AB0125 RAPID AND COMPLETE REMISSION IN TREATMENT RESISTANT ANKYLOSING SPONDYLITIS WITH ETANERCEPT – A BETTER DRUG FOR REFRACTORY AS THAN FOR REFRACTORY RA?

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Background Two treatment-resistant, HLA-B27 positive patients with ankylosing spondylitis (AS-pat.1&2) are described in whom etanercept led to a rapid profound improvement in symptoms as well as normalisation of CRP.

Objectives

Methods AS-pat.1 is a 37 y.o. male with highly active AS with generalised stiffness and pain. Subcutaneous (s.c.) weekly MTX over one year in addition to the prior regimen of indomethacin 150 mg/d led to only moderate improvement in symptoms and reduction of CRP from 8 mg/dl to 4 mg/dl. A trial of I. V. pamidronate failed. Etanercept 25 mg s.c. twice/wk was added to MTX. He reported an immediate dramatic improvement of symptoms and stopped indomethacin the day after the first injection. CRP normalised. MTX was stopped after 1 month. He describes a “new life” and that he now plays badminton with his children which he was unable to do before.

AS-pat.2 is a 66 y.o. male with longstanding AS and a history of recurrent iritis. He suffered from morning stiffness and from repeated flarings of varying peripheral joints despite corticosteroid joint injections, indomethacin up to 150 mg/d and a 2 1/2 months trial of MTX 15 mg weekly. Etanercept 25 mg s.c. twice weekly led to rapid and dramatic improvement of pain and stiffness within 2 days, such that the patient did not continue MTX. CRP of 3 mg/dl normalised. No new flare of arthritis or iritis has occurred.

Results Both AS-pat. results (follow up of 8 months) appear particularly remarkable since none of the 9 RA pat. (disease duration more than 4 years, more than 3 failed DMARDs) treated with etanercept-DMARD combination in the same practice (community based, single practitioner rheumatology) in a one year period (9/99–8/2000) had a similar response. Only 4 stayed on etanercept, 3 withdrew due to lack of efficacy, 2 because of side effects.

Conclusion The herein described profound improvement of so far treatment resistant AS with etanercept and its superior efficacy for AS compared to RA warrants further confirmation. Etanercept's only moderate benefit for RA in this setting might be explained by a selection of aggressive cases not having responded to prior DMARD combination therapy.

AB0126 ASSESSMENT OF SULPHASALAZINE (SS) AND METHOTREXATE (MT) EFFICACY IN TREATMENT OF ANKYLOSING SPONDYLITIS (AS).(PRELIMINARY DATA)

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Background

Objectives To assess the efficacy of methotrexate and sulphasalazine in patients with active AS.

Methods 30 patients with AS satisfying the New York criteria for AS were randomly divided into two groups. One group (21 patients) received 1.5–2 g/d SS for 6 months and the other (9 patients) – methotrexate 7.5–10 mg/week. 25 clinical and

laboratory criteria were assessed. Positive changes (over 20% from baseline) in 20 and more variables were considered as excellent effect; 14–19, good; 6–13, moderate; 1–5, no response.

Results 21 patients completed the study (17 on SS and 4 on MT). In SS group there were 2 patients with excellent effect, 6 with good effect, 7 with moderate one and only 2 had no response. 3 patients treated with methotrexate had moderate effect and 1 patient had good one. 5 patients dropped out of the trial due to adverse reactions: 3 in MT group (liver enzymes elevations, low back pain, myalgia/ossalgia) and 2 in SS group (allergic rash, taste disorder). We observed several transient side effects. 2 patients from SS group complained of dizziness, that resolved spontaneously. One of them had anaemia, for which he experienced benefit with folic acid. One patient had concentration disorder.

Conclusion These data suggest that SS is an effective treatment for AS and it is necessary to continue this comparative study.

AB0127 THYROID HORMONES IN PATIENTS WITH ANKYLOSING SPONDYLITIS OR PSORIATIC ARTHRITIS

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Background Ankylosing spondylitis (AS) and psoriatic arthritis (PA) are diseases related to a group of arthritides known as seronegative spondyloarthropathies. Extraarticular manifestations of SA or PS are a common feature. Thyroid gland involvement have been reported in almost all systemic rheumatic disorders.

Objectives The present study was designed to evaluate serum thyroid hormones in patients with SA or PA.

Methods Forty patients (11F, 29M) aged 52.2 ± 1.9 yrs with AS and 13 patients (4F, 9M) aged 46.4 ± 11.2 yrs with PA as well as 10 healthy subjects (3F, 7M) aged 51.2 ± 2.6 yrs were investigated.

Serum thyroid hormones and thyrotropin levels were measured in all investigated individuals.

Results A decrease in total triiodothyronine and total and free thyroxine was found in the AS patients. No changes in thyroid hormone levels were found in the PS patients.

There was no correlation between the hormone levels, age, ESR and duration of symptoms, except negative correlation between free triiodothyronine and ESR in the controls ($r = -0.5977$), ESR and total triiodothyronine ($r = -0.2160$) and ESR and total thyroxine ($r = 0.2321$) in the AS patients.

Conclusion From clinical point of view, thyroid involvement in AS or PA seems to be less important than in patients with other systemic rheumatic diseases.

AB0128 USEFULNESS OF MRI FOR THE DIAGNOSIS OF INFLAMMATORY SACROILIITIS

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Background The diagnosis of sacroiliitis is usually performed on X-rays but frequently this method of imaging can be normal and

the diagnosis of sacroiliitis can be missed, particularly in patients B27 negative.

Objectives To determine which signs are the most accurate in the diagnosis of sacroiliitis with MRI.

Methods 15 patients with inflammatory low back pain have been referred to us.

The patients were divided in 2 groups.

Group 1: 8 patients with normal X-rays; 6 were B27 negative and 2 were B27 positive: MRI showed abnormalities related to sacroiliitis.

Group 2: 7 patients with normal X-rays; 6 were B27 positive and 1 was negative: MRI showed inflammatory signs.

Results The examination showed bone narrow oedema, bone erosions, ligamentous contrast enhancement and fluid in the joint space.

Conclusion This study confirms the excellent positive predictive value of MRI for an early diagnosis of active sacroiliitis, especially in B27 negative patients and/or with normal X-rays.

AB0129 IS THE ASSOCIATION SJÖGREN'S SYNDROME-SPONDYLARTHROPATHY FORTUITOUS?

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Background Secondary Sjögren's syndrome is known to occur with rheumatoid arthritis, systemic lupus erythematosus, but apart from a few cases, has not been reported with spondylarthropathy.

Objectives To determine the prevalence of Sjögren's syndrome in spondylarthropathy patients.

Methods Patients with spondylarthropathy (n = 62) with inflammatory back pain and/or peripheral arthritis were diagnosed as ankylosing spondylitis, undifferentiated spondylarthropathy, psoriatic arthritis and arthritis associated with inflammatory bowel disease. The investigation of sicca symptoms in the spondylarthropathy group and healthy controls (n = 102) was based on a validated questionnaire. Patients with spondylarthropathy with sicca symptoms and/or positive antinuclear antibodies (ANA) were investigated for Sjögren's syndrome by minor salivary gland biopsy.

In the spondylarthropathy group, the laboratory variables were: HLA B27, HLA DR, DQ, anti ENA, serology hepatitis B, C.

Results In 17/62 patients (11 undifferentiated spondylarthropathy, 5 ankylosing spondylitis, 16 females, 1 male) Sjögren's syndrome diagnosis by the Europeans criteria indicated a frequency of 27.4%. Of 62 spondylarthropathy, 12 were ANA positive (19.3%), of whom 5 had Sjögren's syndrome. ANA were detected in 8/17 (47%) patients with Sjögren's syndrome. Of 62 spondylarthropathy patients, 20 had sicca symptoms (32.2%), compared to 3 of 102 (2.9%) controls. HLA B27 is positive in 12/17 patients (70.5%). The results of the study of HLA DR, DQ seem to show a high frequency of HLA DR4, and DQ3 in the association group, but the difference is not significant.

Conclusion The frequency of Sjögren's syndrome is 27.4% in the spondylarthropathy group, thus more than in controls. The association Sjögren's syndrome and spondylarthropathy seems to be not fortuitous, and the HLA class II study seems to show a probable genetic predisposition.

AB0130 CHEST EXPANSION IN RHEUMATIC DISEASES

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Background Decreased chest expansion is a time honoured sign in patients with ankylosing spondylitis (AS). However, the clinical usefulness of this measurement and the frequency with which it is used remains largely unknown.

Objectives We studied: 1) the frequency of its clinical use among rheumatologists and 2) its inter and intra-observer variation along with its sensitivity and specificity among a group of patients with AS and suitable controls.

Methods

- A total of 300 rheumatologists in the United States and in Europe were contacted by e-mail. The frequency they measured chest expansion in their daily practices and the characteristics of their patients they performed the test on, were inquired.
- Thirty patients with AS, 36 with rheumatoid arthritis (RA), 31 with systemic lupus erythematosus (SLE) who were regularly followed in the Rheumatology Department of Cerrahpasa Medical Faculty and 76 healthy controls (HC) who consisted of healthy hospital staff were recruited. Chest expansion was measured at the 4th intercostal space by two independent observers in the morning (between 8–10 AM) in the afternoon (between 2–4 PM) and one week after the initial determinations. The relationship between the chest expansion and gender, age and vital capacity (VC), body mass index (BMI) were determined in all the patients and controls.

Results Eighty-two (27%) of the 300 rheumatologists responded. Three of the responders (4%) stated that they measured chest expansion in every patient whereas 72 (87%) said that they performed the test only in patients suspected to have ankylosing spondylitis. Seven rheumatologists (9%) reported that they never measured chest expansion.

There was a good intra and inter-observer agreement in chest expansion measurements as judged by a difference of less than 1 cm in 80% of the calculations. A chest expansion of less than 2.5 cm had a sensitivity of 23% in patients with AS whereas it had a specificity of 49% (2 patients with RA, 1 with SLE and 5 HC had values below 2.5 cm). There was a significant correlation between vital capacity and chest expansion only in male patients with AS ($r = 0.51$, $p = 0.005$). Chest expansion decreased with age in all groups ($r^2 = 0.083$, $F = 0.0001$). There was no relationship between the chest expansion either with gender or with BMI, both among the patients and the controls.

Conclusion Most of the rheumatologists measure chest expansion only in patients suspected to have AS. It is a test that has good intra and inter-observer reliability. However it has a limited sensitivity and specificity in AS and its value in differential diagnosis is limited.

AB0131 ANKYLOSING SPONDYLITIS IN WOMEN

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Background