($p = 0.03$) and particularly with a more important radiological progression ($p = 0.03$) was the LFT.

Conclusion Whatever the method used, indirect immunofluorescence or ELISA, anti-filaggrin do not allow to predict radiological damage in community cases of RA of limited duration.

AB0044 AN OUTSTANDING LATE RHEUMATOID ARTHRITIS IN A PATIENT WITH ACROMEGALIC ARTHROPATHY: A CASE REPORT

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Background

Objectives Arthropathy is a consequence of growth hormone excess in acromegalic patients due to articular cartilage and nearby soft tissue involvement. Rheumatoid arthritis (RA) is, on the other hand, another entity, which may sometimes look alike due to the similar clinical findings. We present this case where these both diseases exist at the same time.

Methods A 63-year old male complaining of joint pain and ankle swelling was evaluated. The arthralgia he described, was mainly in his knees, elbows and shoulders, and exaggerated especially at night. Recently accompanying swelling and erythema in his left ankle and in the left second metacarpophalangeal (MCP) joint did exist. He has been diagnosed as acromegalia for 15 years whereas his symptoms related with the joints came out within the last 6 years. He is somatotropinectomized and has also received radiotherapy for his primary disease. His neck, bilateral wrist, elbow and shoulder joints were involved, thus were painful and limited during normal range of motions. MCP joints being worse than the interphalangeal joints were likewise involved. His left ankle and MCP joints were swollen and red additionally. Laboratory and radiological evaluations comprising complete blood count, liver and kidney function tests, serological tests, direct x-rays of the joints were carried out. His erythrocyte sedimentation rate (ESR) was 93 mm/h, RF: 685 IU/ml. The diagnosis of rheumatoid arthritis other than the concurrent acromegalic arthropathy was confirmed with the radiological and clinical findings according to the ARA criteria. He was then treated with steroids.

Results We considered this case challenging and notifying since an acromegalic patient can easily be misdiagnosed as having RA especially when high ESR and morning stiffness accompanies the case. We think the uncommon coexistence i.e. not mentioned up to date in the literature, may enlighten the still unknown pathogenesis of RA with the probability of growth factors mastering the whole event.

Conclusion

AB0045 PERIPROSTHETIC BONE REMODELLING AND RADIOGRAPHIC FIXATION OF A CEMENTLESS TOTAL HIP ARTHROPLASTY WITH TITANIUM STEM IN RHEUMATOID ARTHRITIS AND OSTEOARTHRITIS PATIENTS

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Background New bone formation around cementless stem after total hip arthroplasty is dependent on implant design, material, and mode of porous coating. These osteogenesis patterns are classified as follows, proximal endosteal bone bridging spot welds, increased cortical thickness (cortical hypertrophy) and thin radiodense lines surrounding the tip of the implant (halo pedestal). However, no reports showed the comparison of bone remodelling patterns surrounding stem among diseases: such as osteoarthritis (OA), rheumatoid arthritis (RA), avascular necrosis and neck fracture.

Objectives The purpose of this study is to clarify whether there are differences of the postoperative bone remodelling pattern around the femoral stem between RA and OA patients.

Methods Total hip arthroplasty with the Mallory-Head cement less titanium prosthesis has been performed since 1992 in our institute. This tapered stem has plasma spray coating in proximal one third of it. RA group included 18 hips (mean age at operation was fifty-five years old and mean duration of follow-up was 4.6 years). OA group included 70 hips (mean age at operation was fifty-eight years old and mean duration of follow-up was 5.2 years). Anteroposterior radiographs of the hip were made at 6 weeks, 3 months, 6 months, one year and every year after the operation. We evaluated the frequency and time of new bone remodelling appearance around the stem such as spot welds, cortical hypertrophy, and pedestal. We defined that the radiographic signs of instability were progressive subsidence or the presence of radiolucent lines around the porous coating (1). To evaluate the differences in both groups, the Mann-Whitney's U test and chi-square test were used. P values of less than 0.01 were considered significant.

Results In both groups, there was no case, which has radiographic sign of instability. Age and intramedullary canal fill of the stem at the operation and follow-up period were not significantly different between RA and OA groups. In endosteal spot welds, the time of its appearance in RA group (2.7 months after operation) was significantly shorter than that in OA group (5.2 months) and the frequency of it did not differ between both groups. However, in halo pedestal, the frequency in RA group (50%) was significantly lower than that in OA group (87%) and the time of its appearance did not differ between both groups. On the other hand, concerning about cortical hypertrophy, time and frequency showed no significant differences between two groups.

Conclusion We revealed that in RA patients, endosteal spot welds appeared significantly earlier than that in OA patients, and the frequency of halo pedestal was significantly lower than that in OA patients.

AB0046 PREVALENCE OF TUBERCULOSIS INFECTION IN RHEUMATOID ARTHRITIS PATIENTS TREATED BY CORTICOSTEROID PULSE THERAPY

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Background Several pathogens have been previously reported in rheumatoid arthritis (RA) patients treated by corticosteroid pulse therapy (CPT)¹⁻³ and we recently described a case of upper lobe cavitary tuberculosis in a patient with RA under CPT associated to methotrexate.⁴