THU0206 CLINICAL SIGNIFICANCE OF QTc DISPERSION AND EJECTION FRACTION OF THE LEFT VENTRICLE IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background QTc dispersion (QTc-d) is an indicator of imbalanced ventricular activity and represents a useful prediction for the appearance of ventricular arrhythmias. The longer QTc-d is more frequent in the patients with the duration of rheumatoid arthritis (RA). Echocardiographically estimated systolic function by ejection fraction (EF%) has a clinical and therapeutical significance.

Objectives The objective of the research was to examine two groups of patients with RA as regards the duration of the disease to 5 and 10 years.

It was necessary to establish in which group ventricular arrhythmias were more frequent in relation to QTc-d and in relation to EF% as well.

Methods 50 patients were examined, 30 females and 20 males, whose average age of 58 ± 3 . All the patients were divided into two groups. The first group included 28 patients with the duration of the diseases to 5 years, and the second group consisted of 22 patients with the duration of the disease from 5 to 10 years. On 12-lead ECG QTc-d was measured as a difference QTc max – QTc min and it was corrected by Bazett's formula. All the measures were done in sinus rhythm. Echocardiographic estimation of the systolic function was determined from EF%, 2-D-Echocardiography.

Results The values of QTc-d in the first group were 50.5 ± 2.5 msec, whereas EF% was $48\% \pm 3.5$.

In the second group QTc-d was $78.5 \text{ msec} \pm 3.2$ and EF% was $39\% \pm 2.5$.

The longer QTc-d and lower EF% were noted in all examined patients. However, in the second group of the patients, these values were considerably changed, which indicates that the duration of the disease is important. In the second group the ventricular arrhythmias were more frequent and they are very important in prognosis and treatment of those patients.

Conclusion Examined showed that the longer QTc-d was considerably longer in the second group of the patients. EF% was considerably lower in the second group. The longer QTc-d and low EF% were in good correlation with the ventricular arrhythmias.

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THU0207 ASYMPTOMATIC AND SYMPTOMATIC MYOCARDIAL ISCHEMIA IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background Holter electrocardiography (Holter-ECG) is a useful uninvative method with 24-hour-following of patients in hospital and especially out-of-hospital conditions. It was noticed that the

ischaemic changes are noted on ECG and they can be without any subjective problems. Since the patients with rheumatoid arthritis have frequent chest pains, 24-hour-Holter ECG can indicate to whether those pains come from the heart.

Objectives The objective of the research was to place Holter ECG for 24 h to the out-patients with rheumatoid arthritis.

The objective was to follow ST-changes on Holter ECG with noting of the daily activities and subjective discomfort during those activities.

It was also important to examine the possible ischemias and the time of their appearance.

Methods 50 patients were examined, 30 females and 20 males, with the average age of 58 ± 3 .

All the patients were after the medical check-up placed Holter ECG and given the paper for notes. It was advised that they should do all the activities and note all the difficulties 24 h a day. The analysis of Holter ECG and the notes were done separately by two different doctors.

Results Out of the 50 examined patients, 30 patients had 3 risk factors (hypertension, diabetes mellitus and hyperlipidaemia). 20 patients out of 50 examined had the risk factor – smoking. Episodes of symptomatic ischemia were noted in 20 patients and those were in the group which had all the three risk factors. Asymptomatic ischemia was noted in 15 patients and all of them had diabetes. Episodes of asymptomatic and symptomatic ischemia were noted in 15 patients. Asymptomatic and symptomatic ischemia occurred most frequently in the early morning hours, between 6 and 9 am, and 3 and 5 pm.

Conclusion The examination showed that the patients with rheumatoid arthritis had ST segment changes on Holter ECG. Episodes of symptomatic ischemia were more frequent, though special attention was paid to the episodes of asymptomatic ischemia as well, which most often appeared in early morning hours.

Episodes of asymptomatic ischemia were followed by complicated ventricular arrhythmias. Holter ECG is a useful method for following the patient with RA, because in this group the patients with the coronar diseases can be found. This is essential for the choice and dosage of a medicine.

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THU0208 EFFECTIVE AND SAFE LONG-TERM PREDNISONE THERAPY WITH STARTING DOSES OF 4 MG OR LESS IN 96 OF 102 CONSECUTIVE PATIENTS WITH RHEUMATOID ARTHRITIS

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Background Traditional approaches to corticosteroids in rheumatoid arthritis (RA) have been to avoid and/or discontinue their use if at all possible. However, corticosteroids are associated with improved patient well being, and are recognised to be disease modifying in RA.

Objectives To analyse results in use of long-term low-dose prednisone in 102 consecutive patients with RA seen in a weekly academic rheumatology clinic from 1982 to 1999, with a mean starting dose of 4.3 mg/day, according to scores for functional capacity and pain on a multidimensional health assessment questionnaire (MDHAQ), and possible toxicities of corticosteroids.

Methods Each patient completed a multidimensional health assessment questionnaire (MDHAQ) at each visit to assess functional disability, pain and drugs taken. Drugs taken, changes in scores for functional disability pain, and possible corticosteroid toxicities were analysed using descriptive statistics.

Results Among the 102 consecutive patients, 96 (94%) were taking low dose prednisone over a median of 6.1 consecutive years. All but 6 patients were also taking disease-modifying antirheumatic drugs, including 86% taking methotrexate. The mean starting dose of prednisone in 74 patients whose prednisone was begun at this rheumatology clinic was 4.3 mg (median dose 5 mg/day), compared to 13.1 mg/day (median dose 10 mg/day) in 22 patients whose prednisone was begun at other clinical sites. At the most recent visit, 53 patients (52% of all patients and 55% of corticosteroid users) were taking < 5 mg/day; 48 of these patients had their prednisone begun at this clinic. By contrast, 4 patients were taking >10 mg/day, all of whom had prednisone begun at another site. Median functional disability scores were 0.5 (range 0–3), and 3.4 for pain (range 0–10); scores for functional disability and pain tended to be higher in patients who took higher doses of prednisone, and the highest scores were seen in the 4 patients who took >10 mg/day. Compared to baseline 0.1–18 years earlier, 40% of patients had MDHAQ functional disability scores indicating improvement by >0.25 units, 39% were unchanged by <0.25 units, and 21% had progression of functional disability by 0.25 units, results considerably different from reports published in the 1980s. In analyses of possible corticosteroid toxicities, 32% of patients had hypertension, 4% had diabetes mellitus, and 20% had cataracts, percentages that are similar to those found in published reports of patients with RA.

Conclusion Long-term low-dose prednisone with a starting and maintenance dose of <5 mg/day appears to be a safe therapy, in contrast to high-dose prednisone, with long-term efficacy and low toxicities. Further studies are needed lead to more accurate characterise of the risks and benefits of long-term low dose corticosteroid therapy in RA.

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THU0209 FOLLOW UP OBSERVATIONS OF THE PATIENTS WITH RHEUMATOID ARTHRITIS (RA) AND REACTIVE AMYLOIDOSIS

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Background Secondary amyloidosis is a serious complication of rheumatoid arthritis and may result in significant morbidity and early death. The knowledge on standard and effective management of patients with secondary amyloidosis is limited.

Objectives The objective of the study is follow up observation of RA patients with established reactive amyloidosis concerning the clinical aspects of the disease, acute phase reactants and the response to cytostatic treatment.

Methods 43 patients with rheumatoid arthritis and histologically confirmed secondary amyloidosis were followed for 3 to 6

(mean 4,6) years. The patients were treated with cyclophosphamide or methotrexate combined with small doses of prednisone. Clinical symptoms, laboratory tests and general outcome were analysed after 3 to 6 years of development of amyloidosis.

Results The time from the diagnosis of RA to the development of amyloidosis was 4 to 16 years, mean 8,7 years. In all patients advanced radiological changes were observed (radiological Steinbrocker stage III or IV).

The most common symptoms of amyloidosis were: proteinuria-27(62,8%), nephrotic syndrom -12(27,9%), diarrhoea-4 (9,3%). In most of the patients the course of RA was very severe since the onset and high activity parameters were observed despite treatment.

Amyloidosis was histologically confirmed by subcutaneous fat tissue biopsy in 38(88,4%) cases. In 8 patients amyloid deposits were found in other organs (kidney, stomach, salivary gland).

After the treatment with cyclophosphamide or methotrexate we observed decrease of some activity parameters (ESR, CRP) and decrease of proteinuria level. The treatment was well tolerated and we didn't observe serious side effects. In the observed group 7(16,3%) patients died after 3 to 6 years of the diagnosis of amyloidosis. The most common cause of death were uremia (4/7) and infections (2/7).

Conclusion Aggressive treatment with cytostatics influences the survival of patients with reactive amyloidosis in RA.

The time of survival in 83,7% of the observed patients was longer than 4,6 years.

The outcome of patients with RA and reactive amyloidosis is better when the diagnosis of amyloidosis is confirmed in the early stage of the disease.

THU0210 CLINICAL LONGTERM UPDATEABLE EVALUATION (CLUE) FORMS FOR CLINICAL FEATURES AND MEDICATIONS USED IN THE MANAGEMENT OF PATIENTS WITH RHEUMATOID ARTHRITIS

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Background Rheumatologists collect similar data in the care of patients with rheumatoid arthritis (RA) concerning clinical features, such as extra-articular disease, comorbidities, and classification criteria, as well as a history of therapies used in patient management. However, these data generally are collected in non-standard formats. Therefore, much clinical data are not easily accessible to the clinician in routine long-term care of individual patients, or to workers in clinical research concerning cohorts of patients at one centre or multiple centres. Advances in laboratory and clinical science are enhanced when data are collected in a standard format.

Objectives To develop two clinical long term updateable evaluation (CLUE) standard forms for use in the management of patients with RA, one concerning clinical features, and the second concerning medication history, which can be maintained indefinitely at the front of the medical record.

Methods Two one page CLUE forms were developed for use in usual clinical care. The RA clinical features CLUE form includes extra-articular disease, comorbidities, classification criteria for RA, possible family history of RA, records of joint surgeries/dates and radiographs. The medication review CLUE form includes all DMARDs and most current NSAIDs. Each form is designed to