Objectives: To determine adherence to the RCOphth guidelines for HCQ screening within the Rheumatology departments in the North-West of the UK.

Methods: Data for patients established on HCQ and those initiated on HCQ therapy were collected over a 7 week period from 9 Rheumatology departments.

Results: 473 patients were included of which 56 (12%) were new starters and 417 (88%) were already established on HCQ. 79% of the patients were female, with median ages of 60.5 and 57 years for new and established patients respectively. The median (IQR) weight for new starters was 71 (27.9) kg and for established patients, 74 (24.7) kg.

20% of new starters exceeded 5mg/kg daily HCQ dose. 16% were identified as high risk (9% had previously taken chloroquine, 5% had an eGFR <60ml/min/m² and 2% had retinal co-pathology). Of the high-risk group, 44% were taking <5mg/kg. In total, 36% of new starters were referred for a formal baseline Ophthalmology review. In the established patients, 74% were taking ≤5mg/kg/day HCQ dose and 16% were categorized as high risk (10% had an eGFR less than 60ml/min/m², 3% had previous chloroquine or tamoxifen use and 2% had retinal co-pathology). In the high-risk group, 75% were not referred for spectral domain optical coherence tomography (SD-OCT). 41% of patients established on HCQ for <5 years, and 33% of patients on HCQ for >5 years were not referred for SD-OCT. Reasons for not referring included; awaiting 5 year review, previous screening already performed and optician review advised.

Since the introduction of the RCOphth guidelines, 29% patients already established on HCQ had an alteration in the dosage of HCQ in accordance with the guidelines. In the high-risk group, 16% were not on the recommended HCQ dose.

Conclusion: This audit demonstrates inconsistencies in adherence to the RCOphth guidelines for HCQ prescribing and ophthalmology screening within Rheumatology departments in the North-West of the UK for both new starters and established patients. Plans to improve this include wider dissemination of the guidelines to Rheumatology departments and strict service level agreements with ophthalmology teams to help optimize HCQ prescribing and screening for retinopathy.

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HPR Epidemiology and public health (including prevention)

FRI0650-HPR SEXUAL DYSFUNCTION IN WOMEN WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: Sexual dysfunction is the alteration in one or several phases of sexual activity (desire, excitement, plateau, orgasm and resolution), which can culminate in frustration, pain and a decrease in the frequency of sexual intercourse. There are few studies that associate sexual dysfunction with Systemic Lupus Erythematosus (SLE) due to the difficulty in assessing it and its multifactorial cause.

Objectives: Determine the frequency of sexual dysfunction and analyze associated factors in patients with SLE.

Methods: A descriptive cross-sectional study was conducted. We included patients who attended the Rheumatology unit between May and July 2019; over 18 years of age, with a diagnosis of SLE according to the ACR 1997 and / or SLICC 2012 criteria, and healthy patients matched by age as control. Demographic and disease-related variables were studied. The DASS-21 (Depression Anxiety Stress Scale) scale that evaluates depression, anxiety and stress, and the Female Sexual Function Index (FSFI) that assesses 6 domains (desire, excitement, lubrication, orgasms, satisfaction and pain) were applied with a cut-off point ≤ 26.5 to define sexual dysfunction. Women over 50 years old, with secondary Sjogren's syndrome, menopause, severe depression and illiterate patients were excluded.

Results: One hundred and twenty three women were included (60 with SLE and 63 controls), with a mean age of 34.3 ± 8.3 and 31.7 ± 4.4 years respectively. The prevalence of sexual dysfunction in the SLE group was 71.7%; 95% CI = [58.5 – 82.5], and 23.8%, 95% CI = [13.9 – 36.2] in healthy patients. There were significant differences in all domains of sexual function between women with SLE and healthy group. In the desire, excitement and pain domains the differences were notable. The total FSFI score in patients with SLE was 18.2 ± 11.2 and in healthy women 28.3 ± 6.9 (p=0.001). Stress, anxiety and depression were observed in 58.4%, 58.3% and 50% of women with SLE and 19%, 20.6% and 28.5% of healthy women respectively (p=0.001). No association was found between sexual dysfunction and age, age at diagnosis, disease activity or treatment (pNS). No association was found in patients

with SLE when analyzing the effect of sexual dysfunction in stress, depression and anxiety variables, in opposition to the healthy group (p<0.05).

Conclusion: The prevalence of sexual dysfunction in patients with SLE was high (71.7%). Depression, Anxiety, and Stress were not decisive variables in Sexual Dysfunction.

Disclosure of Interests: None declared

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FRIDAY, 05 JUNE 2020

HPR Service developments, innovation and economics in healthcare

FRI0651-HPR A RANDOMIZED PROSPECTIVE OPEN-LABEL CONTROLLED TRIAL COMPARING THE PERFORMANCE OF A CONNECTED MONITORING INTERFACE IN PATIENTS WITH RHEUMATOID ARTHRITIS VERSUS PHYSICAL ROUTINE MONITORING

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Background: Telemedicine has found wider application in chronic diseases for encouraging tight home-monitoring in order to improve patients' outcome (Smolen et al. 2017).

In previous studies, a high feasibility and high patient-satisfaction rate was found as well as the evidence for a superior or equal effectiveness of telemedicine compared to the standard face-to-face approach, however the results were weakened by some methodological biases and wide heterogeneity of interventions, thus preventing to draw definitive conclusions (Piga et al. 2017; Najm, Gossec, et al. 2019).

Objectives: In rheumatoid arthritis (RA), telemedicine may allow a tight control of disease activity while reducing hospital visits. We developed a smartphone application connected with a physician's interface to monitor RA patients. We aimed to assess the performance of this e-Health solution in comparison with routine practice in the management of patients with RA.

Methods: A 6-month pragmatic, randomized, controlled, prospective, clinical trial was conducted in RA patients with high to moderate disease activity starting a new Disease Modifying Anti-Rheumatic Drug (DMARD) therapy. Two groups were established: "connected monitoring" and "conventional monitoring". The primary outcome was the number of physical visits between baseline and 6 months. Secondary outcomes included adherence, satisfaction, changes in clinical, functional, and health status scores (SF-12).

Results: Of the 94 randomized patients, 89 completed study: 44 in the "conventional monitoring" arm and 45 in the "connected monitoring" arm. The total number of physical visits between baseline and 6 month was significantly lower in the "connected monitoring" group (0.42 ± 0.58 versus 1.93 ± 0.55; p<0.05). No differences between groups were observed in the clinical and functional scores. A better quality of life for SF-12 subscores (Role-Physical, Social-Functioning and Role-Emotional) were found in the "connected monitoring" group.

Conclusion: According to our results, a connected monitoring reduces the number of physical visits while maintaining a tight control of disease activity and improving quality of life in patients with RA starting a new treatment.

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FRI0652-HPR DEVELOPMENT OF THE ADVANCED PRACTICE NURSING CONSULT IN RHEUMATOLOGY IN THE MULTIDISCIPLINARY APPROACH OF INFLAMMATORY DISEASES MEDIATED BY IMMUNITY

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Background: Patients with immunity mediated inflammatory diseases (IMID) often have clinical manifestations and comorbidity in the field of various medical specialties. A center has been created in our hospital for the comprehensive care of patients with IMID. It is an innovative healthcare model, that incorporate patients into its governance. Physicians, pharmacists and advanced practice nurses (APN), collaborates in consultation or in the day hospital (DH).

Objectives: To analyze the activity of the rheumatology APN consult integrated in the multidisciplinary team, and the impact on health care and quality of life on IMID patients.

Methods: Descriptive study of the rheumatology APN activity since the opening of the center for a year. The APN consultations were face-to-face (scheduled or demanded) or by telephone. Variables measured: demography, diagnosis, treatments, clinic activity and patient reported outcomes (PRO). In the face-to-face consultation, was included: integral valuation (clinic, functional and psychosocial), education for Health (information about disease and treatments, adverse effects, healthy living habits), drug administration, emotional support. In the telephone consultation, the rheumatology APN is the reference professional for monitoring, question solving and advice in case of flare or adverse event.

Results: 721 patients were evaluated, mean age 54.6 years, (range, SD) (20-90, 13.9), 61.3% women, with a total of 1737 consults. Diagnosis: 324 (44.9%) RA, 221 (30.6%) SpA, 100 (13.9%) PsA and 76 (10.5%) other diseases. Treatment modality: IV 293 (40.4) SC 399 (55.3%) and oral 29 (4.0%). Rheumatology APN activities are described in Table 1. 1415 face-to-face consultation were made, 82.7% scheduled and 17.2% demanded either by the patient, the rheumatologist or another member of the multidisciplinary work-team. Among the face-to-face consultations, 62 (4.4%) patients were attended the same day in the medic consult due to disease flare or other disease problems, 38 (2.7%) patients were sent to another specialist of the work-team due to co-morbidity. The activity executed in the rheumatology APN consultation is shown in Table 2

Table 1. Educative interventions by the APN.

- Information about the disease
- Information about the treatment
- Medicine administration
- Adverse effects of the medicine
- Healthy life style habits
- Vaccines
- Evaluation of cardiovascular risk
- Signs and symptoms of alerts due to the pathology
- Ongoing following of the evolution of the disease.
- Support for the achievement of the treatment and possible difficulties.

Table 2. Activity done in the consult. N° 1.737

Face-to-face activity	N° consults 1.415	Non face-to-face activity	N° consults 322
Complete valuation due to necessities	721 (51%)	Valuation	58 (18.0%)
Educative Interventions	1.305 (92.2%)	Questions	96 (29.8%)
Valuation and following	1.372 (97.0%)	Test result	26 (8.1%)
PRO execution	1.156 (81.7%)		
Articular counting's	733 (51.8%)		
Valuation of the diseases activity	737 (52.1%)	Process of appointment	105 (32.6)
•DAS28 PCR	419 (26.6%)	•Requested by the doctor	50 (47.0%)
•ASDAS-PCR		•Requested by the patient.	55(53.0%)
Cardiovascular risk valuation.	721 (51.0%)	Derivative to different medical consults	37 (11.5%)
Blood extraction	724 (51.2%)	Solved by APN	285(88.5%)
Analytics monetarization	1.171 (82.8%)		
Medicine monetarization	1.372 (97.0%)		

Day Hospital Management

Conclusion: The rheumatology APN takes a vital part in the multidisciplinary team, offering a holistic approach, as well as efficient and high-quality care, offering quick response, reducing waiting time and becoming an important part of this patient-centered model.

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HPR Interventions (educational, physical, social and psychological)

FRI0653-HPR AN OLEUROPEIN-BASED DIETARY SUPPLEMENT IMPROVES JOINT FUNCTIONALITY IN OLDER PEOPLE WITH HIGH KNEE JOINT PAIN

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Background: OLE provides oleuropein the most prevalent phenolic component in olive leaves and has been shown to have potent anti-inflammatory and anti-oxidant effects potentially interesting for joint health (1).

Objectives: The aim of this study was to investigate the effects of a 6-month intervention with an Olive Leaf Extract (OLE) standardized for oleuropein content on knee functionality and biomarkers of bone/cartilage metabolism and inflammation.

Methods: The study was a randomized, double-blind, placebo-controlled, multi-centric trial of 124 subjects with mild knee pain or mobility issues. Subjects were randomized equally to receive twice a day one capsule of either maltodextrin (control treatment, CT) or 125-mg OLE (BonoliveTM, an Olive Leaf Extract containing 50mg of Oleuropein) for 6 months. The co-primary endpoints were Knee injury and Osteoarthritis Outcome Score (KOOS) using a self-administered questionnaire and serum Coll2-1NO2 specific biomarker of cartilage degradation. The secondary endpoints were each of the five sub-scales of the KOOS questionnaire, Knee pain VAS score at rest and at walking, OARSI core set of performance-based tests and serum biomarkers (Coll2-1, MPO, CTX1, osteocalcin, PGE2 and Vplex cytokines assay in serum) and concentration of Oleuropein's metabolites in urine.

Results: Primary (global KOOS score, biomarker Coll2-1 NO2) and secondary endpoints (the five subscales of the KOOS score) improved time dependently in both groups. OLE treatment showed significantly elevated urinary oleuropein metabolites (oleuropein aglycone, hydroxytyrosol, homovanillyl alcohol and isomer of homovanillyl alcohol), and was well tolerated without significant differences in number of subjects with adverse events. At 6 months, OLE group showed a higher global KOOS score compared to placebo (treatment difference = 3.73; 95% CI = [-4.08;11.54]; p = 0.34), without significant changes of inflammatory and cartilage remodeling biomarkers. Subgroup analyses demonstrated a large and significant treatment effect of OLE in subjects with high walking pain at baseline (14.4; 95% CI = [1.19;27.63], p=0.03). This was observed at 6 months for the global KOOS score and each different subscale and for pain at walking (-23.07;95% CI = [-41.8;-4.2];p=0.02). These treatment effects at 6 months were significant for KOOS score as well as for the subscales Pain and QoL and the pain at walking.

Conclusion: OLE was not effective on joint discomfort in people with low to moderate pain at baseline but significantly benefited subjects with high pain at treatment initiation. As oleuropein is well-tolerated, OLE can be used to relieve knee joint pain and enhance mobility in subjects with articular pain the most painful subjects.

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