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 marrow 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 European 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

Objectives To investigate whether ankylosing spondylitis (AS) in women comprises a different clinical group compared to men.

Methods Seventy-eight patients with AS were diagnosed and followed up since 1981. We reevaluated all these patients by entering the demographic, clinical, laboratory, radiological and therapeutic disease characteristics in the database.

Results Seventy patients were identified as AS. Eight were excluded. Six developed psoriasis during follow up, one had Forestier's disease and one developed Paget's disease of bone. Sixty-one were men and 9 women. There were no differences between men and women concerning the age at disease onset. However, an infection had preceded the diagnosis of AS in women ($p < 0.01$). Axial and peripheral arthritis were similar between the two groups, although the elbows were more frequently involved in women ($p < 0.05$). Concerning systemic manifestations, no differences were found between the two groups. Finally, female patients had higher values of erythrocyte sedimentation rate (ESR) (47.5 [21.6]) compared to men (31.1 [23.0]) ($p < 0.05$) and presented more frequently with anaemia of chronic disease (ACD) ($p < 0.01$).

Conclusion AS in women is a rare condition (1:8). It seems that it is not a mild disease. The clinical picture is almost similar to men, but expresses high values of ESR and ACD.

AB0132 FOUR CASES IN WHICH THE INITIAL ILLNESS WAS TYPICAL OF REITER'S SYNDROME AND LATER BECAME TYPICAL PSORIATIC ARTHRITIS

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Background It is generally accepted that in some patients reactive arthritis may progress further to ankylosing spondylitis. A generally accepted estimate is that 20 percent of patients with Reiter's syndrome develop peripheral arthritis or axial disease.

Objectives The study group consisted of 500 unrelated consecutive patients with psoriatic arthritis at 15 year follow up at the PsA outpatient clinic. We found four cases in which the initial illness was typical of Reiter's syndrome and later became typical psoriatic arthritis.

Methods

Results One patient had persistent joint symptoms, two patients have at every 5 years recurrent bouts of arthritis and one patient suffered from severe, aggressive and unremitting disease.

Over 1 to 5 years the skin lesions progressively assume the characteristics of psoriasis.

The diagnosis of PsA was set up among 1–10 years.

Conclusion The possibility that psoriatic arthritis and Reiter's syndrome may be similar or closely related is illustrated by our cases, too. Such cases have suggested a more than coincidental interrelationship between Reiter's syndrome and psoriatic arthritis.

AB0133 BLUE COLOURED SKIN IN PSORIATIC ARTHRITIS

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Background

Objectives In this paper, we have analysed blue coloured skin over involved joints as a one of the clinical features of the psoriatic arthritis that is helpful for simpler and earlier reaching the diagnosis.

Methods Clinical material consisted of 650 consecutively hospitalised and outdepartment patients with the diagnosis of PsA and 1265 patients with diagnosis of RA in period between 1975 and 1998 year. Special attention was attended to inspection of the skin over involved joint including skin appearance, colour and size of the involved area and its changes in different conditions of the weather and temperature.

Results We have found blue coloured skin over involved joints in 598 patients with PsA (92%) and in 63 patients with RA (5%) (N2 joints and digits in case of sausage digits. In less involved joints blue colour develops in minor area, usually on central dorsal part of the sin over the joint. Blue coloured skin was better visible in the cold winter days while in the summer season and during the remission of the disease as well as at room temperature, blue colour is less marked or even disappears.

Conclusion This sign is reliable, so it should be very useful in PsA diagnostics.

AB0134 SULPHASALAZINE (SALAZOPYRINE EN) IN TREATMENT OF REACTIVE ARTHRITIS (EFFICACY, SAFETY AND TOLERABILITY)

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Background

Objectives Evaluation of the efficacy and tolerance of sulphasalazine (SALAZOPYRIN EN-tabs) in the management of Reactive arthritis (ReA) triggered by a urogenital infection.

Methods We conducted an open randomised trial on 2 parallel groups of patients, 30 patients each during 12 months (30 treated with SALAZOPYRIN EN 1–2 g/day, versus 30 treated with NSAID or analgesics). Tolerability and safety were assessed with whole blood picture test for liver and renal function, gastro-intestinal (G-I) adverse effects, and other side effects. Every month the efficiency of treatment was checked by clinical and laboratory methods.

Results There were no significant differences in demographic, clinical and laboratory parameters among the two groups at the study entry. By the end of the study, there was evidence of significant improvement shown by pain score, ability of movement, and reduction in the acute phase response in sulphasalazine (SALAZOPYRINE EN) group. Adverse reactions in the sulphasalazine (SALAZOPYRINE EN) group (12% of patients) occurred mainly in the first ten weeks of treatment and were mild, reversible and did not require termination of therapy. In 1% of patients these were severe enough to stop treatment.

The NSAID group encountered adverse reactions in 27% of patients and 4% required termination of therapy.

Conclusion Sulphasalazine (SALAZOPYRINE EN) proved to be a good first choice as a second-line of a disease modifying anti-rheumatic drug because of its early efficacy (8 weeks), persistent efficacy and its good tolerance.