4. Improving treatment recommendations and access to appropriate medicines through fast track pathways;
5. Delivering better quality information to SSc patients.

The survey should provide information on patients’ evaluations of physical functioning and overall health as the main factors in the decision-making process and the assessment of a treatment’s success, showing the inadequacy of current value attribution and appraisal frameworks. Preliminary results are expected to be published at the EULAR Congress.

**Conclusion:** The outcomes of the work done by FESCA aims at improving the SSC continuum of care from earlier diagnosis to better treatments as well as creating greater awareness of scleroderma so that those who suffer from it can access proper, equitable care. Most importantly, the results of both studies highlight the need for developing person-centred care pathways integrating more systematically quality-of-life considerations in healthcare and treatment decisions as well as in value attribution frameworks that are more responsive to patient needs.

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atCTVY2

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**AB1602**

**CROSS COUNTRY DIFFERENCES IN B/TSDMARD PRESCRIPTION BEHAVIOR: ASSOCIATIONS BETWEEN SOCIOECONOMICS, REAL WORLD B/ TSDMARD USE AND DISEASE OUTCOMES**

**Keywords:** Rheumatoid arthritis, Geographical differences, Registries

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**Background:** The development of biologic and targeted synthetic (b/ts)DMARDs contributed to improved treatment outcomes in rheumatoid arthritis (RA). However, high medications costs may limit their use. Previously we showed that in countries with a lower socioeconomic status (SES), b/tsDMARDs were prescribed to fewer patients than in countries with higher SES. In this study we take a more detailed look at b/tsDMARD prescription behavior between countries.

**Objectives:** To explore cross-country relationships between Gross Domestic Product (GDP) per capita, specific indicators of b/tsDMARDs use and disease outcomes in patients with RA.

**Methods:** This multinational observational study included countries that had contributed ≥100 patients using b/tsDMARDs, with available follow up, to one of 2 registries: METEOR, an international registry capturing daily clinical practice data of patients with a clinical diagnosis of RA, and JAK-POT, an investigator-initiated collaboration between national registries aiming to evaluate clinical aspects of b/tsDMARDs in RA. On a per-country basis, mean DAS28 was calculated from the last available follow-up visit per patient. b/tsDMARD usage was determined as mean time to start b/tsDMARD therapy since date of diagnosis, mean number of b/tsDMARDs tried per patient and mean duration of b/tsDMARD therapy. To calculate the time to start a first b/tsDMARD per country included from the JAK-POT registry, only bionaive patients were included. Possible associations between GDP per capita and country-level indicators of b/tsDMARD use and DAS28 were tested in univariable linear regression models. Regression coefficients (β) are interpreted as the numerical increase in the outcome per 1 point increase in the predictor.

**Results:** Data from 25,832 patients living in 17 different countries showed varying b/tsDMARD prescription behavior. GDP per capita ranged from 6505 (India) to 93350 Intl$ (Ireland). Time to start b/tsDMARD therapy ranged from 0.5 (Austria) to 11.1 (Finland) years. Mean number of b/tsDMARDs tried per patient ranged from 1.0 (Turkey) to 2.4 (Switzerland). Duration of b/tsDMARD therapy ranged from 0.9 (India) to 5.5 (Portugal) years (Figure 1). Baseline DAS28 ranged between 3.7 and 6.1, but was not related to any of the indicators of b/tsDMARD use: time to start a b/tsDMARD β = 0.08 (95% CI -0.7; 0.9), number of prescribed b/tsDMARDs β = 0.06 (95% CI -0.3; 0.2), duration of b/tsDMARD treatment β = 0.1 (95% CI -0.3; 0.5). No statistically significant associations were observed between GDP per capita and time to start b/tsDMARD therapy (Figure 1A, β = 0.09 CI 95% -0.7; 0.9), the number of b/tsDMARDs tried per patient (fig 1B, β = 0.07 CI 95%-0.2; 0.2) or the duration of b/tsDMARD treatment (fig 1C: β = 0.1 CI 95%-0.3; 0.3). None of the indicators of b/tsDMARD prescription were significantly related to DAS28 at the end of follow up: time to start a b/tsDMARD β = 0.02 (95% CI -0.05; 0.1), duration of b/tsDMARD therapy β = -0.03 (95% CI -0.2; 0.1) and number of b/tsDMARDs β = -0.03 (95% CI -0.6; 0.8).

**Conclusion:** This study showed varying b/tsDMARD prescription behavior and disease activity across 17 countries worldwide. Overall, differences in b/tsDMARD prescription behaviour did not appear to be related to socioeconomic welfare and, no significant association was observed between b/tsDMARD prescription behavior and disease activity at a country level. This seems to indicate that once patients start a b/tsDMARD, socioeconomic welfare has less impact on b/tsDMARD use.

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AB1603 EVIDENTIAL REQUIREMENTS FOR DECISION-MAKING ABOUT WORKPLACE INITIATIVES TO MITIGATE THE IMPACT OF RHEUMATIC AND MUSCULOSKELETAL DISEASES: QUALITATIVE INTERVIEWS WITH REPRESENTATIVES OF UK ORGANISATIONS

Keywords: Work-related issues, Rheumatoid arthritis, Qualitative research methods

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Background: Decisions about whether to invest in RMD-related workplace initiatives/adaptations can be made by determining, from the relevant perspective, if benefits outweigh the costs of implementation. Little is known about what information organisations need to facilitate these decisions.

Objectives: This study aimed to explore motivations and evidential requirements for employers to invest in workplace health initiatives.

Methods: Semi-structured online interviews with representatives of large UK-based (not-for-profit and for-profit) organisations were audio-recorded. For each organisation, a line manager, director, and representative with workforce health remit were interviewed. Interview data were transcribed verbatim and subject to thematic analysis by two researchers trained in qualitative methods. Themes were agreed in discussion with the study team.

Results: We recruited 13 representatives (5 directors, 3 line managers, and 4 with a specific remit for workforce health). Three not-for-profit organisations (local authority, university, and National Health Service) were represented by seven participants and three for-profit organisations (restaurant chain, telecoms provider, and technology company) were represented by six individuals.

Motivations: All participants believed that investment in measures to promote employee health and wellbeing could potentially contribute to their organisation’s efficiency, ‘there’s loads of academic research that says…’ if you look after your colleagues… if you cater to their… individual needs, then that has a very positive impact on organisation performance. (Director, not-for-profit) Attraction and retention of staff – seen as increasingly difficult - was a motivating factor to invest that was shared by employers, as was the desire to avoid litigation, promote workplace camaraderie, and to maintain organisational reputation. Low RMD prevalence rates in the young workforce in one organisation (a restaurant chain) meant that these conditions did not influence decision-making. For organisations with older workforces doing heavier manual work, higher prevalence rates of RMD were a key reason to act, ‘musculoskeletal is, like, the second biggest reason for sickness within the organisation’. (Line manager, not-for-profit)

Evidential requirements: Use of checklists/assessments to reveal individual health needs, typically related to line managers, would instigate a process where occupational therapist (OT) input may be sought. Requests and OT recommendations are reportedly, without exception and irrespective of cost, met and followed. No organisation had set aside a specific budget for workplace initiatives. Decisions involving significant investments in workforce health initiatives were usually made by committees or by small teams comprising senior staff and directors. Line managers and those with a health remit would put forward a case for investment to these bodies: ‘…we would pull together a bit of a proposal really on what that would look like…what is the impact of it?…we support it with facts…even benchmarks of what’s going on in the outside. (Health remit representative, for-profit)

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AB1604 PRE-EXPOSURE PROPHYLAXIS WITH TIXAGEVIMAB/ CILGAVIMAB: SINGLE CENTRE EXPERIENCE IN A COHORT OF RHEUMATIC PATIENTS

Keywords: Vaccination/Immunization, Safety, COVID

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Background: Vaccination against SARS-CoV-2 had a critical role in the fight against COVID19 pandemic. A weaker humoral response to COVID19 vaccine has been found in rheumatic patients treated with Rituximab (RTX) or Myco- phenolate Mofetil (MMF)[1]. Despite the evidence that anti-SARS-CoV-2 mRNA vaccines can elicit a T-cell response [2], some data show that even the cellular immunity could be impaired in rheumatic patients [3] but COVID19 serology is the only parameter that is feasible to measure in daily practice. Tixagevimab/cil- gavimab are two human-derived monoclonal antibodies administered parenterally and authorized by regulatory agencies in February 2022 for pre-exposure prophylaxis (PrEP) against COVID19 from different virus variants in fragile patients.

Objectives: To demonstrate safety and effectiveness of tixagevimab+cilgavimab.

Methods: Patients with autoimmune rheumatic diseases undergoing immuno- suppressive treatment with RTX or MMF during the vaccination campaign were enrolled between April and June 2022. All patients must have anti-spike antibody levels below the protective threshold (defined by anti-spike IgG titre <250 BAU/ml) after receiving at least 2 vaccine doses. Patients were monitored with a questionnaire every month about COVID19 symptoms (including respiratory and gastrointestinal symptoms, anosmia and ageusia, skin rash and potential contact with COVID19+ subjects) and were checked for anti-spike and anti-nucleocap- side antibodies titres every 2 months for a total of 6 months follow-up. MMF dose was reduced at 1g/day at the time of vaccine administration.

Results: Fifteen patients were enrolled: 9 participants had a connective tissue disease (CTD; 1 dermatomyositis, 3 anti-synthetase syndrome, 4 systemic sclerosis, 1 systemic lupus erythematosus) and 6 had vasculitis (all granulomatosis with pol- yangliitis). 12 of them received RTX in the preceding 12 months and 3 were taking MMF. About safety, the therapy was very well tolerated and only 4 patients (26%) reported a non-severe adverse event in the 2 weeks following drug administra- tion (myalgia, headache, fatigue). All of them reported a CTX2 infection (20%) with mild symptoms and no need for hospitalization except for 1 patient who received an antiviral drug (nirmatrelvir+ri- tonavir). All infected patients had a CTX2 diagnosis. No significant correlation was observed between the type of rheumatic disease and the risk of infection or response to tixagevimab+cilgavimab.

Conclusion: None of our patients developed severe adverse events after tix- agevimab+cilgavimab administration and, among the 3 SARS-CoV-2 infected patients, none required hospitalization nor oxygen therapy.

We conclude that in our experience tixagevimab+cilgavimab is a safe and useful complementary immunization strategy to vaccination for COVID19 prophylaxis. These data will be implemented in a larger study, comprehending various immu- nocompromised patients from several departments.

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[3] Picchianti-Diamanti et al., Front Immunol, 2021