prospectively. An independent Gastrointestinal Events Committee (GEC) reviewed all data in a blinded fashion. Events were categorised as UGI ulcer complications (perforations, gastric outlet obstruction, bleeding) or symptomatic UGI ulcerations (pre-defined as in CLASS). A total of 144 cases were reviewed and adjudicated by the GEC.

Results See Table 1.

Abstract THU0182 Table 1

	Celecoxib N = 8800	NSAIDs N = 4934	Odds Ratio	95% CI
Exposure (pt-yr)	1721.2	857.9		
Ulcer Complications (annualised rate)	2/1721.2 (0.1%)	7/857.9 (0.8%)*	7.02	1.46-33.80
Ulcer Complications + Symptomatic Ulcers (annualised rate)	18/1721.2 (1.0%)	21/857.9 (2.1%)*	2.01	1.04-3.86

*p < 0.05 vs celecoxib.

Conclusion These data confirm CLASS results that celecoxib is associated with significantly fewer ulcer complications and symptomatic UGI ulcerations than conventional NSAIDs. The differences in event rates between SUCCESS and CLASS may relate to regional differences in surveillance or clinical practice.

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THU0183 SIGNIFICANTLY IMPROVED UPPER GASTROINTESTINAL (UGI) TOLERABILITY WITH CELECOXIB, A COX-2 SPECIFIC INHIBITOR, COMPARED WITH CONVENTIONAL NSAIDS. THE SUCCESS I TRIAL

¹JL Goldstein, ²N Agrawal, ³G Eisen, ⁴W Stenson, ⁵AE Bello, ⁵JG Fort, ⁵SP Boots. ¹Department of Medicine, University of Illinois at Chicago, Chicago; ²Department of Medicine, Duke University Medical Center, Durham; ³Department of Medicine, Vanderbilt University Medical Center, Nashville; ⁴Department of Medicine, Washington University Medical School, St Louis; ⁵Research and Development, Pharmacia Corporation, Skokie, USA

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Background The Celecoxib Long-term Arthritis Safety Study (CLASS), a prospective outcomes study conducted in North America, demonstrated a significant reduction in UGI ulcer complications and improved tolerability.

Objectives To extend our understanding of the UGI safety advantages of celecoxib over conventional nonsteroidal anti-inflammatory drugs (NSAIDs), in day-to-day practice, a naturalistic study was conducted worldwide.

Methods SUCCESS I, a large, 12-week, multinational, double-blind, randomised trial in 13,274 osteoarthritis patients, was conducted in 39 countries. There were 6547 patients from Europe/Africa, 2756 from North America, 2889 from Latin America, and 1082 from Asia/Pacific. Celecoxib 200 mg/d (n = 4421) and 400 mg/d (n = 4429) was compared with naproxen 1000 mg/d (n = 914) and diclofenac 100 mg/d (n = 3510) with regard to GI tolerability.

Results The frequency of all reported GI adverse events (AEs), the three most frequently reported UGI AEs, and withdrawals due to GI AEs are shown in the Table 1.

Abstract THU0183 Table 1

NSAIDs (N = 4394)	Celecoxib (N = 8800)	% Reduction	p Value
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All GI AEs	21.0%	16.7%	20.4%	<0.001
UGI AEs	15.6%	11.9%	23.7%	<0.001
Abdominal pain	6.2%	4.8%	22.5%	<0.001
Dyspepsia	5.9%	4.8%	18.6%	<0.008
Nausea	3.4%	2.4%	29.4%	<0.001
Withdrawals due to GI AE	6.8%	5.2%	23.5%	<0.001

Conclusion UGI symptoms, more commonly associated with NSAID use, were consistently and significantly lower with celecoxib. The percent reduction ranged from 18.6% to 29.4%. These data confirm the superior GI tolerability of celecoxib vs conventional NSAIDs and establish that this difference is clinically meaningful in terms of discontinuation of therapy for such symptoms. Sponsored by Pharmacia Corporation and Pfizer, Inc.

THU0184 POLYMORPHONUCLEAR CELL COUNTS (PMN) EFFECTIVELY PREDICT MORTALITY IN RHEUMATOID ARTHRITIS (RA) PATIENTS FOLLOWED FOR UP TO 20 YEARS

¹F Wolfe, ²HK Choi. ¹National Data Bank for Rheumatic Diseases, Arthritis Research Center Foundation, Wichita, USA; ²Rheumatology Unit, Harvard Medical School, Boston, USA

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Background Mortality is increased in rheumatoid arthritis (RA), and this increase is related to disease severity markers, disease activity and psychosocial factors. It has been previously reported that white cell counts (WBC) predict total joint replacement in RA,¹ and WBC levels are associated with cardiovascular mortality in non-RA populations.² The effect of WBC, especially PMN, on mortality has not been studied in RA, but might be clinically important.

Objectives To investigate the relation between PMN and mortality in RA.

Methods During a 20-year period ending in 2000, 1500 consecutive RA patients had 21,581 clinic visits at which 18,850 WBC tests were performed. 544 patients died. The predictability for mortality of PMN 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 models (Cox). To assess the impact of covariates on the predictability of PMN, we controlled for RF, ESR, age, disease duration, sex, HAQ, and prednisone use in multivariate Cox models. Generalised estimating equations (GEE) were used to describe the relation of PMN to other variables.

Results The mean (SD) of WBC and PMN was 8.0 (2.8) and 6.0 (2.5), respectively. Total PMN but not lymphocyte counts predicted mortality (p < 0.05 and p = 0.522, respectively). The mean PMN values in its quartiles were 3.5, 4.9, 6.2 and 9.0. Over the entire course of RA the hazard ratios (HR) for mortality compared with Q1 were Q2 1.5 (1.1,1.9), Q3 1.9 (1.4,2.5) and Q4 2.8 (2.2,3.7). By contrast, the HR for rheumatoid factor positivity (RF) was 1.6 (1.3, 2.1). HR for PMN during the 1st 2 years of follow-up were Q2 1.5 (1.1,1.9), Q3 2.0 (1.6, 2.6) and Q4 2.4 (1.8, 3.1). For those in Q1-Q4 during the 1st 2 years, the predicted 25% time to death was 11.7, 8.8, 7.2 and 4.6 years, respectively. To assess the effect of covariates on the predictive ability of PMN, covariates that included RF, ESR, age, disease duration, sex, HAQ, and prednisone use were added to the 2-year and lifetime PH models. PMN remained significant in the multivariate Cox models, and was a stronger predictor of