diagnosis was older than 70 years (59%), mean age was 72 years, 68% were female and 41% had a diagnosis of seropositive RA (M05). 4 out of 5 patients were in rheumatologist or pulmonologist care (36% both, 22% only rheumatologist, 22% only pulmonologist). In total, 67% received glucocorticoids, 49% csDMARDs and 19% bDMARDs and 1.8% tofacitinib. TNF inhibitors were the most frequently prescribed bDMARDs followed by abatacept and tocilizumab. Persons without specialized care received considerably less DMARD therapy (Table 1). Nintedanib was prescribed to 14 patients, pirfenidone to 10 patients, all of them were in specialist care.

Table 1. Demographics and treatment of persons with RA and ILD diagnosis, numbers are percentages unless indicated otherwise.

Variable	Not treated by rheumatologist or pulmonologist	Treated by rheumatologist and/or pulmonologist	All
N (%)	326 (20%)	1274 (80%)	1,600 (100%)
Age, mean years (std)	75 (10)	72 (10)	72 (10)
<70 years	35	43	41
70 to 80 years	31	39	37
>80 years	35	18	22
Female sex	67	69	68
Glucocorticoids	49	72	67
csDMARDs	24	56	49
MTX	13	30	27
Leflunomide	4.9	10	8.9
(Hydroxy-)chloroquine	2.8	9.0	7.8
Mycophenolate	1.2	2.2	2.0
Sulfasalazine	2.1	3.8	3.4
bDMARDs	7	22	19
TNF-alpha Inhibitors	3.4	9.0	7.9
Abatacept	2.1	5.6	4.9
Tocilizumab	1.2	3.6	3.1
Rituximab	0.9	2.9	2.5
Tofacitinib	1.5	1.9	1.8

Conclusion: ILD was diagnosed in one of 100 persons with RA diagnosis. Specialist care is necessary to provide disease-specific therapies. While methotrexate is the most commonly used DMARD, the bDMARD prescription is heterogeneous.

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POS1415 SOCIO-ECONOMIC IMPACT OF SJÖGREN'S SYNDROME IN WESTERN SWITZERLAND: A CROSS-SECTIONAL STUDY

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Background: Several studies investigated the socio-economic impact of Sjögren's syndrome (SS) showing an increased risk of work disability and a reduced health-related quality of life. SS is also associated with increased direct and indirect healthcare costs. There are no published data about Switzerland, a country with high resources and easy access to healthcare except dental care, which is rarely reimbursed.

Objectives: To evaluate the professional and economic impact of SS in patients living in Western Switzerland.

Methods: Cross-sectional survey-based study conducted in December 2020, during the pandemic. Patients suffering from SS and living in Western Switzerland (Geneva and Lausanne region) were invited by the regional association of patients with SS to complete a survey assessing the socio-economic impact of SS.

Results: Among the 86 patients who were contacted, 55 (64%) completed the survey. Participants were predominantly female (95%) with a mean (SD) age of 54.2 (12.3). Mean (SD) EULAR SS Patient Reported Index (ESSPRI) was 6.5 (1.6), assessing pain, fatigue and dryness.

In the working age population (under 65, n=39), 64% of the participants reported to be employed, 88% of whom working part-time. They reported to work 23.3 (10.1) hours per week (mean, SD). 60% reported SS-related work incapacity periods during the past year. 72% of participants had to reduce their working

hours and 27% had to change careers due to their medical condition. 16% benefited from an adaptation of their workstation to their health status.

In terms of work disability, 27% of the participants depended on disability insurance pension, of whom 38% received a full pension. 16% of the participants applied for a disability pension and were waiting for an administrative decision. A minority of participants (11%) reported to receive a minimum subsistence allowance from the local social service.

Participants estimated to pay 2752 CHF (3000) per year (median, IQR) out of their own pocket (Swiss monthly median wage: 6500 CHF) for health care not covered by health insurances. 95% of the patients had to pay for dental medicine costs, at least partially. Public health insurance contributed to dental costs for 44% of the patients and private health insurance for 28% of them. 22% of the patients reported to limit dental care for financial reasons.

Conclusion: Two-thirds of the patients with SS remained in active employment, but the majority of them working in part-time, with a substantial loss of income. One third of the patients are work disabled and depend on a disability pension. Dental care was not reimbursed in half of the patients by their health insurance, leading to dental care access restriction for 20% of the patients with SS. Despite a relatively high wage level in Switzerland, SS represents a substantial financial burden for most of the patients.

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POS1416 THE IMPACT OF NON-PERSISTENCE ON RESOURCE UTILIZATION COSTS IN IMMUNE-MEDIATED RHEUMATIC DISEASES

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Background: Rheumatoid arthritis (RA), psoriatic arthritis (PsA) and ankylosing spondylitis (AS) are chronic progressive immune-mediated rheumatic diseases (IMRD) that can cause a progressive disability and joint deformation and thus can impact in healthcare resource utilization (HCRU) and costs.

Objectives: To describe the HCRU and treatment costs in IMRD patients initiating subcutaneous tumour necrosis factor-alpha inhibitors (SC-TNFi) therapy, based on treatment persistence.

Methods: Retrospective cohort study including all naïve patients initiating SC-TNFi therapy for IMRD from 2015-2018 in a tertiary university hospital.

Patients were divided into two cohorts: persistent and non-persistent. Treatment persistence was estimated as the duration of time from SC-TNFi therapy initiation to discontinuation during one year of follow-up.

SC-TNFi therapy and HCRU costs (outpatient care, rheumatology specialized outpatient care, inpatient care, emergency care, laboratory testing and other non-biological therapies) were calculated one year before and after initiation of SC-TNFi and compared between persistence and non-persistence groups.

Results: 110 patients were identified.

Baseline characteristics: Non-persistent cohort (n=25) versus Persistent cohort (n=85): median age 48.6(12.7) vs 47.3(15.4) (p=0.692). Female (n=12;48%) vs (n=49;57.6%) (p=0.493). Race: Caucasian (n=22;88%), Asiatic (n=3;12%), Other (n=0;0%) vs Caucasian (n=75;88.2%), Asiatic (n=5;5.9%), Other (n=5;5.9%) (p=0.351). IMRD: RA (n=14;56%), PsA (n=2;8%), AS (n=4;16%), other spondyloarthropathy (n=5;20%) vs RA (n=34;40%), PsA (n=11;12.9%), AS (n=24;28.3%), other spondyloarthropathy (n=16;18.8%) (p=0.470). SC-TNFi therapy: adalimumab (n=4;16%), etanercept commercial (n=4;16%), etanercept biosimilar1 (n=5;20%), etanercept biosimilar2 (n=5;20%), golimumab (n=5;20%), certolizumab (n=2;8%) vs adalimumab (n=22;25.9%), etanercept commercial (n=11;12.9%), etanercept biosimilar1 (n=7;8.3%), etanercept biosimilar2 (n=10;11.8%), golimumab (n=24;28.2%), certolizumab (n=11;12.9%) (p=0.398).