Results 17 patients were enrolled, 9 men and 8 women, aged 34 to 76, with various stages of AVN (from stage 1 to 4). Antithrombin III deficiency was diagnosed in a woman. Resistance to activated protein C was found in another woman. Hyperhomocysteinemia was identified in 6 patients: two women (associated with antiphospholipid antibodies in one case), and 4 men. A lupus anticoagulant was found in one man and one woman. Two other patients were found to be homozygous to methyl-tetrahydrofolate reductase (MTHFR) mutation, condition which leads to a susceptibility to hyperhomocysteinemia.

Conclusion 59% of our patients with AVN were found to have a thrombophilic disorder. We suggest that such a disorder may precipitate thrombosis when added to other risk factors. Among these thrombophilic disorders, hyperhomocysteinemia seemed to be the most frequent factor associated with AVN. If hyperhomocysteinemia is confirmed to be involved in AVN, these results should be of special interest in prevention of recurrences, as hyperhomocysteinemia can be corrected by folic acid, B6 and B12 supplementation.

SAT0105 LOSARTAN BUT NOT IRBESARTAN REDUCES SERUM URIC ACID IN HYPERTENSIVE PATIENTS WITH GOUT

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Background Losartan is the only angiotensin II receptor antagonist with uricosuric properties and has been shown to decrease serum uric acid (SUA) levels in normal subjects as well as in hypertensive patients.

Objectives To assess and to compare the effects of losartan and irbesartan on serum uric acid in hypertensive patients with gout.

Methods Prospective, randomised, double-blind, cross-over study preceded by a three weeks run-in period with enalapril 20 mg od. During the first four weeks, patients received a morning dose of either losartan 50 mg or irbesartan 150 mg and a evening dose of placebo. The dose was then increased to losartan 50 mg bid or irbesartan bid. The losartan and the irbesartan phases were separated by three weeks of treatment with enalapril 20 mg od.

All drugs were provided in an electronic pill container allowing to monitor compliance (MEMS system).

Results Thirteen male hypertensive (office blood pressure > 140/90 mmHg or under antihypertensive therapy) and hyperuricemic (SUA over 420 µmol/L or over 7.1 g/dL, without any hypouricemic agents) patients completed this study.

The changes in blood pressure induced by losartan and irbesartan were comparable. In contrast to irbesartan which had no effect on SUA, losartan (50 mg od) decreased SUA significantly from 538 ± 26 µmol/L to 491 ± 20 µmol/L ($p < 0.01$) and to 484 ± 25 µmol/L at 50 mg bid. During the first 4 h after drug intake, the first dose of losartan increased the urinary uric acid/creatinine ratio when compared with irbesartan (0.525 ± 0.071 vs 0.358 ± 0.045 , $p = 0.019$). This increase was still present at week 4 (0.485 ± 0.085 vs 0.331 ± 0.057 , $p < 0.01$) but was not found at week 8 when patients received a bid regimen (0.316 ± 0.043 vs 0.331 ± 0.029 , $p = \text{ns}$). The frequency of acute gout episodes did not differ between treatments. The monitoring of compliance showed that the adherence to the morning dose was good ($89.2 \pm 2.8\%$) and significantly greater than that to the evening dose ($78.9 \pm 3.1\%$, $p < 0.001$).

Conclusion These results demonstrate the potential benefits of using losartan in hypertensive patients with hyperuricemia and gout. They also suggest that losartan-treated patients reach a new uric acid steady-state during a sustained administration (>1 month). Hence, the uricosuric effect tends to decrease with time as SUA is reduced. Increasing the dose of losartan to 50 mg bid does not appear to induce a further decrease in serum uric acid.

Pediatric rheumatology

AB0158 MUSCULOSKELETAL PAIN IN CHILDREN AND ADOLESCENTS

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Background

Objectives The purpose of this study was the determination of the frequency and consequence of musculoskeletal pain in urban children and adolescents.

Methods This study was performed in unselected population of two urban schools. Two Rheumatologists visited 479 children (216 boys and 263 girls) in their school. Mean age was 11 ± 2.4 years, range 6–17 yr. The survey included a detailed interview on the basis of a standardised questionnaire and physical examination. The severity of their pain was assessed by visual analogue scale and a subjective disability index.

Results About 30.3 percent (145/479) of cases had musculoskeletal pain. The pain was located at lower extremity in 74% of children. Thirty-one case (21.4%) had spinal pain and 19 (13.1%) had upper extremity pain. The severity of their pain, by visual analogue scale, had a mean 3.2 ± 1.8 (range 0.1–8) and $\frac{3}{4}$ of cases had disability. Pain relapses weekly in 38% and persists part of a day in 74%. Twenty eight percent (40/145) consulted their physician and 31 children consumed drugs. The physical activity and schoolbag carriage was associated with pain in 61% (89/145) of cases.

There were no statistically significant demographic differences among cases with and without musculoskeletal pain, except for sex, as is shown in the Table 1:

Abstract AB0158 Table 1

	Age	Sex*	Sports	Weight	Height
Pain	10 ± 2.2	F = 93; M = 52	43	43.3 ± 14.4	144.6 ± 13.3
No pain	11 ± 2.5	F = 170; M = 164	107	42.9 ± 14.5	145.2 ± 14.6

* $p < 0.05$.

Conclusion In our population lower extremity pain was more prevalent. It had a relapsing character and determines disability and consumption of medical services. The relationship with physical activity (practice of sports) was referred by children and was evaluated in other study.

AB0159 JOINT HYPERMOBILITY AND MUSCULOSKELETAL PAIN

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