of radiological changes. Rheumatoid factor has low specificity and is often negative in ERA. The other non-rheumatological disorders (viral infection, neoplastic and endocrine diseases) may also in the early stage present like RA symptoms.

The objective of this study was to revise the preliminary diagnosis of ERA in hospitalised patient.

Methods Clinical examination (including laboratory tests and X ray), immunological tests: RF, antikeratin antibodies (AKA).

Results During the last 26 month 510 RA patients (according ACR criteria) were hospitalised in Rheumatology Department. Among this group of patients 94 (18%) were admitted with the preliminary diagnosis ERA. All of this patients group fulfilled the first four clinical ACR criteria. The duration of the disease was varied 3 to 9 months. All patients were carefully examined according number of painful and swollen joints, their symmetry and localisation, presence of RF, AKA antibodies and radiological erosions. In cases where RA diagnosis was doubtful other needful examination were done. The diagnosis of ERA was established in 48 (52%), but in 46 (48%) was excluded. ERA patients were predominately women, symmetrical polyarthritis of the hands was present in 45 (52%). RF in 28 (58%), radiological erosions were found in 5 (10%). In group of patients with excluded ERA the following diagnosis was established: osteoarthritis 14 (31%), RA ? like (nonclassified) 13 (28%), reactive arthritis 3(7%), hepatitis viral infection 2 (4%), neo 2 (4%), Hashimoto syndrome 5 (11%), Sjogren syndrome 2 (4%), Polymyalgia 2 (4%), Fibromyalgia 3 (7%). AKA were present in 30 (62%) patients in group with established diagnosis of RA and RF was present in 28 (58%) patients in this group. AKA was present in 10 (21%) patients with different diagnosis and RF was observed in 8 (17%) patients in this group.

Conclusion 1) ACR criteria are insufficient in aspect of differential diagnosis of ERA and non ERA. 2) Present RF and AKA are more specific in ERA than in non ERA patients. 3) The diagnosis of ERA should be established by specialists.

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THU0170 IMMUNOGLOBULIN G FC-RECEPTOR (FCGR) IIIA POLYMORPHISMS AND DISEASE EXPRESSION IN RHEUMATOID ARTHRITIS

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Background Fc receptors for IgG (FcγR) modulate immune responses. Fcγ receptors are expressed on various leukocytes and contain allelic polymorphisms with different capacity for IgG binding and phagocytosis. The FcγR polymorphisms have been implicated as genetic factors that may influence the susceptibility to autoimmune disease. FcγRIII has two isoforms (A and B) and is encoded by genes on chromosome 1. For FcγRIIIA, the presence of the valine (V) allele confers a higher receptor affinity for IgG1, IgG3 and IgG4 than does the presence of the phenylalanine (F) allele.

Objectives We investigated the distribution of the FcγRIIIA alleles in rheumatoid arthritis (RA), and whether they were related to disease expression and severity.

Methods Ninety-six controls and 114 patients fulfilling ACR criteria for RA were genotyped for FcγRIIIA polymorphisms using PCR. Physician's global assessment of RA type estimated RA disease expression. In addition, usual measures of disease activity were recorded.

Results Crosstabulation of the FcγRIIIA genotypes V/V and V/F combined vs the F/F genotype showed that more patients with aggressive RA than expected had the V/V and V/F genotypes ($P < 0.05$). The FcγRIIIA V/F genotype and the V allele was slightly more frequent among RA patients than among controls. This finding however, was not statistically significant. We found no significant associations with the clinical and laboratory variables of disease activity.

Conclusion The results of previous studies regarding FcγRIIIA in RA are not consistent. The present findings of a more severe disease among patients homo- and heterozygous for the valine (V) allele, and the suggested tendency of more than expected V/V and V/F genotypes among RA patients as compared to controls, lend support to the notion of FcγRIIIA as a possible disease susceptibility and disease-modifying gene in RA.

THU0171 A CLINICAL RELEVANT INCREASE IN RADIOLOGICAL PROGRESSION, THE PATIENT'S PERSPECTIVE

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Background Radiological progression is considered the most important outcome for Rheumatoid Arthritis, but there is no established definition, as to what constitutes a clinical important progression of joint damage. The smallest detectable difference (SDD) for the modified Sharp method and the Larson method was taken as a starting point. And expert opinion of rheumatologists was used to determine the clinical relevant progression. However these findings might not reflect the true clinical important progression in radiological damage. The clinical important difference should be the effect this progression has on the patient, being the development of physical disability.

Objectives To estimate the clinical relevant increase in radiological damage, using the effect on physical disability.

Methods This study elaborates on the findings of studies, investigating the clinical relevant increase in the HAQ-DI score, and on a study investigating the relation between disease activity, radiological damage, sociodemographic factors, and physical disability. The clinical relevant difference in physical disability (HAQ-DI) has been determined by asking patients to rate themselves relative to another patient, and was estimated to be between 0,2 and 0,3. The relation between physical disability (HAQ-DI), disease activity (DAS), and radiological damage (Modified Sharp score) was determined, using the follow-up data of 378 patients from an open prospective study of early RA (disease duration < 1 year). Linear regression was used at 0, 3, 6, and 9 years after inclusion with as dependant variable the HAQ-DI, and as independent variables, disease activity (DAS), radiological damage, and sociodemographic factors. The main results of this study were that the relation between radiological progression and physical disability was dependent on the activity of the disease and the present radiological damage (5). With higher disease