therapy except in the RA scenario with severe disease activity/severity. For mild disease activity/severity: 1) a surprisingly high percent employed NSAID and/or CS alone; 2) half of the rheumatologists did not prefer MTX, gold, azathioprine, cyclosporine or any of the newer DMARDs (leflunomide, etanercept, infliximab) in this broad RA patient population. For the first-line treatment of early RA, aggressive DMARD therapy is not universally employed by all rheumatologists in the regions studied.

OP0119 RADIOLOGICAL PROGRESSION IN PATIENTS WITH EARLY RHEUMATOID ARTHRITIS IS SIGNIFICANTLY RETARDED BY COMBINATION THERAPY WITH METHOTREXATE AND CYCLOSPORIN-A COMPARED TO CYCLOSPRIN-A ALONE

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Background Cyclosporin-A (CsA) added to low dose methotrexate (MTX) in patients with advanced rheumatoid arthritis (RA) is clinically superior to MTX alone.¹ The potential of CsA and MTX to inhibit radiological progression has not been established yet.

Objectives To assess in patients with early, active and potentially aggressive RA whether the combination of CsA and MTX results in less radiological progression as compared to CsA alone.

Design A randomised double blind placebo controlled trial of 48 weeks duration.

Methods 120 patients with active RA: mean age 52 yrs, mean disease duration 3 months, 95% rheumatoid factor positive, 49% erosions and/or joint space narrowing. Patients received CsA and MTX or CsA and placebo. MTX was started at 7.5 mg/week, and was increased to 15 mg/week after 16 weeks. CsA was started at 2.5 mg/kg/day, and was increased to a maximum of 5 mg/kg/day. Plain X-rays of hands and feet were obtained at week 0 and week 48 and were read in chronological order by two independent observers, blind for the study medication, using the Larsen-modified Larsen score.²

Results The Table 1 summarises the Larsen Score of patients in which 2 sets of films were available.

Abstract OP0119 Table 1

	Baseline	Change from baseline
CsA and MTX (n = 58)	2.0 (0.0–5.5)*	4.0 (1.0–10.5)
CsA and placebo (n = 57)	2.5 (0.5–5.5)	10.0 (3.5–13.3)
p-value for the difference**		0.004

*Median (interquartile range).

**Mann-Whitney two-sample test.

Conclusion CsA and MTX significantly retards radiological progression in comparison with CsA alone in patients with early, active and potentially aggressive RA.

REFERENCES

- 1 Tugwell. *NEJM* 1995;**333**:137–41
- 2 Larsen. *J Rheum.* 1995;**22**(10):1974–5

OP0120 CAUSE OF DEATH IN A PROSPECTIVE STUDY OF RA PATIENTS: DO RHEUMATOLOGY DRUGS PLAY A PART?

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Background Few prospective studies in RA have reported on the occurrence of comorbid conditions and mortality, and what proportion could be either disease or treatment related. The Early Rheumatoid Arthritis Study (ERAS) has prospective outcome data on patients followed for as long as 13 years.

Objectives To classify the cause of death and investigate any possible relationship with second line (disease modifying), steroidal or non steroidal anti-inflammatory drugs (NSAIDs).

Methods Consecutive patients with RA of less than two years duration have been recruited into an inception cohort from 9 rheumatology units. 1500 patients have been recruited into the study, prior to the use of second line drugs within 2 years of onset of symptoms of RA. Standard clinical and laboratory data were recorded yearly. Details of medication have been collected prospectively. Nearly all patients received non steroidal anti-inflammatory drugs (NSAIDs) at some stage, 84% received second line (disease modifying) drugs and 4% steroids alone. 166 deaths have been recorded from clinical notes, death certificates and the NHS Central Register (NHSCR). Cause of death has been categorised according to both aetiology and main organ involvement.

Results Major causes of death in 166 patients (males n = 71 and females n = 95) were as follows: cardiovascular disease (n = 56,33.7%), cerebrovascular (n = 14,8.4%), malignancy (n = 45,27.1%) and respiratory (n = 32,19.3%). Pulmonary infections were recorded in 22 of the latter, Pulmonary Fibrosis in 6 (2 on methotrexate, but present prior to start of therapy), and others (n = 4). 19 miscellaneous conditions included gastrointestinal haemorrhage (n = 4, NSAID related in 3) and septicaemia (n = 5, 2 on steroids and 1 with neutropenia probably methotrexate induced).

Conclusion No direct link could be established between cause of death and rheumatoid disease or drug therapy in most patients, except those with Pulmonary Fibrosis (4%), and in 6 patients where drug therapy could have been a contributory factor to cause of death.

OP0121 ENBREL® (ETANERCEPT) VS. METHOTREXATE (MTX) IN EARLY RHEUMATOID ARTHRITIS (ERA TRIAL): TWO-YEAR FOLLOW-UP

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Background The first year of this 2-year study of patients with early erosive RA (mean disease duration 1 year) demonstrated that ENBREL 25 mg twice weekly gave a more rapid clinical response and was more effective in preventing erosions than high dose (median 20 mg/wk) oral MTX.¹