Associates of North Alabama (RANA) is a large, community-based rheumatology practice that treats approximately 6,000 patients with RA.

Objectives To document the experience with commercial infliximab in patients with RA treated in a community rheumatology practice.

Methods In an ongoing chart review of all patients receiving infliximab at RANA, the following information was documented: age, concomitant medication use, tender and swollen joint counts, and adverse side effects.

Results Baseline information was collected for 137 patients with RA. These patients ranged in age from 33 to 84 yrs (mean of 62.7 yrs). Among the 114 patients receiving concomitant methotrexate (MTX), doses ranged from 2.5 to 30 mg/day (mean of 17.2 mg/day). At baseline (prior to the first infliximab dose), the mean dose of prednisone was 6.2 mg/day, and the mean tender and swollen joint counts were 22.4 and 13.7, respectively. Patients were treated with the currently recommended dosing regimen of 3 mg/kg at Weeks 0, 2, and 6 followed by q 8 wk dosing. Forty (29%) patients received concomitant disease-modifying antirheumatic drugs (DMARDs); 15 of these patients received concomitant leflunomide (12 with and 3 without MTX). Nine patients received infliximab without a concomitant DMARD. Data were available for 74 of these patients at Week 14 (fourth infliximab infusion). At this time point, the mean prednisone dose was 5.1 mg/day, and mean tender and swollen joint counts had improved by 65% and 69% (to 7.8 and 4.3), respectively. Improvements in steroid use and tender and swollen joint counts also were observed at Week 30 (n = 42; mean prednisone dose of 2.9 mg/day and tender/swollen joint counts of 4.4/1.7) and Week 54 (n = 14; mean prednisone dose of 2.1 mg/day and tender/swollen joint counts of 1.6/0.8) among the patients who had received treatment this long. Ten patients discontinued the use of infliximab due to lack of response (3 patients), rash (3 patients), cost (2 patients), abdominal pain (1 patient), and an unrelated side effect (neck pain in 1 patient). Five patients experienced infections (shingles, soft tissue abscess, pneumonia, and bronchitis in 2 patients); all patients responded to antibiotic therapy and continued treatment with infliximab.

Conclusion In a community rheumatology practice, infliximab 3 mg/kg, both with and without MTX, produced compelling improvement in the signs and symptoms of RA. Infliximab was safe and well tolerated when administered in the outpatient infusion setting.

FRI0056 TNFALPHA THERAPY INITIATION AUDIT: RATIONING ON AN EQUITABLE BASIS – THE NORFOLK AND NORWICH (N/N) EXPERIENCE

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Background BSR¹ and EULAR² consensus guidelines have been published regarding the evolving use of TNF@ therapy in rheumatoid arthritis (RA). It is anticipated that demand will exceed supply. Norfolk Health Authority has allocated £210,000 (for approximately 30 patients) for initiation of this treatment during 2000–01. An initial review highlighted discrepancies between the DAS28 (ie consensus guidelines), and our individual clinical assessment of patients.

Objectives To evaluate prospectively a cohort of consecutive eligible patients, prioritise them according to a weighted scoring system, which we developed and observe changes in the profile of those fulfilling these revised criteria for treatment.

Methods In a 3 month period, potential patients were recruited to an assessment clinic. Those fulfilling the criteria were further stratified using a 5- point cumulative scoring system based on 4 variables: 1) DAS28, 2) Age, 3) Disease duration and 4) Steroid dose. This weighted towards younger patients with shorter disease duration, requiring steroids and having a high DAS28, on the assumption that treating such patients would be more cost-effective. This resulted on a final list of 30 patients selected for treatment (N/N Priority).

Results 135 out of 139 patients assessed, fulfilled the BSR eligibility criteria. Nearly two thirds of the 30 patients with the highest DAS28 (BSR priority) were subsequently replaced on our stratified list (N/N Priority). However, funding is still not available for 78% of our patients, who are otherwise eligible for treatment.

Abstract FRI0056 Table 1

Variables	N	DAS28 (Range)	Age (Years)	Duration
TOTAL	135	7.06 (5.1–8.9)	57 (17–82)	14 (0.6–55)
BSR PRIORITY	30	8.16 (7.69–8.9)	59 (30–82)	14 (1–35)
N/N PRIORITY	30	7.57 (5.1–8.9)	46 (17–78)	8.1 (0.6–20)

Conclusion Rationing creates difficult choices. We have attempted to select patients according to need and cost effectiveness. These decisions should be debated openly as they have important implications for health policy and clinical management.

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- 1 British Society for Rheumatology – Report of a Working Party, April 2000
- 2 Updated consensus statement on TNF blocking drugs for the treatment of RA. *Ann Rheum Dis.* 2000;**59**(Suppl 1):i1–i2

FRI0057 EFFECTS OF CYCLOSPORINE/METHOTREXATE COMBINATION THERAPY FOLLOWED BY SINGLE AGENT TREATMENT ON RADIOGRAPHIC PROGRESSION IN EARLY RHEUMATOID ARTHRITIS

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Background Early treatment of severe rheumatoid arthritis (RA) with cyclosporine (CsA) and methotrexate (MTX) in combination is now considered one of the best strategies to control the arthritic symptoms and prevent structural joint deterioration.

Objectives This trial was aimed at evaluating the clinical and radiographic outcome of a cohort of patients with early rheumatoid arthritis (RA) first treated with an association of CsA and MTX, and then randomly stepped down to one of two agents.

Methods Fifty-seven patients (54 F and 3 M) (mean age 49.5 yr., range 20–64) with early, active RA (mean disease duration 0.8 yr., range 0.5–2), were treated with CsA (3 mg/kg/day) and MTX (10–15 mg/week) in combination for 6 months and then 49 of them were randomised to receive single therapy with either CsA (22 patients) or MTX (27 patients) for another 18

months. The radiographic evaluation was carried out on an intention-to-treat basis on all of the patients who completed the combination period using hand and foot radiographs taken at baseline, and after 12 and 24 months. The reading was blindly performed by two radiologists using the 32-joint damage score (DS) of the Larsen-Dale method and the count of the eroded joints (EJC).

Results Seven patients discontinued the study therapy because of adverse events during the first period of the trial, and 18 patients prematurely withdrew, mainly because of lack of efficacy, during the second study phase. Using the last-observation-carried-forward method, the good or moderate responders according the EULAR criteria were 42 (73.7%) at the end of the 6-month combination period, and 36 (73.5%) at the end of the single agent phase. Overall, safety and tolerability was good. At baseline, the mean DS ($\pm$ SEM) in the CsA and MTX groups was respectively 5.1 ± 1.5 and 5.0 ± 1.7 , and the mean EJC ($\pm$ SEM) was 1.1 ± 0.3 and 0.7 ± 0.3 . The differences in the radiographic scores after 12 and 24 months were as follows. In the CsA group: DS12 month-0 = $+7.3 \pm 3.2$, EJC12 month-0 = $+2.1 \pm 1.1$, DS24 month-0 = $+10.5 \pm 2.6$ ($p < 0.01$), EJC24 month-0 = $+3.2 \pm 0.8$ ($p < 0.01$). In the MTX group: DS12 month-0 = $+5.2 \pm 2.0$, EJC12 month-0 = $+1.5 \pm 0.7$ ($p = 0.01$), DS24 month-0 = $+10.4 \pm 1.7$ ($p < 0.01$), EJC24 month-0 = $+2.3 \pm 0.5$ ($p < 0.01$). The comparison between the two therapy groups did not show any significant difference.

Conclusion Radiographic deterioration occurred in both treatment groups but was mild and slow. Combination therapy with CsA and MTX followed by single agent maintenance treatment seems to induce a persistent retardation of radiographic damage. Longer period of combination therapy could yield better control of the joint structural damage.

FRI0058 PRESCRIPTION OF FOLIC ACID WITH METHOTREXATE IN RHEUMATOID PATIENTS: VARIATION AMONGST RHEUMATOLOGISTS IN WALES

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Background Many rheumatologists would now consider methotrexate (MTX) as the disease modifying anti-rheumatic drug (DMARD) of choice in the treatment of rheumatoid arthritis (RA). Despite having the best efficacy-toxicity profile of the DMARDs, up to 30% of patients will discontinue treatment within the first year because of adverse effects.

The mechanism of toxicity remains unclear but folate metabolism is thought to play a part. Studies have shown that folic acid (FA) is superior to folinic acid in that high (>10 mg/wk) or low dose FA reduces gastroenterological toxicity by 80%¹ without loss of efficacy, and is cheaper than folinic acid. Haematological toxicity is also more common in patients who have not received any folate supplementation.

Various authors have suggested different FA regimes^{2,3} but there remains a lack of consensus on whether FA should be prescribed universally to patients taking methotrexate, whether it should be initiated only if side effects occur and what is the most effective regime?

Objectives To observe the variation in FA prescription amongst rheumatologists in Wales.

Methods A survey was conducted amongst all rheumatologists in Wales at consultant, specialist registrar, staff grade and clinical

assistant levels, based at 11 district general hospitals and 1 University hospital. We asked if FA was prescribed routinely in all patients starting MTX; if so, what was the dose and frequency? If FA was prescribed daily, did it include the day of MTX administration?

Results Of the 35 rheumatologists contacted, there were 25 responses. 19 out of 25 prescribed FA routinely (76%) when initiating MTX. 3 (12%) did not prescribe FA routinely and 3 (12%) sometimes prescribed FA.

14 out of 19 (74%) who prescribed FA routinely used a dose of 5 mg/wk given 2–3 days after MTX. 2 (11%) prescribed 5 mg/day, excluding the day of MTX; 1 (5%) prescribed 10 mg/wk; 1 (5%) prescribed 5 mg twice/wk; 1 (5%) did not specify a dose. Of the 3 rheumatologists who sometimes prescribed FA, 1 used a dose of 5 mg/wk; 1 prescribed 5 mg/day, excluding day of and day after MTX; 1 prescribed 1 mg/day, excluding day of MTX.

Conclusion Amongst 25 rheumatologists in Wales there are at least 6 variations in FA prescribing patterns, the most common regime being 5 mg/wk given 2–3 days after MTX. As there are no published guidelines, it would be reasonable to assume that the variation reflects the individual's personal preference and also reflects the lack of consensus.

We are now completing a further study comparing which of these regimes appears to be most effective in reducing adverse effects of MTX amongst RA patients newly started on therapy. The results of this study are expected in July 2001.

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FRI0059 THE EFFICACY AND SAFETY OF PEGYLATED RECOMBINANT METHIONYL HUMAN SOLUBLE TUMOUR NECROSIS FACTOR RECEPTOR TYPE I (PEG STNF-RI; P55) IN A RANDOMISED, PLACEBO-CONTROLLED, CLINICAL STUDY OF PATIENTS WITH RHEUMATOID ARTHRITIS (RA)

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Background

Objectives PEG sTNF-RI was administered weekly for 12 weeks at 400 or 800 μ g/kg vs placebo to assess efficacy and safety for the treatment of patients with RA.

Methods Subjects were randomised at 15 U. S. centres to receive PEG sTNF-RI or placebo (1:1:1). Subjects with disease duration of at least 6 months with ≥ 10 swollen joints and ≥ 12 tender/painful joints, and morning stiffness ≥ 45 min, C-reactive protein (CRP) ≥ 1.5 mg/dL, or erythrocyte sedimentation rate (ESR) ≥ 28 mm/hr were eligible for study. Subjects were allowed to continue most single or combination background DMARD therapies. If taking DMARDs, the doses must have been stable for 8 weeks before entry; only combination therapy