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