recommendations for the role of the RNS which were recently updated (Beech et al., 2019). This framework maps all of these requirements.

Objectives: This work supports the development of roles, improve access for patients and reduce. This document will act as a foundation for building sustainability and a more robust education and role development strategy. This work will strengthen rheumatology nursing and support all 4 UK nation's issues regarding recruitment, retention, sustainability, succession planning and benchmarking. Dissemination is key and we will work hard with stakeholders to ensure centralization of a nationally adopted framework. This abstract submission will increase dissemination opportunities.

Methods: Online data sources were searched for the most relevant and current evidence. Where research evidence wasn't available, existing and new knowledge was utilised from a consensus of clinical expert and patient opinions, several rounds of discussions took place virtually and face to face. RCN Rheumatology Nurse Forum Workshop attendees in June 2019 also answered a questionnaire to elicit views and demographic information regarding roles.

Results: The questionnaire results demonstrated 100% (n37) agreement with the development of the framework and that only 2 respondents had completed a competency process. 60% were RNS. Of these 52% (n13) were band 6, 47% (n9) were band 7, and 1% were band 8 consultant nurses. The questionnaire highlighted the need to develop the framework. Results were fed back to the working party to inform the domains to be included.

Conclusion: Document will be at BSR 2020 having successfully submitted a session proposal and abstract. Evaluation will begin later in the year 6 to 12 months from launch. We will measure impact using a variety of methods including membership Facebook pages and the questionnaire at point of download request. We will measure where and how the competency is being used and adoption of the framework throughout the UK.

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AB1358-HPR DIAGNOSIS OF AXIAL SPONDYLOARTHRITIS: A PRIMARY UNMET EDUCATIONAL NEED FOR RHEUMATOLOGISTS

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Background: Diagnosis of axial spondyloarthritis (axSpA) is challenging because of absent physical findings in early disease and the limited diagnostic performance of laboratory markers. Considerable reliance is placed on imaging of the sacroiliac joints (SIJ) but specialty training is primarily focused on interpretation of plain radiographic abnormalities.

Objectives: We aimed to identify what might be the primary unmet educational needs of rheumatologists completing fellowship training by using clinical and imaging data from an inception cohort of patients presenting with undiagnosed back pain. We hypothesized that concordance would increase after imaging is reviewed after the clinical data.

Methods: The diagnosis of axSpA was compared between local rheumatologists, axSpA experts and pF using clinical and imaging data from the multicenter Screening for Axial Spondyloarthritis in Psoriasis, Iritis, and Colitis (SASPIC) Study. In this inception cohort, patients ≤45 years of age with ≥3 months back pain undergo diagnostic evaluation by a local SASPIC rheumatologist, including

imaging of the SIJ, who then records a global evaluation of presence/absence of axial SpA. This is done at 3 consecutive stages: 1. After the clinical evaluation. 2. After the results of labs (HLA B27, CRP) and radiography. 3. After review of the local MRI. In this exercise, 20 cases were selected from the SASPIC cohort and the rheumatologist global evaluations were removed from the eCRFs. Four experts in axSpA reviewed the clinical and imaging data in each eCRF and provided their global evaluations for stages 1, 2, and 3 of these 20 cases. Subsequently, 4 pF rheumatologists conducted the same exercise blinded to the assessments of the local rheumatologist and experts in axSpA. Concordance (% agreement) between the assessors was analyzed.

Results: Diagnosis of axSpA by the local SASPIC rheumatologist was made in 90%, 65%, and 75% of cases after stages 1, 2, and 3, respectively. Majority diagnosis of axSpA by experts was made in 84.2% (16/19), 57.9% (11/19), and 63.2% (12/19), after stages 1, 2, and 3, respectively. Majority diagnosis of axSpA by pF rheumatologists was made in 94.4% (17/18), 100% (16/16), and 93.8% (15/16). Concordance among experts and between experts and local SASPIC rheumatologists increased after review of imaging data. For pF-rheumatologists concordance with experts increased after review of imaging for 2 assessors and decreased for the other 2 assessors. For the latter, the primary reason for decrease in concordance with experts was false positive diagnosis of axSpA in 35% and 30% of the cases after review of the imaging.

Conclusion: A structured case-based and sequential evaluation of clinical and imaging data suggests a gap in the training of recently graduated rheumatologists, with over-interpretation of imaging leading to false positive diagnosis of axSpA.

Assessors	Mean % Concordance (range) for diagnosis of axSpA		
	Stage 1	Stage 2	Stage 3
Experts in axSpA	64.2 (45-80)	75.8 (65-85)	84.2 (70-95)
Local rheumatologist vs Experts in axSpA	73.8 (70-80)	83.8 (80-85)	83.8 (80-90)
pF rheumatologist 1 vs Experts consensus	78.9	94.4	94.7
pF rheumatologist 2 vs Experts consensus	89.5	61.1	68.4
pF rheumatologist 3 vs Experts consensus	63.2	72.2	84.2
pF rheumatologist 4 vs Experts consensus	89.5	66.7	68.4

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AB1359-HPR PERCEPTION ABOUT FIBROMYALGIA AND ITS ACCOMPANYING SYMPTOMS AMONG MEXICAN PHYSICIANS

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Background: Previous studies showed that 93% of rheumatologists consider fibromyalgia (FM) as a clinical entity. However, accompanying symptoms such as fatigue, widespread pain, sleep disturbance and headache are underrecognized among physicians. According to a previous study, most recognized symptoms by general practitioners are fatigue and widespread pain (72.6%), while about thirty percent of physicians recognize sleep disturbance and depression as symptoms.

Objectives: To investigate physicians' point of view of FM accompanying symptoms in northeastern Mexico.

Methods: We designed an electronic survey about physicians' perceived importance of depression, fatigue, widespread pain, sleep disturbances, headache and irritable bowel disease symptoms (pain and cramping) in patients with FM. Questions were answered using a 5-point Likert scale: 1, strongly disagree; 2, disagree; 3, neutral; 4, agree; 5, strongly agree. General practitioners, rheumatologists, neurologists, psychiatrists were included.

Results: A total of 236 physicians were included: general practitioners, 149 (59.3%); rheumatologists, 21 (8.9%); neurologists 18 (7.6%); psychiatrists 8