

Objectives: To determine the full economic cost, including medical productivity loss and other out of pocket related costs of delayed diagnosis for AS in the UK.

Methods: We are building an economic Markov model to determine a total cost per patient per year of delay. The model will project disease progression forward in time-steps with feedback loops to allow movement in states back and forth. Transition states within each time-step will be constructed according to the various stage of the disease and they will be used primarily to demonstrate an assessment of the costs in the time taken to a confirmed diagnosis. The model will capture symptoms and impacts of AS leading up to that diagnosis and before initiation of treatment. Assuming the one-year maximum 'gold standard' time to diagnosis that NASS would like to see to, the sum of costs prior to this in each consecutive cycle will be estimated. The inputs will consist of the average delay to diagnosis per gender and age group, the health resources utilisation, the cost of managing the symptoms, cost related to productivity losses and any other parameters and costs reflecting real resources required to diagnose, confirm, treat, cope with, manage and accommodate AS symptoms. Data include anonymised diagnosed patient data with the pathways they followed pre-diagnosis shared under strict confidentiality data sharing agreement from the secondary health units participating in the project. Cost data gathered from national sources and research into AS, NHS unit costs reports, productivity related reports and interviews with people with AS and clinicians providing valuable insight into the condition. The model will be validated by experts in the field and sufferers of AS to ensure accurate representation of actual events.

Results: The results will be provided at the conference and this is work in progress. A preliminary analysis of anonymised data of the pathway of 513 people towards an AS diagnosis show that the delay on female patients is slightly longer (mean of 9.85 years) compared to male patients (mean of 9.39 years). In both genders the delay is higher if the patient present symptom after the age of 31 years increasing the mean of previous age groups by 5 to 9 yrs.

Table 1.

Age Group	Female			Male		
	Obs.	Mean	95% CI	Obs.	Mean	95% CI
0-15	1	1	-	2	1.00	0.00, 13.71
16-30	49	3.59	2.69, 4.49	144.00	4.01	3.45, 4.57
31-45	50	11.72	9.64, 13.80	161.00	9.61	8.58, 10.65
46-60	24	18.17	13.05, 23.28	60.00	15.90	13.30, 18.50
61+	3	17.33	0.00, 52.58	19.00	28.58	21.14, 36.02

Conclusion: The results will help the National Axial Spondyloarthritis Society (NASS) to build an economic case for earlier diagnosis. The interactive model will support decision making in the future by allowing assumptions to be changed e.g., changing prices over time; varying wage rates depending on staff and skill mix; and the anticipated scale of savings in actual practice.

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Acknowledgements: With thanks to the National Axial Spondyloarthritis Society for commissioning this research and special thanks to Dale Webb and Jill Hamilton for their valuable support to contact clinician and sufferers of AS and for accessing necessary data. Importantly, thank you to the clinicians and sufferers of AS for their contribution to the research.

Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2022-eular.4727

AB1417

CORRELATION BETWEEN THE ATTITUDE OF PATIENTS SUFFERING FROM CHRONIC RHEUMATIC DISEASES TOWARDS REMOTE CONSULTATIONS BY RHEUMATOLOGIST AND THE HEALTH LOCUS OF CONTROL

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Background: During the COVID-19 pandemic telemedicine has become an important and safe means for patients suffering from chronic diseases to control their condition with the assistance of a physician [1]. In order to ensure that treatment of chronic rheumatic diseases is effective, it is important that patients develop a favorable attitude towards telerheumatology [2] as well as disease-related individual behavior, which significantly depends on the patients' health locus of control [3].

Objectives: To analyze the attitude of patients suffering from chronic rheumatic diseases towards peculiarities of remote consultations by a rheumatologist and their correlation with health locus of control.

Methods: To reveal the patients' attitude towards remote consultations by a rheumatologist, an original questionnaire has been prepared, which contains: reasons for choosing remote consultations, fears about such consultations and their advantages. Health locus of control was evaluated using a Multidimensional Health Locus of Control (MHLC) scale, which consists of three subscales: Internal, Chance, and Powerful Others. Demographical questions and questions related to health are also included in the questionnaire. 207 subjects participated in the study: 177 (85.5 %) women and 30 (14.5 %) men, ($M_{age}=39.4$, $SD=11.76$). The majority of subjects were diagnosed with spondyloarthritis ($n=83$), connective tissue diseases ($n=53$), rheumatoid arthritis ($n=49$), and osteoarthritis ($n=20$), 42 subjects were diagnosed with some other rheumatic diseases. 111 (53.6%) patients had the previous experience of remote consulting by a rheumatologist.

Results: It has been determined that the attitude of patients with rheumatic diseases is related to various demographic characteristics of patients, e.g., gender, etc., and the peculiarities of the disease, e.g., strength of the symptoms, etc. It has been found that patients without experience of remote consultations have more fears about such consultations ($p=0.024$). When comparing the average of statements revealing a positive attitude $M=66.4\%$ with the average of statements revealing a negative attitude $M=27.3\%$, it becomes clear that the overall attitude of subjects toward remote consultations of a rheumatologist is favorable. To assess correlations between positive or negative attitude of patients with rheumatic diseases and health locus of control correlational analysis was performed. The results did not confirm the expected correlations between the positive attitude of patients with the internal locus of control. However, it has been obtained that negative attitude towards remote consultations by a rheumatologist positively correlates with two indicators of health locus of control – Chance ($r=0.203$, $p\leq 0.0001$) and Powerful Others ($r=0.194$, $p=0.01$), although the said correlation is not strong, but statistically significant.

Conclusion: The study has revealed the major fears and satisfaction sources related to remote consultations of Lithuanian patients with rheumatic diseases. In addition, it has shown that personal convictions of a patient that health depends on the circumstances and the influence of other people exacerbates the attitude towards remote consultations.

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2022-eular.4831

AB1418

A SYSTEMATIC REVIEW OF CURRENT RHEUMATOLOGY GUIDELINES FOR GERIATRIC PERSPECTIVES

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Background: Geriatric population (GP) includes people over 65 years of age. GP can also be divided into the 65-75 age group and >75 age group. In the last 50 years, the proportion of the elderly in the society has increased (1). Meanwhile, GP has higher frequency of rheumatological disorders. While managing the treatment of this special patient group, some physiological differences of the elderly should be considered. Elderly patients are at increased risk for adverse drug reactions as a result of age-related changes in pharmacokinetics and pharmacodynamics. Polypharmacy is contributing to increased risk of clinically significant drug interactions. In addition, alterations in cognitive functions may impair drug compliance. On the other hand, clinicians may hesitate to apply more effective treatment due to safety concerns. (2). Rheumatologists should be aware of the problems they may encounter when planning the treatment of this privileged group.

Objectives: We reviewed rheumatology guidelines to assess rheumatology organizations' perspective on GP.

Methods: Guidelines published by EULAR, ACR and the British Society for Rheumatology (BSR) for adult patients from 1970-2022 were reviewed by two

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 patients 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

	Number of guidelines (n)	Guidelines with specific recommendation for GP
EULAR	38	1-2-3-4-5-6
ACR	11	6
BSR	9	7

¹EULAR points to consider for the management of difficult-to-treat rheumatoid arthritis (recommendation 6)². Points to consider for the development, evaluation and implementation of mobile health applications for self-management in patients with rheumatic diseases (points to consider 8)³. 2019 update of EULAR recommendations for Vaccination in Adult Patients with Autoimmune Inflammatory Rheumatics⁴. EULAR Recommendations for prevention and management of osteoporotic fractures (recommendation 6)⁵. EULAR Points to consider for monitoring (detection/prevention) comorbidities in inflammatory rheumatic diseases (point to consider 10)⁶. 2015 Recommendations for the management of polymyalgia rheumatica: a European League Against Rheumatism/American College of Rheumatology collaborative initiative (recommendation 9)⁷. BSR guidelines for the management of polymyalgia rheumatica (recommendation 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.

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Disclosure of Interests: None declared

DOI: 10.1136/annrheumdis-2022-eular.4931

AB1419 PERFORMANCE OF AN EARLY TRIAGE SYSTEM FOR IDENTIFICATION OF PATIENTS WITH INFLAMMATORY RHEUMATIC DISEASES

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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 rheumatologic center 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 36 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 (82.6%) 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 syndromes 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

DOI: 10.1136/annrheumdis-2022-eular.5124

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 aspects 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 (68%, 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 clinicians 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. While 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

DOI: 10.1136/annrheumdis-2022-eular.5311