Table 1. Efficacy scores proposed by a PsA expert group and consensus achieved by an online survey among PsA treating physicians Efficacy scores for different drugs and manifestations range from 0 (no effect) to 5 (maximal effect). Green fields indicate, that at least 65% of the survey participants agreed on the proposed efficacy score.

	Peripheral arthritis	Axial disease	Enthesitis	Dactylitis	Skin disease	Nail disease
Methotrexat	2.5	0	0	1	2.5	1.5
Sulfasalazin	1	0	0	0	0	0
Leflunomid	2.5	0	0	1	1	1
Apremilast	3	1	3	2.5	3	3
Etanercept	4	4	4	3.5	3	3.5
Infliximab	4	4	4	4	4	4
Adalimumab	4	4	4	4	4	4.5
Golimumab	4	4	4	4	3	3
Certolizumab pegol	4	4	4	4	4	4
Ustekinumab	3.5	2.5	4.5	3	4.5	4
Secukinumab	4	4	4	4	5	4.5
Abatacept	3.5	0	0	0	1.5	0

Figure 1. Results from an online survey among physicians querying their perception of efficacies of PsA drugs on different manifestations. Therapeutic effectiveness is estimated by the participants on a scale from 0 (no effect) to 5 (maximal effectiveness); NA = no answer. The size of the dots relates to the number of answers given. Red stars indicate the scores proposed by the initial expert group.

Conclusion: Many treatments are available to be used in PsA. The usage of treatment classes seems to depend on experience level and mode of action. Higher agreement on efficacy in specific diseases manifestation was achieved in the class of biologics whereas the opinion on efficacy of csDMARDs in general is divergent. Strategies are needed to guide physicians with lower level of experience in the use of specific drugs to achieve an optimised patient care level using personalized treatment strategies.

Disclosure of Interests: Timm Oberwahrenbrock Grant/research support from: BMS, Hannah Tian: None declared, Diamant Taçi Grant/research support from: Janssen Research & Development, LLC, Klaus Krueger Consultant of: Celgene, Jürgen Wollenhaupt Consultant of: Celgene, Michaela Köhm Grant/research support from: Pfizer, Janssen, BMS, LEO, Consultant of: BMS, Pfizer, Speakers bureau: Pfizer, BMS, Janssen, Novartis, Frank Behrens Grant/research support from: Pfizer, Janssen, Chugai, Celgene, Lilly and Roche, Consultant of: Pfizer, AbbVie, Sanofi, Lilly, Novartis, Genzyme, Boehringer, Janssen, MSD, Celgene, Roche and Chugai

DOI: 10.1136/annrheumdis-2020-eular.5484

AB1290-HPR UTILITY OF FRAX IN THE RISK DETECTION OF FRACTURE IN SPONDYLOARTHRITIS

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Background: Axial spondyloarthritis (SpAax) presents an increased risk of vertebral fracture not fully detected by Dual energy X-ray absorptiometry (DXA). The FRAX algorithms give the 10-year probability of hip fracture and of mayor

osteoporotic fracture (clinical spine, forearm, hip or shoulder fracture), taking into account 11 clinical risk factors.

Objectives: To analyze the suitability of FRAX to detect the risk of fracture in patients with SpAax. To assess whether the incorporation of SpAax as a clinical risk factor to conventional FRAX provides additional information.

Methods: Cross-sectional study in which SpAax patients (ASAS criteria) were included. Clinical-demographic and related to the disease variables were collected. FRIDEX model for Spanish population was used to determine low, intermediate or high risk of mayor fracture by FRAX. These results were compared with those obtained by DXA and trabecular bone score (TBS). In the statistical analysis we used mean and standard deviation (SD) in quantitative variables and frequency in qualitative ones. To compare means among 3 groups, ANOVA test was used.

Results: The characteristics of the patients are shown in Table 1. According to FRIDEX, no patient had high risk of fracture and 2.4% had intermediate risk. When SpAax was added as a risk factor, no patient had high risk of fracture and 6.1% presented intermediate risk. According to DXA, 7.3% had high risk of fracture and 41.3% intermediate risk. TBS detected high risk of fracture in 18.3% and intermediate risk also in 18.3% of patients.

Table 1. Sociodemographic, clinical and related characteristics with the disease (BMD: bone mineral density, BMI: index of body mass)

Gender (Male), n (%)	61 (74.4)
Age, mean ± SD	49.48 ± 12.47
BMI, mean ± SD	27.13 ± 4.42
Smoking, n (%)	26 (31.7)
Diabetes mellitus, n (%)	9 (11)
Osteoporotic fracture, n (%)	1 (1.2)
Disease duration (years), mean ± SD	11.77 ± 10
syndesmophytes, n (%)	38 (46.3)
ASDAS-PCR, mean ± SD	2.55 ± 1.07
Lumbar BMD (g / cm ²), mean ± SD	1.032 ± 0.180
BMD femoral neck (g / cm ²), mean ± SD	0.816 ± 0.140
Lumbar TBS, mean ± SD	1.383 ± 0.133

Conclusion: FRAX does not seem an adequate tool to detect the risk of fracture in patients with SpAax since it did not improve the results obtained by DXA meanwhile TBS did. The incorporation of SpAax as a clinical risk factor to conventional FRAX did not provide additional information in most cases

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.3839

AB1291-HPR IMPLEMENTATION OF AN ELECTRONIC SYSTEM FOR ISSUING PRESCRIPTIONS IN PATIENTS WITH RHEUMATIC DISEASES

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Background: Pharmacovigilance is the science and activities related to detection, evaluation, understanding and prevention of adverse effects of medications or any other health problem related to them. (1)

Within the scope of the pharmacovigilance study, following domains are included: adverse drug reaction, interaction between medications, counterfeit or inferior quality medications, lack of efficacy of medications, misuse or abuse of medications and medication errors (ME). (2)

ME is any preventable incident that can cause harm to the patient or lead to improper use of medications when they are under the control of healthcare professionals or the patient. (3)

Objectives: To determine the frequency of ME in the prescriptions among rheumatology outpatient's clinic.

Methods: Prospective observational study.

Frequency of ME was sought by a randomized review of the prescriptions from rheumatology outpatient's clinic of the University Hospital "Dr. José Eleuterio González" before and after the implementation of an electronic medical prescription system (REPAIR®) (January 2018-December 2019)

REPAIR® displays an automated menu with the stages of the medical prescription: Name, presentation and dosage of the medicine and duration of the treatment. Figure 1. Once the review began, semiannual reports were made to the doctors involved in which frequency of errors and the stage of medical prescription with highest incidence of ME were reported.