evaluations employing a 'hard' outcome such as mortality can help overcome these problems.

Objectives To understand the correlates of depression in RA and to determine whether depression itself is predictive of mortality in RA.

Methods We studied 1500 consecutive RA outpatients during a 20 year period beginning in 1981. 1483 patients completed 27,773 depression questionnaires from the Arthritis Measurement Impact Scales (AIMS). The relation of depression to other variables was studied with generalised estimating equations (GEE). For ease of interpretation, depression was considered present when the AIMS score was 4 or greater in the GEE analyses. The predictability for mortality of depression, and other variables obtained 1) during the first 2 years of follow-up and 2) over the entire course of RA was examined using Cox regression (Cox) models.

Results Depression was related to age < 65 years (odds ratio 1.3), non-white ethnic origin (OR 1.9), and decreased family income, but was unrelated to sex or marital status. Compared to university graduates, secondary school graduates and non-graduates had increased risk for depression, OR 1.4 and 2.1 respectively. In multivariate models, education, income and ethnic origin were independently related to depression. In clinical models, ESR, white cell count, joint count, grip strength, patient global severity, pain and HAQ (HAQ OR 2.33 (95% CI 2.11, 2.59, $p < 0.001$) were also strongly related to depression. In univariate Cox models, 2-year depression was predictive of mortality ($z = 3.55$ $p < 0.001$), and remained predictive even when ESR, joint count, WBC and grip strength were added as 2-year covariates ($z = 2.00$ $p = 0.046$). However, when HAQ disability, patient global, or pain was added to the model, depression was no longer significant ($p = 0.388$). The same results were noted when the 2-year depression scores were modelled with full covariates (from first through last observation). Finally the hazard ratio (HR) for the effect of a depression score of 4 or greater over the full course of the disease was 1.33 (95% CI 1.09, 1.63) after adjusting for all covariates. This result was maintained after also controlling for blood pressure, BMI, prednisone use and comorbid illnesses.

Conclusion Depression during the first 2 years of clinical care is associated with increased RA mortality, and is also associated when laboratory or physician associated covariates are added. The effect of depression on mortality is strengthened by follow-up, and this association (HR 1.33) is maintained even after the inclusion of all covariates. These data suggest that depression has a small but definite association with mortality in RA. Even so, it is possible that additional medical factors that were not recognised by our models might be causally related to depression and therefore to mortality.

THU0125 IS ANXIETY A MORE COMMON DISORDER THAN DEPRESSION IN RHEUMATOID ARTHRITIS?

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Background Most of the previous clinical researches published payed more attention to study depressive disorders and/or symptoms in patients with rheumatoid arthritis (RA). Fewer research studies were done to investigate the prevalence of anxiety in patients with RA patients.

Objectives This study was performed to investigate whether anxiety disorder is as common as depressive disorder in RA patients and to look for the sociodemographic as well as the clinical characteristics of the patients developing these disorders.

Methods A detailed physical assessment of 80 patients with RA was performed. Also psychiatric assessment was done using Research Diagnostic Criteria for the International Classification of Disease (ICD-10). In addition, patients answered a Health Assessment Questionnaire (HAQ) to assess their functional capacity.

Results Depression was diagnosed in 66.25% of the total sample while anxiety was diagnosed in 70%. Functional disability, social stress and morning stiffness were the factors highly associated with depression. Using multiple regression analysis, anxiety was also highly associated with depression. On the other hand, Ritchie articular index as well as depression were positively associated with anxiety disorder.

Conclusion Psychiatric illness is a relatively common disorder in patients with RA, with frequency higher than that of other general medical conditions. Anxiety is a more common disorder than depression. The first step in correct management is recognition of anxiety and depression so that appropriate treatment can be tried. Particular attention has to be paid to social stress and lack of social support.

THU0126 DEXTERITY AND ANXIETY IN LARGE COHORT OF RHEUMATOID ARTHRITIS PATIENTS

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Background Psychological distress is often a leading condition in rheumatoid arthritis clinical picture in addition to disability and disease activity measures. Being long lasting process it makes an impact on disease coping process and management itself.¹

Objectives The aim of the study was to determine which demographic and clinical variables relate to anxiety and depression most of all in 225 rheumatoid arthritis (RA) patients cohort.

Methods The study was performed as satellite project to Vilnius rheumatoid arthritis register. The patients were invited to participate in the study and to answer the questions concerning education and employment, physical functioning: ACR functional classes, dependence on relatives and HAQ and patients global assessment of health status. The disease activity was measured by physicians global assessment, pain VAS, morning stiffness and modified DAS. Anxiety and depression were measured by AIMS2 questioner particularly asking about mood alterations with range of possible answers: 1-never and 6-almost ever. The level 6,0 for anxiety and 4,0 for dexterity were used as cut of levels.² The chi-square method was used for evaluation of associations and was qualified as significant if $p < 0,05$.

Results In this particular cohort we found that 32% of patients were experiencing the anxiety and even 42,2% – depressive moods. As the result, we found strong associations between anxiety levels with disease outcome measures: physical functioning classes ($\chi^2 = 12,72$; $p = 0,00$), disability indices ($\chi^2 = 21,09$; $p = 0,00$) and employment holding ($\chi^2 = 5,62$; $p = 0,01$). Global evaluation of disease activity by physician was the only one significantly correlated disease activity measure ($\chi^2 = 12,51$; $p = 0,00$). Dexterity levels showed the same significant associations with the same measures. In addition to it dexterity