Overall cost of SC-TNFi treatment: Non-persistent 11218.81€ (6444.32), persistent 10470.19€ (3465.48); $p = 0.658$.

Table 1. HCRU costs

	Non-persistent(n=25)	Persistent(n=85)	Total(n=110)	P
HCRU costs 12 months prior to SC-TNFi initiation,€(SD)				
Outpatient care	243.48(828.86)	87.17(293.61)	122.70(471.20)	0.204
Rheumatology outpatient care	216.39(169.88)	174.79(101.06)	184.24(120.55)	0.224
Inpatient care	500.41(1542.93)	170.34(846.47)	245.36(1046.74)	0.571
Emergency care	37.77(66.00)	39.30(83.16)	38.95(79.31)	0.850
Laboratory testing	376.12(195.59)	388.20(207.07)	385.46(203.70)	0.458
Other non-biological therapies	10.77(39.83)	36.79(250.55)	30.88(221.01)	0.803
Total	1384.94(1816.17)	896.60(1247.60)	1007.59(1402.87)	0.299
HCRU costs 12 months post SC-TNFi initiation,€(SD)				
Outpatient care	106.11 (172.85)	76.67 (112.90)	83.36 (128.67)	0.682
Rheumatology outpatient care	327.29(170.10)	195.58(100.05)	225.52(130.99)	<0.001
Inpatient care	89.35(446.77)	80.86(466.54)	82.79(460.11)	0.969
Emergency care	89.14(171.89)	36.06(106.23)	48.12(125.31)	0.198
Laboratory testing	182.14(128.62)	146.86(141.48)	154.88(138.89)	0.061
Other non-biological therapies	3859.80(4043.86)	25.89(116.05)	897.24(2493.21)	<0.001
Total	4653.84(4269.61)	561.93(682.14)	1491.91(2709.23)	<0.001

Conclusion: - Non-persistence was observed in less than a quarter of the patients.

- No differences in the costs of SC-TNFi treatment were observed between the persistent and non-persistent groups, leading us to believe that persistence may not be associated with SC-TNFi costs offsets for patients with IMRD.

- During the period post SC-TNFi initiation, the costs of rheumatologic outpatient care and treatment with other non-biological therapies as well as total costs were statistically significantly lower in the persistent cohort. These results suggest that persistence may be associated with HCRU cost savings for IMRD patients.

Disclosure of Interests: None declared

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POS1417 DO SOCIAL FACTORS IMPACT ON BIOLOGICS COSTS IN RHEUMATOID ARTHRITIS? RESULTS FROM THE MOROCCAN RBSMR REGISTRY

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Background:

Objectives: The aim of this study was to estimate the annual direct cost of biologics in rheumatoid arthritis and to evaluate the impact of social factors on biological use and costs.

Methods: Patients in the Moroccan register of biologics (RBSMR) with available 1-year data were included. Variables related to socio-economic status, disease and biological were collected. Direct costs included prices of biologics, costs of infusions, and subcutaneous injections. Biological use and costs were compared based on social factors.

Results: Our study included 197 patients (female sex of 86.8%, mean age of 52.3 ± 11 years). Patients were on one of the following therapies: Rituximab

(n=132), Tocilizumab (n=37) or TNF-blockers (n=28). 44.2% of included patients have the RAMEd medical assistance (health insurance scheme for the economically underprivileged). Illiteracy was noted in 45.7% of cases. Median one-year direct costs per patient were €1,665 [€1,472 - €9,879].

There was no statistically significant difference in costs between men and women ($p > 0.05$), between illiterate and literate ($p > 0.05$). There was a statistically significant difference in costs between patients with the RAMEd medical assistance scheme and other health insurances ($p < 0.01$).

Conclusion: This study showed that Moroccan RA patients had equal access to biologics regardless of their gender or level of education. Indeed, the insurance system influence the costs of biologics. Accessibility of those expensive treatments in a developing country seems to be explained by efforts of the Moroccan ministry of health who has allocated a substantial budget for biologic DMARDs for patients with RAMEd in the tertiary structures in our country.

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Epidemiology, risk factors for disease or disease progression

POS1418 REALIZING EARLY RECOGNITION OF ARTHRITIS IN TIMES OF INCREASED TELEMEDICINE: THE VALUE OF PATIENT-REPORTED SWOLLEN JOINTS

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Background: Early diagnosis and management of patients with inflammatory arthritis (IA) are critical to improve long-term patient-outcomes. Assessment of joint swelling at joint examination is the reference of IA-identification; early access clinics are constructed to promote this early recognition of IA. However, due to the COVID-19 pandemic the face-to-face capacity of such services is severely reduced. The accuracy of patient-reported swelling in comparison to joint examination has been extensively evaluated in established RA (p 0.31-0.67), but not in patients suspected for IA.[1]

Objectives: To promote evidence based care in the era of telemedicine, we determined the accuracy of patient-reported joint swelling for actual presence of IA in persons suspected of IA by general practitioners (GPs).

Methods: Data from two Dutch Early Arthritis Recognition Clinics were studied. These are screening clinics (1.5-lines-setting) where GPs send patients in case of doubt on IA. At this clinic patients were asked to mark the presence of swollen joints on a mannequin with 52 joints. For this study the DIP joints and the metatarsal joints were excluded and, therefore, a total of 42 joints were assessed for self-reported joint swelling. Clinically apparent IA of ≥ 1 joint determined by the physician was the reference to calculate sensitivity, specificity, positive and negative likelihood ratios (LR+, LR-), and positive and negative predictive values (PPV, NPV) on patient-level. Pearson correlation coefficients (ρ) were determined. Predictive values depend on the prevalence of a disease in a population. Because the prevalence of IA in a 1.5-lines-setting will differ from a primary care setting, post-test probabilities of IA were estimated for two lower prior-test probabilities as example, namely 20% (estimated probability in patients GPs belief IA is likely) and 2% (prior-test probability with less preselection by GPs), using likelihood ratios and nomograms.

Results: A total of 1637 consecutive patients were studied. Median symptom duration was 13 weeks. 76% of patients marked ≥ 1 swollen joint at the mannequin. 41% of patients had ≥ 1 swollen joint at examination by rheumatologists. ρ was 0.20 (patient-level)-0.26 (joint-level).

The sensitivity of patients-reported joint swelling was high, 87%, indicating that the majority of patients with IA had marked swelling on the mannequin. However the specificity was 31%, indicating that 69% of persons without IA had also done so. The LR+ was 1.25; the LR- 0.43. The PPV was 46%, the NPV 77%. Thus the PPV increased hardly (from 41% to 46%) and the NPV somewhat (from 59% to 77%). Also in settings with prior-test probabilities of 20% and 2%, estimated PPVs (from respectively 20% and 2% to 24% and 2%) and NPVs (from respectively 80% and 98% to 90% and 99%) hardly increased.

Conclusion: Patient-reported joint swelling had little value in distinguishing patients with/without IA for different prior-test probabilities, and is less valuable in comparison to self-reported flare detection in established RA.

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