had one more additional significant association: the dependence on relatives made those patients evidently depressed ($\chi^2 = 12,96$; $p = 0,00$) but not anxious.

Conclusion The anxiety and depression status of 225 RA patients turned out to be multidependent variables in strong association with social status, disability indices and ACR classes but physicians global assessment as the only one disease activity measure.

REFERENCES

- 1 Meenan RF, Gertman PM, Mason JH, Dunaif R. The arthritis impact measures scales. *Arthritis Rheum.* 1982;**25**:1048–53
- 2 Hawley DJ, Wolfe F. Anxiety and depression in patients with rheumatoid arthritis: a prospective study of 400 patients. *J Rheumatol.* 1988;**15**:932–41

THU0127 THE EVALUATION OF DISEASE OUTCOME MEASURES IN 225 RHEUMATOID ARTHRITIS LITHUANIAN PATIENTS

JJ Jankauskiene, S Stropuviene, J Dadoniene, A Luksiene, A Jurgelenas. *Rheumatology Department, The Institute of Experimental and Clinical Medicine, Vilnius, Lithuania*

10.1136/annrheumdis-2001.1029

Background It is commonly recognised that outcome measures in rheumatoid arthritis depend on the duration of disease and especially disability index reveals that link while the others demonstrate minor changes in the course of disease.

Objectives To test the latter hypotheses we performed the study which aimed to measure long-term outcomes of rheumatoid arthritis in 225 patients – Vilnius city inhabitants.

Methods The patients were asked to fill in the self-administered questioners as follows: Stanford HAQ (0–3,3 worth health), AIMS(1–6, 6 worth), SF-36 (0–100, 0 worth health). The entire cohort was subdivided into three groups depending on the disease duration. The first cohort with the short disease less than 5 years encountered 70 patients, second cohort between 5 to 10 years of disease duration encountered 56 patients and 99 patients with long standing disease more than 10 years duration consisted the third cohort. The differences between means (SD) of the variables were measured by F-ratio and qualified as significant if $p < 0.05$.

Results The significant differences between the cohorts were found in disability indices measured by health assessment questioner: 1,21(0,75), 1,17(0,69) and 1,45(0,83) respectively with F-ratio higher than critical value ($p = 0,048$). Aims depression and anxiety measures were not significantly different between the cohorts, the same as quality of life indices measured by SF-36. The study was found to be powerful enough -0,7- to reveal the possible differences.

Conclusion The only differences between disease duration cohorts were revealed in measuring disability indices which tended to grow with increasing disease duration while the other measures were not sensitive to change. This large enough study showed that psychological distress and quality of life measures do not depend on disease duration and the disease impact is particularly visible on disease indices.

THU0128 SYSTEMIC AA AMYLOIDOSIS IN RHEUMATOID ARTHRITIS – THE INFLUENCE OF AGE, SEX, ONSET AND DURATION OF DISEASE. A RETROSPECTIVE STUDY

MI Bely, A Apathy. *Pathology, Polidinic of the Hospitaller Brothers of St. John of God in Budapest, Budapest, Hungary*

10.1136/annrheumdis-2001.1030

Background Rheumatoid arthritis (RA) is a chronic, recurrent autoimmune inflammatory disease, which may be complicated, like other chronic inflammatory diseases, by systemic secondary (reactive) AA amyloidosis (AAa). The precursors of AA amyloid protein fibrils are produced by the liver. During the progressive, cumulative process of systemic AAa the serum amyloid A proteins spread via the blood-stream and deposit throughout the body. AAa in its early stage involves only a few tissue structures (blood vessels, collagen, and reticulin fibres, basal membranes, etc.) in some organs, and increasingly more in its later stages. In advanced stages of AAa massive amyloid deposits in the kidney lead to renal insufficiency and the patients die of uremia. The extension and quantity of amyloid deposits depend on the production, and/or elimination (resolution, excretion) of amyloid proteins, or from the pathologist's point of view on the stage of this progressive disease at death.

Objectives The aim of this study was to determine the influence of age, sex, onset of RA, and disease duration on amyloidosis.

Methods A randomised autopsy population of 161 in-patients (female 116, average age of 64.9 years; male 45, average age of 66.2 years at death) with rheumatoid arthritis (RA) was studied.

The existence of amyloidosis and extent of amyloid deposits at death was determined histologically.

The average amount of amyloid deposition in various structures was visually evaluated on a 0 to 4 plus scale.

The correlations were determined by Mann-Whitney (Wilcoxon), critical random check, Student (Welch) t-probe, and by χ^2 -tests, comparing the age, sex, onset of RA, and duration of disease at the time of death: with or without amyloidosis, mild (? <2? per patient) and severe amyloidosis (?2

Results Systemic secondary (AA) amyloidosis was observed in 34 (21.1%) of 161 cases: in 21 cases amyloidosis was, and 13 it was severe. There was no significant difference of survival time (age at death), onset of RA, and disease duration between males and females, or between patients with and without amyloidosis. RA started earlier, the disease duration was longer, and the age of the patients at death was significantly lower ($p < 0.005$) in cases with severe amyloidosis, in comparison to those with mild amyloidosis.

Conclusion Amyloidosis may develop in both sexes, and may start at any time during RA. AAa existed in different stages (mild: characterised by sporadic and minimal amyloid deposits, or severe: characterised by diffuse and massive amyloid deposits) at the time of death. There were no significant differences in disease duration and survival time between males and females, or between patients with and without amyloidosis, suggesting that amyloid deposition may occur at different rates. AAa may develop as a rapidly progressive, or as a chronic, slowly progressive disease. Possibly, the process may become inactive (quiescent), or even regress at some point in time.

The risk of severe amyloidosis (2 <) is higher in patients with early onset and with long duration of RA, and in these patients the age at death is significantly lower ($p < 0.005$).

THU0129 UNAVOIDABLE AND MODIFIABLE RISK FACTORS FOR ISCHAEMIC HEART DISEASE (IHD) IN RHEUMATOID ARTHRITIS (RA)

¹NX Erb, ¹MJ Banks, ²IF Rowe, ¹GD Kitas. ¹Department of Rheumatology, Dudley Group of Hospitals NHS Trust, Dudley; ²The High Field Rheumatology Unit, Worcestershire Acute Hospitals NHS Trust, Worcester, UK

10.1136/annrheumdis-2001.1031