% of patients presented with RA, OA or OP. Mean age ($\pm$ SE) was 78 ± 7 in PEMF-45 and 77 ± 7 in PEMF-60. As expected, all physical performance tests improved significantly from baseline to 6 months in both groups. Mean ($\pm$ SE) 4MGS increased significantly more in PEMF-45 (from 3.24 ± 0.12 sec to 2.83 ± 0.18 sec) compared to PEMF-60 (from 3.22 ± 0.21 sec to 3.02 ± 0.30 sec, $p = .018$). Likewise, mean ($\pm$ SE) CST improved more in PEMF-45 (from 12.4 ± 0.9 sec to 8.7 ± 0.4 sec) compared to PEMF-60 (from 11.1 ± 1.5 sec to 9.8 ± 0.7 sec, $p = .002$). No significant difference between groups was found for the other tests, although a trend toward better results in PEMF-45 was manifest: SPPB improved by 6.4% in PEMF-45 and by 3.0% in PEMF-60, and TUG decreased by 7.8% in PEMF-45 and by 6.1% in PEMF-60. During the 6 months observation period no adverse event was observed.

Conclusion: Preliminary results of our ongoing prospective observational study suggest that a more frequent administration of PEMF produces greater improvements in some but not all physical performance parameters compared to a standard validated regimen^{1,2}.

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Education

POS1448

EVIDENCE BASED PRACTICE: WHAT IS THE EVIDENCE THAT BRITISH SOCIETY FOR RHEUMATOLOGY GUIDELINES ARE EVIDENCE BASED?

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Background: Clinical practice guidelines are designed to ensure that patients are treated according to best evidence, with the goal of optimizing clinical outcomes and reducing unwarranted variation in care. They compile, rate and translate the data available into recommendations that form the basis of evidence-based practice for most clinicians. Despite their importance, the evidence base informing different guidelines varies in quality. A recent study of American College of Rheumatology (ACR) Practice Guidelines demonstrated only 17 of 35 class I (strong benefit to harm ratio) recommendations were supported by level A evidence (high quality randomized controlled trials or meta-analyses)¹.

Objectives: To review the evidence supporting the British Society for Rheumatology (BSR) guidelines.

Methods: Thirteen sets of guidelines that were available on the BSR website as of October 16th 2019 were reviewed (<https://www.rheumatology.org.uk/practice-quality/guidelines>). A range of methodologies (including Grading of Recommendations Assessment, Development and Evaluation (GRADE), Scottish Intercollegiate Guidelines Network (SIGN), EULAR and Royal College of Physicians (RCP) recommendations) were used to assess the quality of evidence and strength of recommendation. For comparability between guidelines the level of evidence was converted to a score between I (highest quality) and IV (lowest quality) and the strength of recommendation was converted to a rating between A and D. The polymyalgia rheumatica guideline was not assessed due to unclear methodology and lack of level of evidence for all recommendations.

Results: Of the 12 BSR guidelines assessed, there were 554 recommendations in total. The number of recommendations per guideline ranged between 13 and 80. Across all assessed guidelines, 94 recommendations (17.0%) were classified as level I, 161 (29.1%) as level 2 and 299 (54.0%) as level 3 or 4. These figures are similar to those reported in the ACR guidelines (23%, 19% and 58% respectively)¹. The proportion of level I evidence varied from 46.2% (Axial Spondyloarthritis guideline) to 0% (Hot Swollen Joint guideline).

Conclusion: Over half of all BSR guideline recommendations have level of supporting evidence of III/IV. A wide range of methodologies are used to generate BSR guidelines (GRADE, SIGN, RCP / EULAR). This makes it challenging for

readers unfamiliar with these approaches to interpret evidence and hinders comparisons between guidelines. A standardized methodology for future guideline development would overcome these barriers.

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POS1449

SEGMENTED SHORT-FORMAT ONLINE EDUCATION SIGNIFICANTLY INCREASES PREDICTION, PROGNOSIS, AND MANAGEMENT OF FIBROSING INTERSTITIAL LUNG DISEASE ASSOCIATED WITH CONNECTIVE TISSUE DISEASE

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Background: Identifying fibrosing interstitial lung disease (ILD) at the earliest opportunity remains one of the most urgent challenges for the effective management of this potentially rapidly progressive and burdensome condition, which is frequently associated with several connective tissue diseases (CTDs). However, knowledge on how to identify early hallmarks and predictors of fibrosing ILD, as well as knowing which steps to take next is frequently lacking in clinical practice. **Objectives:** This study was conducted to determine whether online independent medical education could improve rheumatologists' and pulmonologists' knowledge and competence in identifying and managing progressive fibrosing ILDs earlier in the disease course.

Methods: Rheumatologists and pulmonologists participated in five ~10-min presentations about the early identification of fibrosing ILD in patients with or without CTDs and completed all pre- and post-questions.¹ The effects of the education on knowledge and competence were assessed using a 3-question, repeated pairs, pre-assessment/post-assessment study design. For all questions combined, the chi-square test assessed differences from pre- to post-assessment. P values <.05 are statistically significant. The activity launched on October 9, 2020, and data were collected through December 18, 2020.

Results: Overall significant improvements were seen after participation for both rheumatologists (average correct response rate of 28% at pre-assessment vs 74% at post-assessment; $P < .001$, representing a 165% relative percentage change [RPC]; $N = 39$), and pulmonologists (average correct response rate of 39% at pre-assessment vs 67% at post-assessment; $P < .001$, representing a 72% RPC; $N = 102$). Specifically, significant improvements were observed in clinicians' knowledge of predictors of fibrosing ILD in patients with CTD, as well as competence in selecting the right HRCT parameters to assess prognosis and select a treatment approach to reduce the risk of disease progression (Figure 1).

Figure 1.

After participating in the activity, 59% of rheumatologists and 50% of pulmonologists had measurable improved confidence related to identifying early disease progression in patients with progressive fibrosing ILDs.