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

R Prasad, M De Silva. *Rheumatology, Prince Charles Hospital, South Wales, UK*

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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)

¹M Schiff, ²D Furst, ³R Fleischmann, ⁴M Macri, ⁵T Joh, ⁶CK Edwards, ⁷MW Davis. ¹Rheumatology, Denver Arthritis Clinic, Denver; ²Rheumatology, Virginia Mason Research Center, Seattle; ³Rheumatology, Metroplex Clinical Research Center, Dallas, USA; ⁴Clinical Affairs; ⁵Biostatistics; ⁶Inflammation, Amgen, Thousand Oaks; ⁷Clinical Research

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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