of difference between cancer and SSc diagnosis. No association was found between neoplasia and certain antibodies. We recommend further studies to evaluate the relationship between SSc and cancer.

Disclosure of Interests: None declared

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THU0636-HPR REMS TECHNOLOGY APPLIED TO RHEUMATIC DISEASE

M. D. Tomai Pitinca¹, C. Caffarelli², S. Gonnelli². ¹National Research Council, Institute of Clinical Physiology, Lecce, Italy; ²Department of Medicine, Surgery and Neuroscience, University of Siena, Siena, Italy

Background: Many Rheumatic disease such as rheumatoid arthritis, juvenile idiopathic arthritis, psoriatic arthritis, ankylosing spondylitis, systemic lupus erythematosus, dermatomyositis/polymyositis and vasculitis are characterised by osteoporosis and fragility fractures. Inflammatory cytokines, steroid treatment, immobilization and reduced physical activity due to joint pain and muscle weakness are considered the major risk factors for the development of low bone mineral density in these diseases. Many evidences have highlighted the role of pro-inflammatory cytokines (TNF- α , IL-1, IL-6, IL-7, IL17) in bone homeostasis regulation. Chronic inflammation is often characterized by an imbalance between bone formation and resorption, with a clear prevalence of osteoclastogenesis which is a strong determinant in rheumatic diseases bone loss.

Objectives: The aim of this study is to evaluate the REMS (Radiofrequency Echographic Multi-Spectrometry) technology in rheumatologic patients, compared to DEXA currently recognised as the gold standard for the evaluation of bone mineral density.

Methods: Twenty female patients (mean age 60.6 $\pm$ 14.41 years) with different rheumatologic diseases were considered. Each patient underwent a lumbar spine and hip examination performed by DEXA and REMS technology. In particular, after a quality control to assess that both the exams were performed correctly, 18 lumbar and 20 femoral exams (DEXA vs REMS) were compared.

Results: As Expected the exams performed show a good diagnostic match (>60%LS and >85% FEMORE). The tests that didn't show diagnostic concordance were those affected by arthrosis processes (greater on the Spine). The REMS T-score values were lower than those obtained with the DXA method.

Conclusion: These results show how REMS technology can discriminate patients with osteoporosis as much as DEXA technology. The REMS technology can be a diagnostic option especially in patients with rheumatologic diseases that cause alterations in the spine reducing the diagnostic sensitivity of DXA technology.

Disclosure of Interests: None declared

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THU0637-HPR THE ASSOCIATION BETWEEN THE RECALL PERIOD AND THE AMOUNT OF INFORMATION ABOUT REPORTED ADVERSE DRUG REACTIONS BY PATIENTS USING BIOLOGICALS

A. Laurijssen¹, J. Van Lin², B. Van den Bemt^{1,3}, L. Beijer^{1,3}, N. Jessurun².

¹Radboud University, Nijmegen, Netherlands; ²Pharmacovigilance centre Lareb, 's Hertogenbosch, Netherlands; ³Sint Maartenskliniek, Nijmegen, Netherlands

Background: In order to monitor the safety of medicines pharmacovigilance, it is important that patients report their adverse drug reactions (ADRs). Theoretically, the quality of the reported information might be affected by the elapsed time between the onset of the ADR and the moment of reporting. Real-life evidence demonstrating a negative relationship between this recall period and the quality of reported ADRs is however lacking.

Objectives: To assess the effect of recall period on the amount of information that patients report about their ADR (information density) in patients using a biologic for an immune-mediated inflammatory disease (IMID).

Methods: The Dutch Biologic Monitor is a multi-center cohort ADR monitoring system collecting data on reported ADRs by patients using a biologic for an IMID. Per patient, every first unique reported ADR between 1 February 2017 and 1 September 2019 was eligible. ADR reports were selected by stratified random sampling based on length of recall period and biologic. The recall period was defined by the number of days between the onset and reporting date of the ADR. The amount of information in an ADR report (information density) was determined based on eleven domains: specification, location, frequency, time-to-onset, course, causality, cause or consequence, health care professional (HCP) visits, HCP action, patient action and ADR burden. Information density was

calculated by the number of reported domains divided by the number of domains deemed relevant in the ADR report. The association between the information density of the ADR reports and different recall periods was compared using a one-way ANOVA test. One-way ANOVA and independent t-tests were used to assess the impact of gender, age, type biologic and burden of the ADR on the information density of the reported ADRs.

Results: Out of 1109 reported ADRs by 531 IMID patients, we included 402 ADR reports of 294 patients (55%) (see table 1). Included reports were equally divided over seven different recall periods: 0-1, 1-2, 2-4, 4-8, 8-12, 12-26 and 26-52 weeks. Results have shown no association between the information density in patient-reported ADRs and the length of recall period ($p=0.805$) (figure 1). However, the proportion of reported information about HCP visits for the ADR increased with increasing recall period: 0-1 week (14%), 1-2 weeks (24%), 2-4 weeks (34%), 4-8 weeks (40%), 8-12 weeks (48%), 12-26 weeks (50%) and 26-52 weeks (46%).

Table 1. Characteristics of included patients with adverse drug reactions

Characteristics (N=294)	N (%)
Gender (female)	202 (69%)
Age (years) (mean $\pm$ SD)	53 $\pm$ 13
Smoking	59 (20%)
BMI (kg/m ²) (mean $\pm$ SD)	25.7 $\pm$ 5.3
Reported ADRs (mean $\pm$ SD)	1.4 $\pm$ 0.8
Indication	
Rheumatoid arthritis	129 (44%)
Psoriatic arthritis	51 (17%)
Axial spondyloarthritis	43 (15%)
Crohn's disease	42 (14%)
Other indications	29 (10%)
Biologic	
Adalimumab	97 (33%)
Etanercept	72 (24%)
Infliximab	27 (9%)
Tocilizumab	16 (5%)
Secukinumab	15 (5%)
Rituximab	14 (5%)
Other biologics	53 (18%)

Female patients reported more information about their ADR ($p=0.002$), whereas the patient's age was not associated with information density ($p=0.221$). Etanercept (ETA) users report significantly more information than adalimumab (ADA) users ($p=0.019$). The number of patients using other biologics was too low for further analysis. A higher ADR burden tended ($p=0.120$) to result in more reported ADR information (figure 2).

Conclusion: The length of recall period did not affect the amount of information that patients report about their ADR(s). The recall period was longer for patients reporting information about their HCP visit. Furthermore, female patients tend to report more information about their ADR than male patients and ETA-users tend to report more than ADA-users.

Figure 1: No effect of length of recall period on information density in patient-reported ADRs