New approaches: A recent controlled study reported that mycophenolate mofetil is equally effective to a regimen of oral cyclophosphamide and azathioprine used sequentially in patients with proliferative lupus nephritis. However, in this study follow up was short, patients had relatively mild disease and patients with high-risk factors were not included. A controlled study comparing mycophenolate mofetil to pulse cyclophosphamide is in progress. Other investigations explore the therapeutic potential of high-dose, immunoablative cyclophosphamide therapy alone or in combination with autologous stem cell transplantation, low-dose cyclophosphamide in combination with nucleoside analogues, or biologic response modifiers. High-dose cyclophosphamide or combinations of low-doses with fludarabine may result in profound bone marrow and immune suppression. Combinations of cyclophosphamide with biologic response modifiers have shown encouraging results in preclinical animal studies and may provide a major breakthrough in the treatment of severe lupus, similar to the introduction of cytotoxic agents a few decades ago.

SP0103 CHRONIC RENAL FAILURE IN SYSTEMIC RHEUMATIC DISEASES

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Prevalence of end-stage chronic renal failure (ESRF) in patients with systemic lupus erythematosus (SLE) and lupus nephritis varies considerably, supposedly due to not completely comparable groups of patients and different modes of treatment, but it may be estimated that about 15–20% of patients with lupus nephritis ultimately reach ESRF. This proportion is probably similar in adults and children, but may be substantially higher in African Americans (43% in one study). Rapid progression to ESRF during the first year of follow-up is uncommon and may occur in some patients with active multisystem disease, more than half of patients with lupus nephritis ultimately reaching ESRF do so in more than 5 years. Chronic renal failure may be reversible in about 20% of patients with lupus nephritis starting dialysis treatment. Although the mechanisms of this very high reversibility of renal failure in lupus nephritis remain unclear, immunosuppressive treatment does not seem to be of utmost importance and other factors (e.g. hypertension, renal vasoconstriction, endothelial dysfunction, etc.) may play a role. The view that the activity of SLE remits when lupus nephritis progresses to ESRF (so called lupus burn-out) is probably no longer substantiated and according to the Dutch study 71% of patients with lupus nephritis progressing to ESRF had flares with multi-system involvement in the last 4 years before the initiation of dialysis treatment. Lupus nephritis may represent between 1–4% of all patients treated by renal replacement therapy, their mean age is about 30 and males are more represented than in unselected SLE population. Estimated 5-year survival during hemodialysis treatment is between 81–89% and is at least comparable to other dialysis patients. Rather surprisingly, 5- and 10-year survival of patients with lupus nephritis treated by renal replacement therapy is not different from the survival of patients not progressing to ESRF. Extrarenal activity of SLE seems to be lower in patients treated by hemodialysis, but some extrarenal activity may be present in about 2/3 of dialyzed patients. Vascular access thrombosis may be much more frequent in dialyzed patients with lupus nephritis compared to other causes of ESRF,

the role of antiphospholipid antibodies is suspected, but not firmly substantiated. Experience with peritoneal dialysis in patients with lupus nephritis is limited and the potential risk of infectious complications is of major concern. Renal transplantation results in relatively high risk of not surviving in the first year after transplantation (5–15% mainly due to infectious complications. 5-year cadaveric graft survival is about 60% and renal transplantation probably does not result in higher 5-year survival than hemodialysis. Recurrence of lupus nephritis in transplants is rare, milder and better controlled by the instituted therapy. Repeated requirement of longer dialysis treatment (usually 6–12 months) before transplantation to achieve disease quiescence does not seem to be fully substantiated.

Acute renal failure is a common presentation of ANCA-positive renal vasculitis with focal segmental necrotizing/crescentic glomerulonephritis. Dialysis dependent renal failure may occur in 24–63% of these patients (of mean age 50–60 years) according to the severity of disease and time of referral. Early immunosuppressive treatment is able to spare renal function, e.g. initial dialysis was required in 59% and long-term dialysis in only 36% of patients from Wessex. Need for dialysis clearly confers poorer 5-year survival (about 50% vs. 75%). Renal transplantation is probably performed in no more than 10% of (usually younger patients with 92% 1-year patient and 85% 1-year graft survival. Delay in diagnosis and treatment remains to limit the therapeutic potential of current immunosuppressive treatment to improve long-term outcome of these patients.

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ERASS Symposium – Saturday 16 June, 10.00-11.45/Meeting Hall I

SP0106 CURRENT CONCEPTS IN ARTIFICIAL REPLACEMENT OF THE RHEUMATOID WRIST AND FINGER JOINTS

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Prosthetic replacement of wrist and finger joints is a key stone in the surgical treatment in rheumatoid arthritis. Severely destroyed joints are a source of pain and create deformities, which will severely affect the functionality of the hand. The wrist joint consists of a radiocarpal joint which provides flexion/extension and a radio-ulnar joint which allows pro-/supination.

A mobile radiocarpal joint helps to compensate for impaired elbow and finger joint. There is a variety of wrist prosthesis on the market. Overall the results with these prosthetic devices are mixed. There is generally a high failure rate with sometimes difficult revisions situations due to missing bone stock. The Swanson silastic implant, with reasonable longtime results, might be an alternative to preserve some motion. Nevertheless arthrodesis is still the gold standard on which the current wrist implants have to be measured. On the level of the radio-ulnar joint ulnar