Week	18.7	1.19	3.81	25.43	0.376	4.95	1.9	27.1
14								
Week	20.7	0.9	6.47	22.9	0.364	4.7	1	27.9
22								
Week	18.5	1.6	1.25	22.67	0.325	5.66	1.83	27.58
30								

Clinical and laboratory data (mean values) after 30 weeks.

Conclusion Our data show that, after 30 weeks of treatment, combination therapy with methotrexate and infliximab is a safe and efficient treatment for patients affected by chronic polyarthritis, not responding to other DMARDs. In most patients a remarkable improvement of clinical activity (VAS for pain, VAS as a global assessment by patient and physician, swollen and painful joint count, HAQ score, morning stiffness) and laboratory tests (ESR, CRP) have been observed. The updated data will be presented.

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FRI0044 EARLY TREATMENT WITH DMARDS IMPROVES RADIOLOGICAL OUTCOME IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background For years, patients with rheumatoid arthritis were treated with DMARDs only if they showed severe disease progression with insufficient relieve with NSAIDs. Anti-malarials were prescribed more often than methotrexate and sulphasalazin. However, since side effects of DMARDs and NSAIDs have been shown to be similar, and because it is apparent that radiological damage occurs early in the course of rheumatoid arthritis, rheumatologists have gradually become more aggressive in the treatment of RA: DMARDs, especially methotrexate and sulphasalazin, are prescribed earlier and in higher dosages, sometimes also in combinations. Do the patients benefit from this change in attitude?

Objectives

Methods Since 1993 patients with recent onset arthritis are seen and followed up in our Early Arthritis Clinic. In a retrospective study of all patients who were diagnosed in 1994 (n = 28) and 1998 (n = 52) with RA and probable RA (1 in 1994, 2 in 1998), we evaluated the erosion progression (Sharp/van der Heijde method) between the time of presentation and 2 years later.

Results in 1994, 28 patients and in 1998, 52 patients were diagnosed with RA or probable RA (n = 1, n = 2, resp.). At presentation, there were no differences in sex distribution, mean age, duration of symptoms, number of inflamed joints, mean ESR, percentage positive for Rheumatoid Factor-IgG, or Sharp/van der Heijde score. Mean duration after presentation before a DMARD was started in 1994 was 7.9 months, in 1998 1,8

months. After 2 years follow-up, 36% of patients included in 1994 were still without DMARD-treatment, and of 36% who started on antimalarials, 60% were still on those drugs. Of the patients included in 1998, 4% had received no DMARDs in the next 2 years, and 63% resp. 13% received sulphasalazin resp. methotrexate as first drug. Of the 20% who started on antimalarials, 60% had discontinued and started another DMARD after on average 6 months. The average progression of the Sharp/van der Heijde score was 36.5 for the patients included in 1994, and 9.5 for those included in 1998.

Conclusion Changes in perception of how to treat RA, inspired by less fear for side effects of DMARDs and awareness of early joint destruction, have resulted in less erosion progression in the patients.

FRI0045 DEVELOPMENT OF AN EVIDENCE-BASED REFERRAL RECOMMENDATION (ERR) FOR THE OPTIMUM DMARD TREATMENT OF PATIENTS WITH EARLY STAGE RHEUMATOID ARTHRITIS (RA)

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Background In patients with active rheumatoid arthritis (RA), early diagnosis and initiation of DMARD therapy can substantially improve the long-term outcome of disease, as well as overall quality of life. However, delay in referral to a rheumatologist for an accurate diagnosis of RA is a major obstacle to early treatment initiation. A clinical guideline that facilitates early referral of the patient with active RA, and thus the early initiation of DMARD therapy, is required so that treatment is initiated at the most appropriate time to positively impact on long-term morbidity and mortality.

Objectives To develop an ERR for early RA that would serve as a clinical guide for primary care physicians to identify patients with suspected RA during the early inflammatory stages of the disease.

Methods A literature search targeting early RA, early RA clinics (EACs), DMARD therapy for early RA, prognostic disease progression, early RA clinical trials and quality of life was performed. Published clinical evidence was reviewed and classified into categories I-IV (I = meta-analysis of/or randomised control trial; IV = expert opinion) and graded (A = category I; D = category IV) according to the methodology defined by Shekelle *et al.* (BMJ 1999;318: 593–6). Key points supported by relevant clinical evidence were developed and critically evaluated. Using an iterative process, participants' views were incorporated into a final draft, resulting in a consensus statement.

Results Clinical evidence (Grade C) derived from EACs, prognostic factors for RA, and the consensus of the authors, resulted in the formation of the ERR, which states that rapid referral to a rheumatologist is necessary in the event of clinical suspicion of RA, which may be supported by the presence of any of the following: more than or equal to 3 swollen joints, metacarpophalangeal/metatarsophalangeal involvement and/or morning stiffness of more than or equal to 30 min. This recommendation is strongly supported by graded clinical evidence that structural damage occurs early in RA (Grade B&C) and that early DMARD therapy improves the long-term outcome of the disease (Grade A).

Conclusion The proposed ERR is a sensitive evidence-based tool that summarises essential diagnostic criteria derived from prospective clinical investigations and should be used to identify patients with early stage, active RA. The use of the EER should result in early referral to a rheumatologist for definitive diagnosis and early DMARD treatment, facilitating an improved long-term outcome in these patients.

FRI0046 SIDE EFFECTS OF METHOTREXATE IN THERAPY FOR RHEUMATOID ARTHRITIS ? FIVE YEARS PROSPECTIVE STUDY

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Background Methotrexate (MTX) has one of the best efficacy/toxicity ratios. Toxic effects, rather than lack of response, were the major reason for discontinuing MTX.

Objectives Our aim was to determine the frequency and spectrum of side effects in patients with rheumatoid arthritis (RA) receiving low doses of MTX and eventually to determine existence of risk factors for appearance of side effects.

Methods During five years period, 70 patients with active RA were enrolled in a prospective study. They all fulfilled ARA criteria. There were 54 women and 16 man, between 27 and 76 years. The mean duration of disease was $9,76 \pm 7,58$ years. They were treated with low doses of MTX ($5 \pm 12,5$ mg once a week; mean dose $7,5$ mg once a week). The mean duration of MTX treatment was $2,82 \pm 2,27$ years. MTX was given to 27 (38,57%) patients without prior treatment with disease modifying antirheumatic drugs. Most of the patients were treated with NSAID and low doses of prednison, according to indications.

Patients with any of the contraindications for MTX (renal, hepatic and pulmonary failure, malignant disease, alcoholism, haematological disorders and uncontrolled diabetes) were excluded from the study. Monitoring of the side effects included radiography of lungs at the beginning of the study and regularly control of complete blood account, urine analyses, liver and renal function.

Results Adverse effects were found in 27 (38,57%) patients, which required withdrawal of the drug only in 7 (10%) patients. Other adverse effects were transitory and enabled continuation of therapy with dose reduction in 10 (14,28%) patients. The most frequent side effects were gastrointestinal intolerance, in 15 (21,43%) patients, required cessation of therapy in one patient. Four patients had elevated liver enzymes in more consecutive analyses, urging stopping in three cases. Haematological disorders were detected in six (8,57%) patients, with trombocytopenia in four and leucopenia and pancytopenia in rest of two patients. Patient with pancytopenia and one with severe trombocytopenia stopped with therapy. Hypersensitive pneumonitis appeared in one patient, after three months of therapy, with complete resolution after cessation of therapy. One patient had mild herpes zoster infection, which required only transitory withdrawal of the drug.

The adverse effects were seen mostly in the first year of the therapy ?

18 (25,71%) cases. Also all withdrawals were done in the first year, with cumulative dose from 30 mg. to 340 mg. (average 204,29 mg.). The greatest number of side effects was a registry among the oldest group of patients (from 60 to 80 age) ? 16

(59,06%) patients. All three patients with control diabetes showed some adverse effects.

Conclusion Low dose of MTX is a relatively safe therapy, especially with careful patient selection. Special attention is required for older patients as for patients with diabetes and other risk factors for MTX toxicity. Regular monitoring for side effects is mandatory during the whole period of therapy.

FRI0047 TREATMENT OF RHEUMATOID VASCULITIS WITH INFILIXIMAB

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Background Rheumatoid vasculitis (RV) is a systemic late stage complication in patients with rheumatoid arthritis (RA). Despite cyclophosphamide (CYC) therapy which is the treatment of choice the prognosis is very poor and most patients die within two years.

From our last ten patients with RV who had to be treated by CYC five patients had to stop therapy because of serious complications like infection or cardiac failure. Three patients refractory to CYC were treated with infliximab. A 48 year old male RA patient developed systemic vasculitis with a pericardial effusion, which did not respond to pulse corticosteroids, CYC or even to plasmapheresis. The only way to manage this life threatening condition was to drain the effusion continuously. Infliximab therapy at 3 mg/kg was initiated. The pericardial effusion as well as all other signs of the systemic vasculitis resolved within two weeks. The second patient, a 62 year old man who underwent abdominal surgery -retrospectively probably because of vasculitis-developed vasculitic skin ulcers on the scrotum, the lower legs and in the abdominal wound. Since CYC and methotrexate only lead to a partial remission, infliximab infusions were given. Again, the vasculitic lesions healed. The last case is a 58 year old woman with a more classic RV characterised by crural ulcers. After getting pancytopenia caused by CYC, infliximab was given and the vasculitic features disappeared. No complications of infliximab therapy occurred although two patients had superinfected skin ulcers.

Our cases show that infliximab is an effective salvage therapy in patients with RV refractory to even CYC. Given the toxicity and complication rate of CYC in this RA patient subset infliximab may well be considered as a first choice alternative to CYC.

Objectives

Methods

Results

Conclusion

FRI0048 SIDE EFFECTS OF METHOTREXATE IN THERAPY FOR RHEUMATOID ARTHRITIS ? FIVE YEARS PROSPECTIVE STUDY

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10.1136/annrheumdis-2001.1177

Background Methotrexate (MTX) has one of the best efficacy/toxicity ratios. Toxic effects, rather than lack of response, were the major reason for discontinuing MTX.