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AB1413 SURVEY ON THE PRESCRIPTION OF GENERAL CORTICOSTEROID THERAPY BY MOROCCAN RHEUMATOLOGISTS IN RHEUMATOID ARTHRITIS

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Background: The prescription of glucocorticoids at the diagnosis of rheumatoid arthritis (RA) is no longer systematically recommended because of the difficulty of withdrawal and the occurrence of adverse effects. The expert groups currently insist on a short duration of corticosteroids to obtain a low cumulative dose (1, 2). The real-life applicability of the current recommendations may be difficult to achieve (3).
Objectives: Moroccan rheumatologists were interviewed about their experiences on prescription of general corticosteroid therapy during the diagnosis of RA.
Methods: We conducted a descriptive cross-sectional study of practice conducted with the Moroccan rheumatologists belonging to public and private sectors according to a questionnaire established on a declarative and anonymous mode. The questionnaire was validated by a committee of experts before submitting them to rheumatologists and consisted of 24 single or multiple-choice questions. These questions were divided into 5 items: general data (3 questions), initiation of corticosteroid therapy at diagnosis (7 questions), withdrawal modalities and problems of withdrawal (8 questions), self-medication and patient information (6 questions). The elaboration of the questionnaire was done in "Google Forms" then the collected data were analyzed with the Microsoft office software Excel 2013.
Results: A total of 100 Moroccan rheumatologists responded to the questionnaire. In the initial treatment of RA, 14% of the rheumatologists reported starting corticosteroid therapy in all patients, 41% in two-thirds of their patients, 23% in one-third, 20% in half and 2% in none. The initial oral dose of prednisone or equivalent was 7.5 to 10 mg/day for 52% of rheumatologists and between 5 and 7.5 mg/day for 38%. Flare-up of activity and accompanying conventional treatment were the two first indications for initiation of corticosteroid therapy. 46% of rheumatologists considered weaning after 3 to 6 months of treatment, 26% between 6 months and one year, 23% in less than 3 months and 5% in more than one year. 35% achieve withdrawal in two thirds of their patients. The main problems encountered during withdrawal are self-medication and rebound of the disease. 96% of rheumatologists were in favour of introducing therapeutic education sessions using different tools adapted to the context of the patient and the disease.
Conclusion: The prescription of corticosteroids in RA must be based on the evaluation of the risk-benefit balance. A collaboration between rheumatologist and patient is necessary to prevent the risk of toxicity of corticosteroids and to achieve the goal of withdrawing them.
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AB1414 THE COST OF PRENATAL CARE IN WOMEN WITH RHEUMATIC DISEASES.

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Background: In Mexico, over 60% of the population is uninsured and not able to afford private healthcare services. Women with autoimmune rheumatic diseases (ARDs) are a high-risk group during pregnancy. Morbidity associated with ARDs and pregnancy can include lower birth weight, increased preterm delivery, and more emergency cesarean sections than pregnant women without ARDs. Close monitoring and multidisciplinary care are necessary to prevent and timely treat complications, on the other hand these health interventions are not available to all women with ARDs because of the high prices that it represents.
Objectives: The aim of this study was to estimate the cost of prenatal care in women with ARDs without health insurance in Northeast Mexico.
Methods: To assess the costs of prenatal care of women with ARDs in the Northeast of Mexico from the perspective of a women without any health insurance, we estimated only the direct costs of the mandatory medical follow-up. Direct costs are all healthcare costs that are directly related to the consultations with a multidisciplinary team, serological and immune laboratory test, and ultrasounds per trimester. All costs and medical fees were obtained from a university hospital in Monterrey, Mexico. To assess the impact of prenatal care in real life, we compared the health expenditure per trimester reported by the pregnancy and rheumatic diseases clinic from the same institution. The data is presented in USD. We were not able to assess indirect costs related to health coverage (like transportation) and specific medical treatment (antirheumatic drugs or other interventions).
Results: The mean cost for medical consultations and ultrasounds per trimester was $184-277 USD. The average cost of immune test and general lab test ranges from $424-428 USD. The total cost per trimester was from $608 to 705 USD, and the direct cost per three trimesters was $1824-2115 USD.
The average family income per month was $614.23 USD and the average health expenditure (per month) was 105.71 USD; which represents 16.21% of the family income. The average family health expenditure per trimester was $317.13 USD.
Conclusion: The total cost for prenatal care per trimester was calculated in $608 to 705 USD. The cost of prenatal care per trimester is 193.69% higher than the average health expenditure per trimester for uninsured women with ARDs. More and new strategies are needed to solve and reduce inequalities in access to health.

Table 1. Average cost of prenatal care per trimester

Medical consultations and ultrasounds			
Medical Consultations	**Costs (USD)**	**Frecuency**	**COST PER TRIMESTER $184-277 USD**
Rheumatologist	$13	Monthly	
Genetics	$49	At least one	
Obtetrician	$14	Monthly	
US 1st Trimester	$54	Only one time	
US 2nd Trimester	$49	Only one time	
Psychologist	$39	If needed	
Nutritionist	$5	If needed	
Clinical test			
Clinical test	**Costs (USD)**	**Frecuency**	**COST PER TRIMESTER $188 USD**
Complete Blood Count	$9	One per trimester	
Blood Chemistry	$38	One per trimester	
Vitamin D (25-OH)	$59	One per trimester	
Thyroid profile test	$16	One per trimester	
PT, TTP	$36	One per trimester	
Protein C reactive	$20	One per trimester	
Erythrocyte sedimentation rate	$5	One per trimester	
Urine general test	$5	One per trimester	
Immune lab test (For patients with rheumatoid arthritis and spondylarthritis)			
Immune lab test	**Costs (USD)**	**Frecuency**	**COST PER TRIMESTER $240 USD**
Rheumatoid factor	$24	One per trimester	
Anti-CCP	$33	One per trimester	
Anti SS-A/RO	$19	One per trimester	
Anti-SS-B/LA	$19	One per trimester	
Anticardiolipins	$33	One per trimester	
Beta-2-glycoprotein	$66	One per trimester	
Lupus anticoagulant	$46	One per trimester	
Immune lab test (For patients with lupus, antiphospholipid syndrome, Sjogren's syndrome, vasculitis, and others) (Others: rheumatic skin and muscle diseases,)			
Immune lab test	**Costs (USD)**	**Frecuency**	**COST PER TRIMESTER $236 USD**
Anti-SS-A/RO	$21	One per trimester	
Anti-SS-B/LA	$21	One per trimester	
Anticardiolipins	$33	One per trimester	
Beta-2-glycoprotein	$66	One per trimester	
Lupus anticoagulant	$46	One per trimester	
Anti-DNA	$24	One per trimester	
Antinuclear antibodies	$25	One per trimester	

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AB1415 **GENDER EQUITY IN RHEUMATOLOGY IN GERMANY, WHERE DO WE STAND? – PRELIMINARY RESULTS FROM A NATIONWIDE ONLINE SURVEY AMONG RHEUMATOLOGISTS IN GERMANY**

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Background: Despite the increasing number of female medical students and fellows, women are still underrepresented in higher career and academic positions in rheumatology [1].

Objectives: To assess gender distribution in rheumatology in Germany and to analyze potential hurdles of flexible work opportunities with the overall aim to improve gender equity in future German rheumatology.

Methods: A web-based anonymous survey using QuestionPro was distributed among rheumatologists in Germany via newsletters, social media and personal contacts (12/2021-01/2022). The survey was developed based on a narrative literature review [1] and discussions among the commission members. It was composed of 29 questions, with single or multiple answers and/or free text. Non-demographic questions could be answered with "I do not know".

Results: Among the total of 170 respondents who fully completed the survey, 72% were female, 28% were male and 1% was third gender. 73% were employed at a rheumatology clinic with 79% working at an academic institution and 20% at a non-academic clinic, 1% did not specify their institution. Of those working at a clinic, 48% were rheumatologists in training, 35% trained rheumatologists and 7% were head of rheumatology departments. Regarding the gender-ratio in different hierarchical levels, only 17% reported more male than female rheumatologists in training at their workplace, in 32% the gender ratio was balanced. On higher levels, respondents reported more male than female rheumatologist at staff level in 44% (29% balanced) and in leading positions in 74% (12% balanced). 53% of female respondents were responsible for >50% of family and housework, compared to 11% of the male respondents. Most men covered 50% (49% of male respondents) or less than 50% (32% of male respondents) of family work. There were coworkers in part time in the work environment of 86% of respondents, with only women working part time in 56% of cases, both women and men in part time in 29% and only men in part time in 1%. Most respondents stated that men and women working part time did not have the same opportunities as coworkers working full time. (Table 1)

Table 1. Opportunities for advancements of part time working employees compared to full time coworkers with similar qualification in percent of all respondents.

Employees working part time have similar opportunities for advancements as employees of the same gender working full time.

	Yes	No	I do not know
Women	23%	65%	12%
Men	21%	54%	25%

Many respondents perceived a preference of either gender despite equal performance regarding different aspects with men more often perceived as preferred in terms of opportunities for advancements and staffing of positions. (Figure 1)

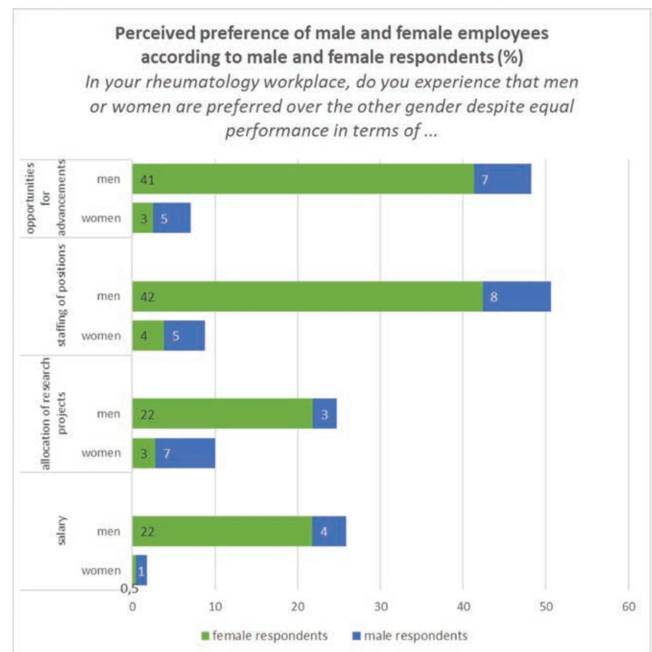

Figure 1. Perceived preference of employees in rheumatology with regards to opportunities for advancements, staffing of positions, allocation of research projects and salary according to gender by female and male survey-respondents. Perceived discrimination was not assessed.

66% of respondents agreed that activities to improve gender equity are necessary. The highest need was seen in the improvement of compatibility of care and work with adequate part time models, childcare options at work, and the higher acceptancy of part time working men and women by employers and persons in higher positions (freetext).

Conclusion: Gender misbalance is prevalent in rheumatology in Germany with lower numbers of women at higher hierarchical levels. Traditional role allocation is still common with a higher frequency of part time working females. Part time employment is perceived to decrease chances of advancement. The focus should be on promoting flexible job-sharing models, part time work among men and gender equity not only at work but also in private life ("care work"). Preference for one gender over the other is perceived differently between women and men.

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AB1416 **WHAT IS THE FULL ECONOMIC COST OF DELAYED DIAGNOSIS OF AXIAL SPONDYLOARTHRITIS IN THE UK?**

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Background: Axial Spondyloarthritis (AS) is an umbrella term for both inflammatory conditions known as Ankylosing Spondylitis and Non-radiographic Axial Spondyloarthritis. AS generally develops in younger people. Symptoms typically start in the late teenage years to early twenties (with the average age of onset being 24). Hence this condition has a life-long impact, which could increase if left untreated. Average delay to diagnosis is over eight years after the appearance of symptoms. There are currently 220,000 people in the UK living with this painful and progressive form of inflammatory arthritis. While people wait for a diagnosis, many withdraw from socialising and find it harder to establish careers, form relationships, and start families. In addition to healthcare costs, that include multiple visits to GPs, prescription of unnecessary medication and extensive use of over the counter painkillers, there are intangible costs that have large impacts on patients and society. For example, quality of life for the patient, their earning and saving for retirement capacity, social care costs.

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