine, %	37/20/6	28/40/11
Captured patients of eligible, %	57	77
Delay in weeks until first visit to FLS, median	14	12
Patient origin: emergency list/inpatient/outpatient, %	100/0/0	59/31/9
DXA performed, %	100	61
Referral to fall prevention school, %	0	26
Criteria to start a treatment, %	67	90*
Referral to the osteoporosis clinic, %	37	7

*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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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 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-specialty 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 IPAF and seven others. Most predominant 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 2.64 L/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 L/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 referrers 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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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 (FAF).

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