Methods 8 patients with active AS (2 women and 6 men, mean age 36 years) were included in this study. AS was diagnosed according to the New-York criteria. Disease activity was assessed by erythrocyte sedimentation rate (ESR) and serum levels of C-reactive protein (CRP). None of the patients had macrovascular complications such as hypertension or clinical evidence of cardiac valvular insufficiency. Sex- and age-matched 8 healthy adults formed the control group. Myocardial involvement was evaluated by serum levels of cardiac specific troponin-I, an intracellular cardiac protein that is not detected in blood unless myocyte necrosis occurs.

Results Mean duration of disease activity was 8 years. Electrocardiograms were normal in all subjects. The ESR and CRP levels were elevated in all patients with AS (mean values were 39 mm/h and 34 mg/l respectively) while they were normal in controls (mean values were 11 mm/h and 2 mg/l respectively). Cardiac specific troponin-I was not detected in the serum of any subject.

Conclusion The absence of cardiac specific troponin-I in the serum of patients with active AS suggest that there is no ongoing primary myocyte necrosis in the active stage of this disease. Previously reported cardiac abnormalities in this disease can be the result of aortic involvement including aortic valve insufficiency.

REFERENCES

- 1 Van Der Linden S, Valkenburg HA, Cats A. Evaluation of diagnostic criteria for ankylosing spondylitis. A proposal for modification of the New-York criteria. *Arthritis Rheum.* 1984;**27**:361-8
- 2 Bergfeldt L, Insulander P, Lindblom D, et al. HLA-B27: an important genetic risk factor for lone aortic regurgitation and severe conduction system abnormalities. *Am J Med.* 1988;**85**:12-18
- 3 Graham DC, Smythe HA. The carditis and aortitis of ankylosing spondylitis. *Bull Rheum Dis.* 1958;**9**:171-4

SAT0038 EVALUATION BY DUAL X-RAY ABSORPTIOMETRY (DXA) OF BODY COMPOSITION IN ANKYLOSING SPONDYLITIS (AS) PATIENTS

E Mendonça, VM Montenegro, C Belleza, L Takayama, FR Lima, CR Gonçalves, LR Battistella. *Division of Rheumatology and Division of Rehabilitation, University of São Paulo, São Paulo, Brazil*

10.1136/annrheumdis-2001.390

Background

Objectives To evaluate body composition in patients with severe AS of long duration and predominant axial involvement by DXA.

Methods Forty-one AS male patients with mean age $38,9 \pm 7,26$ sd years old (23-50 years), and thirty-four controls matched for age, sex, race, weight, height were studied. Body composition was measured by DXA (HOLOGIC QDR 2000) and was compared in the two groups. BMD was also measured in two sites: lumbar spine (L1-L4) and femoral neck.

Comparisons were performed for the group of patients and controls. Differences were analysed using x2-test, Student test and Pearson test. Statistical significance was taken at $p < 0,05$.

Results Body-composition indexes (BMD g/cm², BMC g/cm², fat mass, lean mass, fat mass percentage) were analysed. Patients with AS had a lower total lean mass ($47,72 \text{ kg} \pm 5,82 \text{ sd}/55,34 \text{ kg} \pm 5,48 \text{ sd}$) and lower total bone mass ($1,04 \text{ g/cm}^2 \pm 0,96 \text{ sd}/1,13 \text{ g/cm}^2 \pm 1,16 \text{ sd}$) in comparison with controls. The analysis of BMD-lumbar spine and BMD-femoral neck showed low values ($0,996 \text{ g/cm}^2 \pm 0,20 \text{ sd}/0,752 \pm 0,15 \text{ sd}$) respectively. The diagnosis of osteoporosis/osteopenia was made by WHO criteria. Additionally, there was a difference in the fat mass percentage,

but it may be result of age rather than of disease. There was a significant correlation between the reduction of lean mass and bone mass and Schober test, weight and height ($p < 0,05$).

Conclusion Measures of body composition in AS patients can be important to investigate structural severity of the disease, so prevention of deformity can be promoted early. Low values of lean mass was observed in parallel with osteoporosis, that is frequent finding in male patients with AS.

This analysis showed a positively correlation between lower total lean/bone mass and anthropometric measures, probably secondary to the pathologic loss of mobility in the spine and rizo-melic joints. Then, this appropriate evaluation of the musculo-skeletal changes may be a new approach for effective rehabilitation in AS patients.

SAT0039 CLINICAL CHANGES IN OLIGOARTICULAR FORMS OF PSORIATIC ARTHRITIS AFTER A COURSE OF FIVE YEARS

MD Lopez-Montilla, A Escudero, M Romero, V Perez, C Castro, J Gonzalez, MC Muñoz-Villanueva, E Collantes. *Rheumatology, Hospital Universitario Reina Sofia, Cordoba, Spain*

10.1136/annrheumdis-2001.391

Background One of the most salient features of psoriatic arthritis is the wide variety of clinical manifestations it can exhibit. This facilitates interrelationships among its clinical forms and changes from one to another.

Objectives To evaluate the clinical manifestations of patients with psoriatic arthritis of initially oligo-articular form after a course of five years.

Methods An overall 32 patients with psoriatic arthritis of initially oligoarticular form (viz. with fewer than three joints affected in an unsymmetric form) were examined and the specific form prevailing after a course of five years was determined. Simultaneously, clinical activity was studied on the basis of the following criteria: (a) morning stiffness for less than 15 min; (b) absence of fatigue; (c) absence of articular pain; (d) absence of pain in response to pressure or movement; (e) absence of swollen joints; (f) VSG below 30. Those patients fulfilling at least five of the previous six criteria were considered to be in remission.

Results The following Table 1 classifies the patients according to status and clinical form of the disease.

Abstract SAT0039 Table 1

	Clinical form after 5 years	Polyarticular	Spondyloarthritis
	Oligoarticular		
Clinical Form Active	0	13	9
Clinical Form in remission	6	1	3
Total Clinical Form	6	14	12

Conclusion Our results confirm that oligoarticular forms of psoriatic arthritis are not static, but rather change during the course of the disease.

SAT0040 RHEUMATIC DISEASES IN PATIENTS WITH VITILIGO: A STUDY ON 28 CASES

¹I Olivieri, ¹G Ciancio, ¹A Padula, ¹L La Civita, ²A Piccirillo, ²F Ricciuti, ³F Cantini, ³L Niccoli, ⁴C Salvarani. ¹Rheumatology Department of Lucania; ²Dermatology Unit, San Carlo Hospital, Potenza; ³Rheumatic Disease Unit, Prato Hospital, Prato; ⁴Rheumatic Disease, Arcispedale S. Maria Nuova, Reggio Emilia, Italy

10.1136/annrheumdis-2001.392

Background Recently, we have demonstrated in a case-control study that vitiligo and spondyloarthropathy (SpA) do not coexist by chance in the same patient.¹ Of the 234 patients with SpA seen in the study period 8 (3.4%) were found to be suffering from type A vitiligo. On the contrary, among the 468 control patients only 5 (1.06%) had type A vitiligo. The difference was statistically significant ($p < 0.05$).

Objectives To establish the reasons for the rheumatological consultation in consecutive patients with vitiligo seen for the first time in our department.

Methods All patients that showed visible type A vitiligo in periorificial sites (around mouth, nose, eyes) and/or over the extensor surfaces of hands and wrists, seen for the first time in our department from January 1999 to 31 December 2000, were evaluated clinically. X-ray and laboratory examinations were performed when necessary.

Results Twenty-eight patients with visible vitiligo were seen. Of these, 4 had inflammatory rheumatic diseases associated with vitiligo (2 elderly onset undifferentiated SpA, 2 psoriatic arthritis, 1 rheumatoid arthritis together with lupus profundus). Five patients had inflammatory rheumatic diseases with dubious relationships with vitiligo (3 polymyalgia-like syndrome, 1 seronegative chronic polyarthritis, 1 severe peripheral enthesitis). The remaining 17 patients had vitiligo unrelated rheumatic diseases including osteoarthritis, mechanical low back pain, herniated disc, spondylolisthesis, condrocalcinosis, rotator cuff tendinitis, olecranon bursitis and trigger finger. Seven out of the 28 patients had diseases of the thyroid gland and 1 alopecia areata.

Conclusion The results of the present study confirm the association between vitiligo and SpA. Some patients with vitiligo have undifferentiated inflammatory rheumatic diseases, which need to be followed up.

REFERENCE

1 Padula A, et al. Association between vitiligo and spondyloarthropathy. *J Rheumatol.* 2001;**28**, in press

SAT0041 VALIDITY OF THE APPLICATION OF A DIAGNOSTIC PROTOCOL ACCORDING TO PATTERNS OF CLINICAL PRESENTATION OF UVEITIS TO ESTABLISH DIAGNOSIS

¹G Bonilla Hernán, ¹S Muñoz Fernandez, ²V Hidalgo, ¹J Fernandez Melón, ²A Schlincker, ²A Fonseca, ¹F Gamero Ruiz, ²B Damas, ¹E Martín Mola. ¹Rheumatology; ²Ophthalmology, Hospital La Paz, Madrid, Spain

10.1136/annrheumdis-2001.393

Background

Objectives To validate the efficiency of the application of a diagnostic protocol based on the patterns of presentation of uveitis to establish the diagnosis.

Methods Our Uveitis Clinic is composed of a multidisciplinary team of Ophthalmologists and Rheumatologist.

We defined a clinical diagnostic protocol for the uveitis, based on the frequency of syndromes found in the literature in each clinical pattern of uveitis and the symptoms of the patients. We

routinely performed a careful history, a complete ophthalmologic examination, hemogram, biochemistry, ESR, a fluorescent treponemal antibody absorption test, an urinary test and a chest X Ray. Other diagnostic procedures were ordered according to a established protocol based on the clinic patterns of presentation of uveitis. Data from the patients were prospectively recorded from June of 1997 to October 2000.

Results 366 patients were included, 40 of them (10.7%) were lost of follow-up, 146 of the 336 who completed the study were diagnosed of idiopathic uveitis (43.4%), 70 (21%) had some type of spondyloarthropathy (30 patients were diagnosed in our uveitis clinic), 33 (9.8%) were secondary to infections (23 herpes, 6 toxoplasmosis, 3 tuberculosis, 1 candida), 3 were masquerade syndromes (1 lung cancer and 2 lymphoproliferative diseases), 6 (1.7%) were traumatic, 47 (14%) were ophthalmologic syndromes, 21 (6.25%) uveitis were secondary to other rheumatic diseases (8 Behçet diseases, 8 Sarcoidosis, 4 Sjögren's syndrome and one juvenile chronic arthritis) and 2 were TINU syndromes.

Conclusion We have achieved the etiology of the uveitis in 56.6%. A greater percentage than those found in other series in which the diagnostic procedures have not been preestablished. In addition, it could have a better cost-effective impact and avoid the number of consultations between different specialists. We believe that this is the first study in which a clinical protocol of diagnostic procedures has been validated in patients with uveitis.

SAT0042 CLINICAL FEATURES OF PSORIATIC ARTHRITIS WITH A DELAYED ONSET

MD Lopez-Montilla, A Escudero, M Romero, V Perez, C Castro, J Gonzalez, MC Muñoz-Villanueva, E Collantes. Rheumatology Service, Hospital Universitario Reina Sofia, Cordoba, Spain

10.1136/annrheumdis-2001.394

Background The influence of patient age at onset on the clinical expression of rheumatic diseases has been widely demonstrated in relation to pathologies such as rheumatoid arthritis and ankylosing spondylitis. Such influence, however, has only occasionally been considered in connexion with psoriatic arthritis (PsoA).

Objectives To identify potential differences among the clinical manifestations of PsoA depending on patient age at the onset of the disease.

Methods Ninety-six consecutive patients diagnosed with PsoA as per the criteria of Moll and Wright were split into two groups according to whether their early symptoms of the disease appeared before or after the age of 60. The clinical features of both groups were assessed.

Results The following Table 1 shows the differential clinical features of the two patient groups, established according to onset age.

Abstract SAT0042 Table 1

	Group I (under 60 years)	Group II (over 60 years)
Number of patients	84	12
Gender	48% M/52% F	75% M/25% F
Family history	35%	17% (paternal)
Currently prevailing form	43% SpA/34.5% PA	17% SpA/45% PA
Dactylitis	50%	25%
Sacroilitis	41.5%	17% (unsymmetric)