rheumatologists to assess the existence of specific recommendations for the treatment of adult patients over 65 years of age.

**Results:** In total, 58 guidelines were reviewed. None of the guidelines grouped by age. Seven (12%) guidelines had recommendations or statements about elderly patients (Table 1). As we observe, there are no satisfactory recommendations for the GP with rheumatological diseases. The most probable reason for this result is the lack of studies in the rheumatology literature to lead to guideline recommendations.

### Table 1. Characteristics of guidelines reviewed

<table>
<thead>
<tr>
<th>Number of guidelines (n)</th>
<th>Guidelines with specific recommendation for GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>EULAR</td>
<td>38</td>
</tr>
<tr>
<td>ACR</td>
<td>11</td>
</tr>
<tr>
<td>BSR</td>
<td>9</td>
</tr>
</tbody>
</table>

EULAR points to consider for the management of difficult-to-treat rheumatoid arthritis (recommendation 6)1'. Points to consider for the development, evaluation and implementation of mobile health applications for self-management in patients with rheumatic diseases (points to consider)2. 2019 update of EULAR recommendations for prevention and management of osteoporotic fractures (recommendation 6)3. EULAR Points to consider for monitoring (detection/prevention) comorbidities in inflammatory rheumatic diseases (point to consider)4. 2015 Recommendations for the management of polymyalgia rheumatica: a European League Against Rheumatism/American College of Rheumatology collaborative initiative (recommendation 5)5. BSR guidelines for the management of polymyalgia rheumatica (recommendation 6)6.

**Conclusion:** Current prominent rheumatology guidelines have insufficiently addressed the management of rheumatological diseases in GP. Additional studies are needed to delineate specific guidelines for the management of geriatric patients with rheumatological diseases.

**REFERENCES:**


Disclosure of Interests: None declared


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**Background:** The preselection of patients with suspicion of an inflammatory rheumatic disease is not easy for general practitioners and orthopedists. In countries with a limited number of practicing rheumatologists waiting lists are often long, since a full rheumatologic examination often needs a long consultation time.

**Objectives:** To test the performance of an early triage strategy for early identification of patients with inflammatory rheumatic diseases.

**Methods:** Prior to the SARS-CoV-2 pandemic, physicians caring for patients contacting a tertiary rheumatology service were first contacted by a health-care professional (HPR) who offered an appointment the timing of which was based on the symptoms reported (Step 1). Patients were then seen by a rheumatologist who, within a 10-minute consultation (Step 2), shortly examined the patient to determine the urgency of a planned full work-up. The main outcome of the study was the comparison between the initial assessment and the final expert diagnosis (Step 3).

**Results:** Within 9 months, physicians caring for 1,180 patients contacted the hospital, 972 of whom kept their appointment (82.4%). Most patients were transferred by GPs (73.1%) and orthopedists (22.1%). The mean time between Step 1 and Step 2 was 10.4 days, while 6.2% of patients were seen within 4 days, 24.4% within 7 days and 69.3% within 12 weeks. Only 38 patients (3.7%) of patients had an already established rheumatic disease. Complaints lasting between 0-4 weeks were reported by 69 (7.1%), of > 4-12 weeks by 100 (10.3%), and of > 12 weeks by 973 (87.6%) patients. Almost 90% of patients reported a pain intensity > 4/10 (NRS) for > 2 weeks. An elevated CRP was found in 207 patients (24.5%). Prior treatment with glucocorticoids was reported in 163 (16.8%) and with NSAIDs in 730 (75.1%) of patients. The confirmed diagnosis at Step 3 was rheumatoid arthritis in 127 (13.1%), spondyloarthritis including psoriatic arthritis in 72 (7.4%), systemic diseases including connective tissue diseases in 112 (11.5%), vasculitides in 41 (4.2%), and crystal arthropathy in 38 (3.9%) patients, while 38 (3.9%) had an infection, a malignancy or a differential diagnosis such as Raynaud’s phenomenon or sicca syndrome. Degenerative joint diseases (n=254; 26.1%) and non-inflammatory soft tissue diseases such as fibromyalgia (n=369; 38%) accounted for more than half of the patients.

**Conclusion:** This study describes the performance of a standardized triage system hereby confirming the need for an early identification and preselection of patients with rheumatic musculoskeletal symptoms, including involvement of HPRs in the initial phase of contact. Based on the results, three patients with musculoskeletal complaints had to be examined in order to identify one patient with an inflammatory rheumatic disease.

Disclosure of Interests: None declared


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**AB1420**

**CLINICIAN-RELATED FACTORS MAY INFLUENCE REMOTE CONSULTATIONS IN RHEUMATOLOGY – ANALYSIS OF SENIOR VS TRAINEE CLINICIANS’ OUTCOMES FROM A COVID-19 INITIATIVE**

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**Background:** Since COVID-19 pandemic started, there have been changes in clinical practice to limit transmission, such as switching from face-to-face to remote consultations. Our department switched to delivering remote consultations without suspending service. Patients were offered the preference of either video or telephone consultation. It is unclear what factors including clinician-related factors significantly influence remote consultations in Rheumatology.

**Objectives:** We aimed to study the influence of senior (substantively employed) vs trainee status of clinicians on remote consultations in our experience during the pandemic.

**Methods:** Between 15/10/2020 and 09/11/2020, 12 clinicians in our department completed data collection forms after each remote consultation, recording the technology used (video vs phone); technical problems encountered; discharge and subsequent appointment status; and technical aspects of the consultation itself using 11-point numerical rating scales (NRS) (Time Adequate; Relevant History; Physical Exam; Management Plan; and Communication Quality). Data were collated on an MS Access 2016 database, and transferred to SPSS version 25 for statistics.

**Results:** Nine senior clinicians (3 consultant rheumatologists, 3 Specialist Nurses, 1 Advanced Rheumatology Practitioner and 2 Senior Rheumatology Pharmacists) and 3 trainee clinicians (2 Specialty Trainee Registrars and 1 Foundation Year 2 doctor) completed forms. 285 forms were validated for analysis. The majority of consultations were completed by senior clinicians (266, 93.3% vs 19, 6.7%). Senior and trainee clinicians had a similar proportion of new patients compared to follow-up patients (18%, n=48 vs 15.8%, n=3; p=0.80); of female patients (58%, n=181 vs 63.2%, n=12; p=0.66); and video consultations (17.3%, n=43 vs 10.5%, n=2; p=0.45); and similar mean age of their patients (59.5 vs 56.7 years; p=0.72) respectively. Senior clinician accounted for all the technical issues reported (20%, n=48 vs 0%, n=0; p=0.03). Senior clinicians had lower mean scores compared to the trainee clinicians on NRS for Relevant History (8.68 vs 9.68; p<0.001), Physical Exam (1.49 vs 2.95; p<0.045), and Communication Quality (8.02 vs 9.37; p=0.002); and had no significant differences in scores for Time Adequate (8.46 vs 9.00; p=0.10) and Management Plan (7.17 vs 7.84; p=0.16). Senior and trainee clinicians and a similar proportion requests for subsequent face-to-face appointments (21.9%, n=51 vs 25%, n=4; p=0.77).

**Conclusion:** There were no significant differences between senior and trainee clinicians in distributions of patients and proportion of video consultations. While no technical issues were reported by the trainee clinicians, this may in part be a reflection of their smaller proportion of overall consultations. Although senior clinicians rated their consultations somewhat lower in some of the NRS, there was no significant difference in management plan scores and subsequent face-to-face appointment status compared to trainee clinicians. The lower scores may partly reflect the technical issues reported by the senior clinicians, longer clinical experience and greater knowledge may also be an underlying factor for this. Further studies with larger numbers may clarify these issues.

Disclosure of Interests: None declared