Table 1

	All patients	Only those with suspected autoimmune or chronic inflammatory disease in referral note	Patients referred for other reasons (fibromyalgia, arthralgia, myalgia, osteoporosis, etc.)	p
Number (%)	136 (100)	71 (52.2)	65 (47.8)	NA
Age, mean years (SD)	51.8 (16.3)	50.7 (16.4)	53.1 (16.2)	NS
Men, n (%)	24 (17.6)	15 (21.1)	9 (13.8)	NS
Time between referral and triage, median days (IQR)	46.5 (23-140)	34 (15.5-124.5)	54 (28-441)	0,017
Triage resolution				
Urgent control, n (%)	92 (67.6)	55 (77.5)	37 (56.9)	0,011
Normal Control, n (%)	25 (18.4)	12 (16.9)	13 (20)	NS
Primary care coordination, n (%)	19 (14)	4 (5.6)	15 (23.1)	0,003
Time between triage and first control, median days (IQR)	21 (14-42)	21 (12.5-41)	26 (21-42)	NS
First control resolution, n (%)	96 (70.6)	54 (76.1)	42 (64.6)	NS
Diagnosis confirmation, n (%)	37 (38.5)	26 (48.1)	11 (16.9)	0,028
Continue control, n (%)	41 (42.7)	26 (48.1)	15 (23.1)	NS
Discharge to primary care, n (%)	18 (18.8)	2 (3.7)	16 (24.6)	<0,001

SD: standard deviation; n: number; IQR: Interquartile range

Conclusion: We consider this strategy as successful in reducing care times and identifying patients who require an early start of treatment and close control. Referral notes from primary care were generally adequate to identify patients who required to continue rheumatologist control.

References: None.

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THU0560

PRIMARY CARE PHYSICIAN PERSPECTIVES ON DELAYS IN DIAGNOSIS OF AXIAL SPONDYLOARTHRITIS: A QUALITATIVE STUDY

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Background: The average delay in diagnosis for patients with any form of spondyloarthritis (SpA) ranges from 7 to 10 years [1–5]. In axial spondyloarthritis (axSpA), a subgroup of SpA, it is 5 to 14 years [4, 6, 7]. Factors that contribute to this delay include the lack of diagnostic criteria for axSpA and the difficulty in distinguishing inflammatory back pain (IBP), a key symptom of axSpA, from other highly prevalent forms of low back pain [8–10]. This impedes timely referral of these patients to rheumatologic care and initiation of appropriate treatment.

Objectives: Describe understanding of, attitudes towards, and practices regarding axSpA among primary care physicians.

Methods: We recruited 18 primary care physicians practicing in the United States as part of a larger qualitative study: the SpondyloArthritis Screening and Early Detection (SpA-SED) Study. We used purposive sampling with a goal of including an equal number of family medicine and internal medicine physicians who were balanced by gender. Physicians provided informed consent to participate in an in-depth interview (up to 60 minutes), conducted in person (n = 3) or over the phone (n = 15), between February and May 2019. The interview guide

was developed by a multidisciplinary team, with input from rheumatologists. Topics included the physicians' approaches to evaluating back pain, their awareness about axSpA, their differential diagnosis of axSpA, the laboratory tests and imaging studies ordered when axSpA is suspected, their referral patterns for patients with presumed axSpA, their thoughts about factors contributing to diagnostic delay in axSpA, and their opinions about an Inflammatory Back Pain Assessment – ASAS criteria screening tool [5].

Results: Barriers to early diagnosis included patient factors (eg, multiple complaints, back pain not being the chief complaint), disease characteristics (eg, slow rate of disease progression), physician characteristics (eg, lack of rapport between patients and their primary care physicians), and structural/system issues (eg, lack of time). Most physicians reported that they would perform laboratory tests before referring a patient to a rheumatologist.

Conclusion: Primary care physicians were surprised to learn of the average delay to axSpA diagnosis, considered that this lengthy delay was problematic, and agreed that improvements are needed in screening for and early detection of axSpA. Physicians believed that there would be a role for using a screening tool in the primary care setting to improve diagnostic delay, but that evidence to support its implementation is needed.

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PREDICTING LIVER TOXICITY CAUSED BY CONVENTIONAL SYNTHETIC DISEASE-MODIFYING ANTIRHEUMATIC DRUGS

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Background: Routine laboratory testing is recommended for early identification of toxicity during conventional synthetic disease modifying antirheumatic drug (csDMARD) treatment. Based on expert consensus, testing is recommended every 2–4 weeks for the first 3 months and quarterly thereafter (1).

Objectives: In addition to evaluating the incidence of alanine transaminase (ALT) elevations in rheumatoid arthritis (RA) patients initiated on 1–2 csDMARDs, we aimed to distinguish patterns in ALT levels to develop a model for identifying patients at high risk for liver toxicity.

Methods: We identified RA patients who were initiated a new csDMARD course at the rheumatology clinic of Turku University Hospital in 2013–2019. Baseline and follow-up safety monitoring results were drawn from the electronic health record (EHR) data. Data on diagnoses and csDMARD initiation/cessation dates were manually confirmed from the EHR.

As the primary endpoint, we used ALT-elevations of more than twice the upper limit of reference range (women ≥ 70 U/l, men ≥ 100 U/l) within 6 months after treatment initiation. Intergroup differences were tested using Mann-Whitney test for continuous variables and the chi-square test or Fisher's exact test ($n < 5$) for categorical variables. Associations between different