appropriateness of peri-operative plan and post-operative complications. No data was available on these outcomes prior to the advent of the foot MDT clinic. **Results:** Data from 12 clinics was analysed (n=40). Patients had a median age of 66 years (IQR 27.5 years); 65% of patients were female and 35% of patients were male. The commonest rheumatological foot disease seen was rheumatoid arthritis (67%), followed by psoriatic arthritis (15%). All patients were treated with biologic or non-biologic DMARDs. Treatment outcomes were as follows: 27.5% were offered surgical treatment; 10% were offered intra-articular (IA) injections under ultrasound guidance; 10% were offered IA injections under general anaesthetic; 25% underwent specialist rheumatology podiatry, and the remaining 30% elected for a conservative approach after careful consideration of treatment options. Of those who were offered surgical treatment, 72% of patients were provided with a peri-operative plan which accorded with British Rheumatology Society (BSR) guidelines. Of those whom underwent surgery, one patient's surgical treatment was complicated by a post-operative infection; however, the peri-operative DMARD/biologic plan was not felt to be contributing factor.

Conclusion: The foot MDT clinic provides a comprehensive review of rheumatological foot conditions, with readily available access to a full range of treatment options. Co-location of all relevant professionals allows for real-time interdepartmental communication; shared decision making between clinicians and patients; avoids multiple appointments; reduces uncertainty with peri-operative planning as well as providing a cost-effective and efficacious service. Discrepancies in the peri-operative plan for medicines arose when the treating orthopaedic surgeon was not present in clinic. In these cases, the plan for surgical treatment was made outside of this clinic, without input from the treating rheumatologist. To improve concordance with BSR peri-operative medicine guidelines, it is recommended that all treatment decisions are made during the clinic, allowing input from all relevant partners. Informal feedback from patients commended the foot MDT, this shall be formalised through further qualitative data.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2020-eular.343

AB1346-HPR

REAL-WORLD EFFECTIVENESS AND PERCEIVED USEFULNESS OF SYMPTOM CHECKERS IN RHEUMATOLOGY: INTERIM REPORT FROM THE PROSPECTIVE MULTICENTER BETTER STUDY

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Background: Symptom checkers (SC) promise to reduce diagnostic delay, misdiagnosis and effectively guide patients through healthcare systems. They are increasingly used, however little evidence exists about their real-life effectiveness.

Objectives: The aim of this study was to evaluate the diagnostic accuracy, usage time, usability and perceived usefulness of two promising SC, ADA (www.ada.com) and Rheport (www.rheport.de). Furthermore, symptom duration and previous symptom checking was recorded.

Methods: Cross-sectional interim clinical data from the first of three recruiting centers from the prospective, real-world, multicenter bETTER-study (DKRS DRKS00017642) was used. Patients newly presenting to a secondary rheumatology outpatient clinic between September and December 2019 completed the ADA and Rheport SC. The time and answers were recorded and compared to the patient's actual diagnosis. ADA provides up to 5 disease suggestions, Rheport calculates a risk score for rheumatic musculoskeletal diseases (RMDs) (≥ 1 =RMD). For both SC the sensitivity, specificity was calculated regarding RMDs. Furthermore, patients completed a survey evaluating the SC usability using the system usability scale (SUS), perceived usefulness, previous symptom checking and symptom duration.

Results: Of the 129 consecutive patients approached, 97 agreed to participate. 38% (37/97) of the presenting patients presented with an RMD (Figure 1). Mean symptom duration was 146 weeks and a mean number of 10 physician contacts occurred previously, to evaluate current symptoms. 56% (54/96) had previously checked their symptoms on the internet using search engines, spending a mean of 6 hours. Rheport showed a sensitivity of 49% (18/37) and specificity of 58% (35/60) concerning RMDs. ADA's top 1 and top 5 disease suggestions concerning RMD showed a sensitivity of 43% (16/37) and 54% (20/37) and a specificity

of 58% (35/60) and 52% (31/60), respectively. ADA listed the correct diagnosis of the patients with RMDs first or within the first 5 disease suggestions in 19% (7/37) and 30% (11/37), respectively. The average perceived usefulness for checking symptoms using ADA, internet search engines and Rheport was 3.0, 3.5 and 3.1 on a visual analog scale from 1-5 (5=very useful). 61% (59/96) and 64% (61/96) would recommend using ADA and Rheport, respectively. The mean SUS score of ADA and Rheport was 72/100 and 73/100. The mean usage time for ADA and Rheport was 8 and 9 minutes, respectively.

Conclusion: This is the first prospective, real-world, multicenter study evaluating the diagnostic accuracy and other features of two currently used SC in rheumatology. These interim results suggest that diagnostic accuracy is limited, however SC are well accepted among patients and in some cases, correct diagnosis can be provided out of the pocket within few minutes, saving valuable time.

Figure:

Acknowledgments: This study was supported by an unrestricted research grant from Novartis.

Disclosure of Interests: Johannes Knitza Grant/research support from: Research Grant: Novartis, Jacob Mohn: None declared, Christina Bergmann: None declared, Eleni Kampylafka Speakers bureau: Novartis, Janssen, Melanie Hagen: None declared, Daniela Bohr: None declared, Elizabeth Araujo Speakers bureau: Novartis, Lilly, Abbott, Matthias Englbrecht Grant/research support from: Roche Pharma, Chugai Pharma Europe, Consultant of: AbbVie, Roche Pharma, RheumaDatenRhePort GbR, Speakers bureau: AbbVie, Celgene, Chugai Pharma Europe, Lilly, Mundipharma, Novartis, Pfizer, Roche Pharma, UCB, David Simon Grant/research support from: Else Kröner-Memorial Scholarship, Novartis, Consultant of: Novartis, Lilly, Arnd Kleyer Consultant of: Lilly, Gilead, Novartis, Abbvie, Speakers bureau: Novartis, Lilly, Timo Meinderink: None declared, Wolfgang Vorbrüggen: None declared, Cay-Benedict von der Decken: None declared, Stefan Kleinert Shareholder of: Morphosys, Grant/research support from: Novartis, Consultant of: Novartis, Speakers bureau: Abbvie, Novartis, Celgene, Roche, Chugai, Janssen, Andreas Ramming Grant/research support from: Pfizer, Novartis, Consultant of: Boehringer Ingelheim, Novartis, Gilead, Pfizer, Speakers bureau: Boehringer Ingelheim, Roche, Janssen, Jörg Distler Grant/research support from: Boehringer Ingelheim, Consultant of: Boehringer Ingelheim, Paid instructor for: Boehringer Ingelheim, Speakers bureau: Boehringer Ingelheim, Peter Bartz-Bazzanella: None declared, Georg Schett Speakers bureau: AbbVie, BMS, Celgene, Janssen, Eli Lilly, Novartis, Roche and UCB, Axel Hueber Grant/research support from: Novartis, Lilly, Pfizer, Consultant of: Abbvie, BMS, Celgene, Gilead, GSK, Lilly, Novartis, Speakers bureau: GSK, Lilly, Novartis, Martin Welcker Grant/research support from: Abbvie, Novartis, UCB, Hexal, BMS, Lilly, Roche, Celgene, Sanofi, Consultant of: Abbvie, Actelion, Aescu, Amgen, Celgene, Hexal, Janssen, Medac, Novartis, Pfizer, Sanofi, UCB, Speakers bureau: Abbvie, Aescu, Amgen, Biogen, Berlin Chemie, Celgene, GSK, Hexal, Mylan, Novartis, Pfizer, UCB

DOI: 10.1136/annrheumdis-2020-eular.1604

AB1347-HPR

DIGITAL SOLUTIONS TO AID SELF-MANAGEMENT: DEVELOPING A RHEUMATOLOGY APP FOR USE BY ANY PATIENT ATTENDING OUR DEPARTMENT

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Background: Managing complex rheumatological conditions requires information about the disease itself, treatments regimes and side effects. This is particularly important for those with a new diagnosis.