Table 1. Summary of Positive Predictive Values (PPV) applying our algorithm to identify AAV diagnoses and RTX use

	Trust 1	Trust 2	Combined
Diagnosis of AAV and coded as AAV	69	44	113
AAV coded	74	46	120
Diagnosis of AAV under any code	73	55	128
PPV AAV ascertainment (95% CI)	93.2% (84.9-97.8)	95.7% (85.2-99.5)	94.2% (88.4-97.6)
Sensitivity of AAV ascertainment (95% CI)	94.5% (86.8-98.5)	80.0% (67.0-89.6)	88.3% (81.4-93.3)
RTX given in people coded as AAV	56	15	71
RTX coded in people coded as AAV	59	17	76
RTX given for AAV under any diagnostic or procedure code	64	23	87
PPV RTX ascertainment (95% CI)	94.9% (85.9-98.9)	88.2% (63.6-98.5)	93.4% (85.3-97.8)
Sensitivity of RTX ascertainment (95% CI)	87.5% (76.8-94.4)	65.2% (42.7-83.6)	81.6% (71.9-89.1)

Conclusion: HES data identified patients treated with RTX for AAV with a PPV of 93.4% (85.3-97.8) and sensitivity of 81.6% (71.9-89.1). This demonstrates the utility of national data to identify people receiving RTX for AAV. The REORDER project, within the National Disease Registration Service plans to conduct real-world studies of the high-cost drug RTX, given for AAV, across the whole of England, and assess whether geography, demographics or socioeconomic factors influence frequency of prescription of this, and potentially other, high-cost drugs in line with the NHS long term plan.

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Acknowledgements: I have no acknowledgements to declare.

Disclosure of Interests: Cattleys Godsave: None declared, Mithun Chakravorty: None declared, Megan Rutter: None declared, Peter Lanyon Grant/research support from: P.C.L. is a recipient of a grant from Vifor Pharma. Vifor Pharma had no influence on the design, conduct or interpretation of this study., Jeanette Aston: None declared, Mary Bythell: None declared, Sarah Stevens: None declared, Fiona Pearce Grant/research support from: I have received a research grant from Vifor Pharma

DOI: 10.1136/annrheumdis-2021-eular.1591

POS1413

INTERVAL BETWEEN SYMPTOM ONSET AND DIAGNOSIS AMONG PATIENTS WITH AUTOIMMUNE RHEUMATIC DISEASES IN A MULTI-ETHNIC ASIAN POPULATION

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Background: The interval between symptom onset and diagnosis can often be longer than is ideal in autoimmune rheumatic diseases (ARDs).

Objectives: We aimed to characterise this interval among patients newly diagnosed with ARDs in a multi-ethnic Asian population and to identify factors associated with a longer interval.

Methods: We used Scott's model of pathways to treatment to characterise the interval between symptom onset and diagnosis into 4 intervals: #1 between symptom onset and first seeking medical attention, #2 between first medical attention and rheumatology referral, #3 between rheumatology referral and first rheumatology assessment, and #4 between first rheumatology assessment and diagnosis. Linear regression models were used to identify factors associated with a longer the overall interval between symptom onset and diagnosis and Interval #1.

Results: Among 259 patients (age: 51±15 years, female: 71%, most common three ARDs: rheumatoid arthritis (n = 75), axial spondyloarthritis (n = 40) and psoriatic arthritis (n = 35)), the median overall interval was 11.5 months. Interval #1 (median = 4.9 months) was significantly longer than the other intervals (Table 1). Patients with axial spondyloarthritis had a significantly longer overall interval (median = 38.7 months) and Interval #1 (median = 26.6 months) compared to patients with RA (median = 7.6 and 3.5 months, respectively), PsA (median = 7.0 and 2.6 months, respectively) and the other ARDs. Gender was the only patient-related factor significantly associated with the overall interval (reference = male, coefficient = -15.3, p = 0.033) in regression models.

Conclusion: A longer than ideal interval between symptom onset and diagnosis was observed among patients with ARDs. This was primarily due to a relatively long interval between symptom onset and first seeking medical attention, and highlights the importance of interventions targeting patients prior to first medical attention in reducing the duration between symptom onset and diagnosis.

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Table 1. Interval between symptom onset and diagnosis

	Overall interval, months, median (lower and upper quartiles)†	Interval #1, months, median (lower and upper quartiles)	Interval #2, months, median (lower and upper quartiles)	Interval #3, months, median (lower and upper quartiles)	Interval #4, months, median (lower and upper quartiles)
Overall	11.5	4.9	0.3	1.5	0.0
(n = 259) RA	(4.7 – 36.0) 7.6	(1.0 – 24.0) 3.5	(0.0 – 3.9) 0.2	(0.8 – 1.8) 1.3	(0.0 – 1.2) 0.0
(n = 75) AxSpA	(3.1 – 14.8) 38.7	(1.3 – 11.6) 26.6	(0.0 – 2.5) 1.6	(0.6 – 1.6) 1.6	(0.0 – 0.2) 0.0
(n = 40) PsA	(9.6 – 66.7) 7.0	(4.2 – 56.1) 2.6	(0.0 – 7.6) 0.5	(1.2 – 2.3) 1.6	(0.0 – 2.0) 0.0
(n = 35) Seronegative IA	(3.0 – 28.4) 12.0	(0.2 – 11.3) 6.4	(0.2 – 3.9) 0.1	(0.6 – 1.7) 1.4	(0.0 – 0.0) 0.0
(n = 21) SjS	(4.7 – 22.8) 14.2	(1.9 – 34.4) 4.6	(0.0 – 4.6) 0.3	(1.3 – 1.5) 1.6	(0.0 – 0.8) 0.8
(n = 27) UCTD	(6.0 – 48.0) 15.7	(0.6 – 19.0) 2.2	(0.0 – 3.9) 0.8	(0.9 – 1.9) 1.6	(0.0 – 2.3) 1.2
(n = 27) Other ARDs	(5.1 – 39.8) 8.1	(0.7 – 24.0) 6.3	(0.1 – 8.1) 0.2	(0.5 – 1.8) 1.5	(0.0 – 2.1) 0.3
(n = 34)	(5.3 – 36.0)	(0.9 – 31.7)	(0.0 – 1.1)	(1.2 – 1.8)	(0.0 – 1.1)

Overall interval and Intervals #1-4: refer to abstract for definitions; RA: rheumatoid arthritis; axSpA: axial spondyloarthritis; PsA: psoriatic arthritis; IA: inflammatory arthritis; SjS: Sjögren's syndrome; UCTD: undifferentiated connective tissue disease; other ARDs: systemic lupus erythematosus, systemic sclerosis, idiopathic inflammatory myopathies, palindromic rheumatism and overlap syndromes.†Intervals #1-4 did not sum to the overall interval mainly due to the fact that Intervals #1-4 might not be available for all patients.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2021-eular.1713

POS1414

RHEUMATOID ARTHRITIS AND INTERSTITIAL LUNG DISEASE: PREVALENCE AND DRUG PRESCRIPTIONS IN GERMAN CLAIMS DATA

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Background: Persons with rheumatoid arthritis (RA) have an increased risk of interstitial lung disease (ILD). ILD is a serious extraarticular manifestation in RA with a significantly increased mortality but without evidence-based drug therapy (1).

Objectives: The aim of this analysis was to investigate the frequency of ILD diagnosis in RA using claims data and to identify the medications prescribed.

Methods: Data from a large German statutory health insurance fund were used to identify persons with one inpatient or two outpatient diagnoses of RA (ICD-10: M05, M06) and ILD (J84.1, J84.8, J84.9 and M05.1+J99.0) in 2019. Specialist care by rheumatologists and/or pulmonologists was identified using physician specialty numbers. Drug prescriptions of glucocorticoids, conventional synthetic disease modifying antirheumatic drugs (csDMARDs: methotrexate, leflunomide, sulfasalazine, hydroxychloroquine, mycophenolate), biologic (b) DMARDs (abatacept, rituximab, TNF inhibitors, tocilizumab) or targeted synthetic (ts) DMARDs (tofacitinib) were identified by ATC codes. Prescriptions were included if a person received at least one prescription of the respective drug in 2019.

Results: Among 7,479,000 persons over 18 years of age and insured in 2019 a total of 2.0% (n=148,000) had a diagnosis of RA and 1.1% (n=1,600) of those had an additional diagnosis of ILD. The majority of persons with RA+ILD