Boletín del
Colegio Mexicano de Reumatología

Órgano Informativo y de Vinculación del Colegio Mexicano de Reumatología

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DIRECTORIO

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Boletín Mexicano de Reumatología

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Mensaje del Presidente
El reto para mejorar la atención integral del paciente con Artritis Reumatoide

Durante esta administración, el Comité Ejecutivo del Colegio Mexicano de Reumatología se ha preocupado por mantener informada a la sociedad médica sobre los avances obtenidos para lograr un adecuado diagnóstico y tratamiento de la Artritis Reumatoide y otras enfermedades músculo-esqueléticas que impactan negativamente en quienes la padecen. Asimismo, se han canalizado múltiples esfuerzos para lograr una relación directa con la Secretaría de Salud, con el fin de que dicha institución esté al tanto de la situación epidemiológica de esta devastadora enfermedad y reconozca su repercusión, dado su carácter incapacitante e incluso invalidante que condiciona, además de los estragos implícitos en el ámbito familiar, laboral y económico de estos enfermos.

Por tal motivo, proponemos que se implementen los mecanismos adecuados para brindar el apoyo necesario, con el firme propósito de mejorar la calidad de vida de este grupo de pacientes.

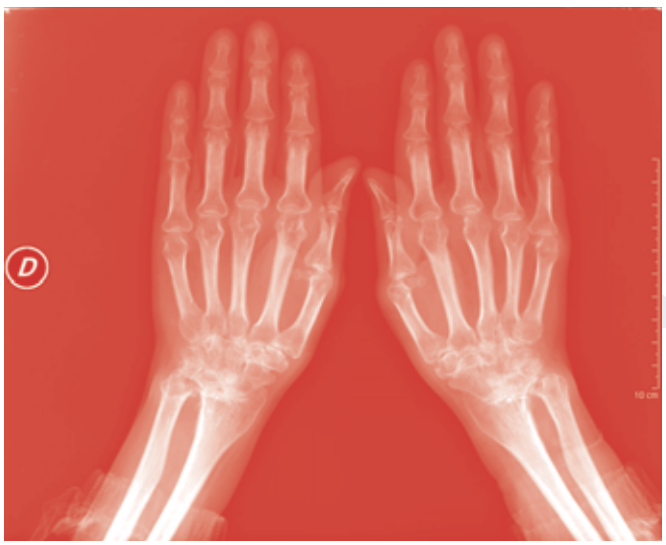
Se presenta este manifiesto, ante las instancias correspondientes, como el inicio de un proyecto en común entre la Secretaría de Salud y el Colegio Mexicano de Reumatología.

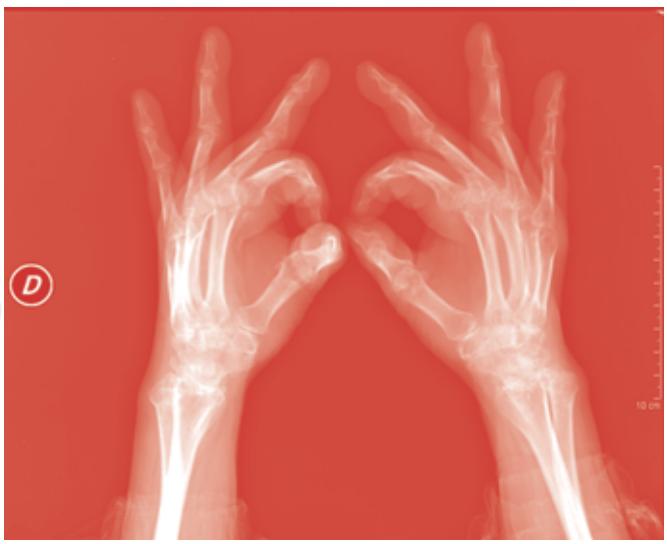
La Artritis Reumatoide (AR) es un padecimiento articular inflamatorio, autoinmune, es decir, una enfermedad en la que las defensas del organismo atacan a los tejidos propios sanos, lastimándolos progresivamente. Si la AR no es diagnosticada y tratada oportunamente, causa daño irreversible en las articulaciones, lo que a mediano y largo plazo resulta en la limitación de la movilidad, invalidez y mucho dolor. Al provocar discapacidad, repercute en el ámbito laboral, familiar, social y económico del paciente. Adicionalmente, esta enfermedad reumática crónica se acompaña de un incremento en el riesgo de muerte prematura debida a procesos infecciosos, cardiovasculares, etc., con una disminución en la esperanza de vida que va de 3 a 18 años.

En México no existe un estudio epidemiológico sobre este padecimiento y no se puede establecer de manera fidedigna cuántos enfermos de Artritis Reumatoide existen. Las estimaciones planteadas en este documento se derivan de la aplicación de un algoritmo elaborado por el American College of Rheumatology (ACR), el cual ha inferido para analizar el relevo de medicamentos sintomáticos y sugerir el uso de fármacos de segunda línea y otros complementarios, en determinada proporción de pacientes con AR. Lo anterior implica que los datos generados sean interpretados con cautela.

Si tomamos en cuenta la prevalencia observada en otros países, se puede estimar la existencia de cerca de 700 mil enfermos con Artritis Reumatoide, la mayoría de los cuales no se está tratando adecuadamente y, en el peor de los casos, los pacientes ni siquiera han sido diagnosticados.

Hasta hoy no se ha encontrado cura para este mal. Sin embargo, las investigaciones realizadas han conseguido desarrollar, mediante biotecnología, tratamientos seguros y efecti-



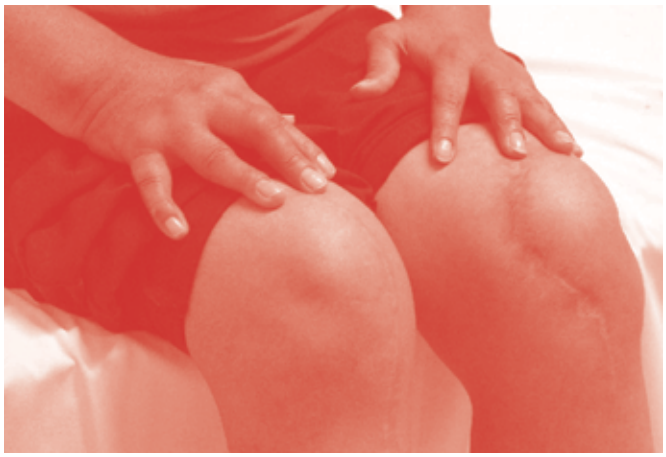


vos. Además de un tratamiento adecuado, la detección temprana es fundamental. Si la AR no se detecta ni se trata durante los dos primeros años, los pacientes se verán envueltos en un proceso de deterioro progresivo que, en la mayoría de los casos, es altamente incapacitante e irreversible.

La severidad y la evolución de esta enfermedad varían de persona a persona, por lo que los tratamientos deben ser ajustados de acuerdo con el juicio clínico del médico tratante, haciéndose indispensable consultar al especialista.

Los objetivos del tratamiento en la AR son aliviar el dolor, controlar la progresión del daño articular, mejorar la capacidad funcional y la calidad de la vida de quienes la padecen. Existen diferentes tipos de medicamentos para tratar esta enfermedad y podemos clasificarlos, según la clase terapéutica a la que pertenecen, en los siguientes grupos:

1. Antiinflamatorios no esteroideos (AINEs). Alivian el dolor y pueden reducir la inflamación cuando se usan durante cierto periodo de tiempo, pero no tienen la capacidad de modificar o mejorar el curso de la enfermedad ni tampoco previenen el daño articular. Suelen ser económicamente accesibles para el paciente. Y casi todos los pacientes los utilizan.
2. Glucocorticoides. En las fases iniciales de la AR los glucocorticoides alivian el dolor y la inflamación mientras los FARMEs inician su acción. Estos medicamentos no detienen la progresión de la enfermedad y si no son manejados adecuadamente pueden ocasionar efectos secundarios severos.
3. Fármacos antirreumáticos modificadores de la enfermedad (FARMEs). No sólo mejoran los síntomas del paciente, sino que modifican o retrasan la progresión del daño de las articulaciones. Sin embargo, los pacientes a menudo pueden presentar reacciones secundarias o no tener una respuesta adecuada a éstos.
4. Terapia biológica. Han revolucionado el tratamiento de la AR. Una de sus principales ventajas es que detienen la progresión del daño articular; además han demostrado ser significativamente más eficaces que el resto de los tratamientos convencionales, siendo además seguras y tolerables, lo que aumenta la adherencia del paciente al tratamiento, mejorando su pronóstico.



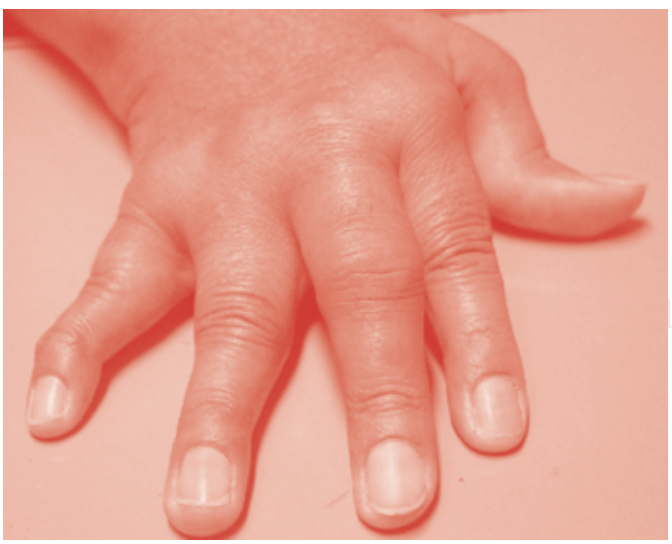
Fotografías clínicas: proporcionadas por el Dr. Juan Elmer Olguín Redes.

Actualmente, en México enfrentamos grandes retos para el diagnóstico oportuno y el tratamiento adecuado de la Artritis Reumatoide, ya que no se cuenta con el personal de salud suficiente y los instrumentos adecuados para ello.

De los cerca de 700 mil habitantes probablemente afectados con AR, se estima que el 40% de ellos cuenta con un diagnóstico clínico, cifra que corresponde a 280,000 enfermos. Bajo esta premisa, las primeras necesidades que se presentan son incrementar el diagnóstico oportuno de las enfermedades reumáticas, contar con datos epidemiológicos certeros y disminuir sustancialmente el rezago de los más de 400,000 afectados sin diagnóstico o atención alguna.

Si aplicamos las guías internacionales de tratamiento y consideramos los datos reportados en la literatura mundial, así como el manejo y la evolución de la enfermedad locales, encontraremos que de estos 280 mil pacientes, un 5% (14,000 pacientes) tienen una remisión espontánea, es decir, la enfermedad se resuelve sin haber utilizado fármacos. Alrededor del 20% de los enfermos con diagnóstico (56 mil pacientes), recurren a las llamadas «terapias alternativas» como acupuntura, herbolaria, homeopatía, masajes, entre las principales. Lo anterior debido a significativas limitantes en el acceso y cobertura de servicios de salud, capacidad económica para sufragar los gastos de un tratamiento formal, además de otros factores como falta de conocimiento de la enfermedad y usos y costumbres de la población. En tanto que el restante 75% (210 mil enfermos) son atendidos con respuestas estructuradas, con tratamiento formal, teóricamente acorde a las guías establecidas (AINEs, glucocorticoides y FARMEs).

De los enfermos que reciben tratamiento con un FARME, solamente el 40% (84 mil pacientes) presentan una respuesta adecuada, mientras que el 60% restante (126 mil enfermos) requiere un cambio o adición de otro FARME. De los pacientes que prueban con una combinación o un segundo FARME, únicamente el 50% (cerca de 63 mil enfermos) reaccionan favorablemente. Ello significaría que de acuerdo con la hipótesis de la aplicación de este modelo internacionalmente probado, y utilizando las guías y recomendaciones para el uso de agentes biológicos establecidas por el Colegio Mexicano de Reumatología, cerca de 25 mil pacientes serían candidatos a una terapia biológica. De acuerdo a las estimaciones del Colegio Mexicano de Reumatología, en México únicamente 4 mil pacientes enfermos con AR son tratados con alguna terapia biológica. Esto significa que apenas el 1.5% del total de pacientes diagnosticados recibe estos medicamentos innovadores. A manera de ejemplo, en otros lugares del mundo como Estados Unidos y la Unión Europea, del total de pacientes diagnosticados, el 20% recibe alguna de las terapias biológicas disponibles, cifra que cubre prácticamente a la totalidad de pacientes que deben recibir este tipo de tratamiento por no tener una respuesta adecuada o ser intolerantes a dos FARMEs.



Conscientes de la problemática que enfrenta nuestro sistema de salud, falta de cobertura, retraso en el diagnóstico, falta de insumos para tratamiento, aunados a una escasa e inadecuada referencia de pacientes, los médicos especialistas en reumatología debemos plantearnos metas a futuro para ir avanzando gradualmente a una atención integral. Con ello, una meta asequible a mediano plazo es el atender a esos 25 mil pacientes con terapias biológicas, puesto que, o no han mostrado o no alcanzarán una respuesta favorable a los tratamientos convencionales.

Por ello, el Colegio Mexicano de Reumatología se encuentra trabajando en conjunto con la Secretaría de Salud para mejorar la cobertura y la calidad de la atención de la Artritis Reumatoide. Mediante este esfuerzo conjunto, se pretende alcanzar las metas siguientes:

1. Fortalecer la capacidad para realizar un diagnóstico oportuno y certero a través de mecanismos relacionados con la formación y capacitación de recursos humanos.
2. Paralelamente, implementar acciones que ayuden a obtener datos epidemiológicos reales en México.
3. Garantizar al paciente el acceso a medicamentos efectivos, con la prescripción de la terapia más adecuada, de acuerdo a las guías y recomendaciones establecidas y a las necesidades del paciente.
4. Dar a conocer a los pacientes las ventajas de la adopción de las terapias biológicas, las cuales son seguras y efectivas, detienen la progresión de la enfermedad y la discapacidad a largo plazo, conservando su productividad laboral y mejorando su calidad de vida. Asimismo, impulsar la adecuada aplicación de los recursos económicos de las instituciones de salud.

El Colegio Mexicano de Reumatología está comprometido con el apoyo al sistema de salud de nuestro país para que, siguiendo criterios de equidad, se pueda priorizar el acceso a los medicamentos innovadores para quien más los necesita, atendiendo a principios éticos y de farmacoeconomía.

Dr. Manuel Robles San Román.

Mensaje editorial

Después de un cordial saludo, me dirijo a ustedes para comentar algunos de los cambios generados en el Boletín Mexicano de Reumatología, el cual, habrán notado, cuenta con nuevo formato, diseñado por la casa editorial que se ha contratado ex profeso para su elaboración e impresión. Se le ha añadido una sección de temas de análisis y reflexión de la autoría del Dr. Arnoldo Krauss, tópicos actuales de gran trascendencia y enorme contenido.

Han sido muy interesantes las cartas al editor, donde se menciona frecuentemente la omisión al reconocimiento a los trabajos presentados por alguno de nuestros colegas reumatólogos; sin embargo, ha sido difícil la *labor reporteril* en este sentido, apegándonos exclusivamente a la publicación de la información recibida por quienes nos favorecen con sus colaboraciones, las cuales, cabe mencionar, han disminuido cada vez más, lo cual también ha sucedido con la Revista Reumatología Clínica, pese a que manejan diferentes tópicos.

Por dicha razón, hago hincapié a los Drs. Luis Javier Jara, Francisco Ramos Niembro y Ulises Mercado, que esta omisión no ha sido intencional y que es importante nos hagan llegar las referencias de los trabajos de investigación, publicaciones, reconocimientos importantes, etc. para poderlos difundir oportunamente.

A manera de sugerencia, sería interesante que cada una de las actividades académicas mencionadas fueran reportadas al Colegio Mexicano de Reumatología para su registro y de esa manera llevar un control sobre la productividad de cada uno de los colegiados, además de contar con un precedente oficial de lo que será difundido en nuestro boletín. Sólo de esta manera podremos hacer del conocimiento de todos ustedes de las personas que tienen el mérito de publicar, enseñar, editar, o que han sido distinguidas con alguna presea o distinción. Lo anterior se hace extensivo para las actividades de las correspondencias, ya que durante los Talleres de Planeación y Estrategia, el reclamo de sus representantes ha sido la falta de difusión de sus actividades académicas, educativas, altruistas o deportivas. Esta es una oportunidad de compartir con todos nosotros su trascendente quehacer cotidiano.

Pienso que de esta forma terminaremos con las omisiones, reclamos, resentimientos, y tendremos la oportunidad de reconocer públicamente a quien honor merece.

Les invito reiteradamente a que participen activamente con la elaboración de nuestro órgano de difusión, y no sólo se incluyan las actividades del Comité Ejecutivo, sino por lo contrario, represente el foro de comunicación de todos los integrantes del Colegio Mexicano de Reumatología, nutrido además de diversos temas de interés colectivo, seleccionados por ustedes mismos.

En este número incluimos una reseña de las novedades surgidas en el Congreso Europeo Contra el Reumatismo (EULAR), lo cual enriquecerá de información científica y mantendrá vigentes a quienes no han tenido la oportunidad de asistir.

Cualquier información será bienvenida a la dirección postal y/o electrónica mencionada o dirigida al secretario actual del CMR, Dr. Lucio Ventura, a la siguiente dirección: lucioventura @hotmail.com.

Atentamente
Juan Elmer Olguín Redes
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Convocatoria para publicar trabajos en el Boletín Suplementario para Pacientes versión 2007

A todos los médicos reumatólogos, especialmente a quienes tienen la responsabilidad de Grupos de Apoyo para pacientes reumáticos, se les informa lo siguiente:

a) Se tiene proyectado un *Boletín Suplementario para Pacientes*, en vista de lo exitoso que resultó el anterior durante la celebración del próximo *Día Nacional del Paciente Reumático*.

b) Podrán colaborar con trabajos que informen a pacientes y a sus familiares que padezcan de enfermedades reumáticas.

c) La información señalada deberá de ser accesible para todo público, fácilmente entendible, concisa y precisa sobre aspectos interesantes de alguna enfermedad reumatológica específica, consejos de utilidad o alguna información que incremente la calidad de vida de los pacientes e incremente su productividad y/o creatividad.

d) La información deberá ser dirigida a la siguiente dirección postal o electrónica:

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Consultorio 312 B. Tercer piso.
Proyecto Río Sonora. Hermosillo, Sonora, México.

o a la siguiente dirección electrónica: *jeolguinr@gmail.com*

Es conveniente se envíen las publicaciones antes del 30 de agosto de 2007, para su inclusión.
Son bienvenidas sugerencias y aportaciones para incrementar la calidad del Boletín.

Convocatoria para ocupar los cargos de Vicepresidente y Tesorero suplente

México, D.F., 13 de julio 2007

A todos los miembros del Colegio Mexicano de Reumatología, A.C.

De mi mayor consideración

Por medio de la presente me permito dirigirme a ustedes para mencionarles que a partir de esta fecha y hasta el 15 de septiembre del presente año, queda abierto el periodo para proponer candidatos a ocupar los cargos de **Vicepresidente** (2008-2009) y **Tesorero Suplente** (2008-2009) de nuestro Colegio.

Para efectos de lo anterior, les solicito sean tan amables de enviar sus propuestas a nuestra sede, antes de la fecha indicada, por correo postal a la calle de Atenor Sala 81, Col. Narvarte, Del. Benito Juárez 03020 México, D.F., o por correo electrónico *colegio@colmexreuma.org.mx* o al fax 55 19 94 89.

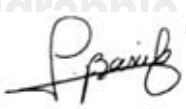
Por su parte, a los miembros del Colegio que sean propuestos para ocupar dichos cargos, les solicito entregar **completa** y **oportunamente** la documentación que se menciona a continuación, con el fin de que todos los miembros del Comité de Proposiciones Nominales puedan analizar detenidamente las propuestas de los candidatos en cuestión y en igualdad de condiciones poder tomar una decisión en caso de que haya más de un candidato:

1) Manifestar por escrito su interés para ocupar el cargo de Vicepresidente y Tesorero Suplente del Colegio Mexicano de Reumatología, A.C. para el periodo 2008-2009.
2) Plan de trabajo (no mayor de dos cuartillas, original y nueve copias)
3) *Curriculum vitae* nominal (original y nueve copias)
4) Copia de la cédula de Especialista en Reumatología

Les recordamos que uno de los requisitos para poder participar como candidato es estar al corriente con sus cuotas ordinarias.

Aquellos candidatos que no cumplan con los requisitos antes mencionados, no serán considerados como tales.

Les presento la seguridad de mi más alta estima



Dra. Leonor A. Barile Fabris
Coordinadora
Comité de Proposiciones Nominales del Colegio Mexicano de Reumatología, A.C.

Convocatoria para proponer candidatos al premio «Maestro de la Reumatología»

El Colegio de Reumatología, A.C. convoca a todos sus agremiados para proponer candidatos al premio «Maestro de la Reumatología»

Antecedentes

El Premio «Maestro de la Reumatología» es la mayor distinción que ofrece nuestro Colegio a los Reumatólogos que se han destacado a lo largo del ejercicio profesional por su trabajo y contribuciones en los campos de la investigación, docencia y asistencia.

Acorde con la naturaleza del premio, será durante el XXXVI Congreso Mexicano de Reumatología en el Puerto de Veracruz, Ver. en el mes de febrero del año 2008, cuando se entregue este galardón a un miembro distinguido de nuestro Colegio.

Bases

El candidato a la distinción de «Maestro de la Reumatología», será elegible si reúne los siguientes requisitos:

Ser Reumatólogo, estar certificado y recertificado por el Consejo Mexicano de Reumatología, pertenecer al Colegio Mexicano de Reumatología, A.C. y estar al corriente de sus cuotas, contar con 25 años de ejercicio profesional o por lo menos 50 años de edad (para el primero de septiembre), que se haya distinguido por contribuir al desarrollo de la Reumatología, con formación académica, docente y de investigación impecables y además de tener un ejercicio profesional honesto, responsable y con una labor ética ejemplar.

Con el objeto de que el Comité de Proposiciones Nominales evalúe las diversas propuestas y seleccione al candidato idóneo para este galardón, les invitamos a proponer candidatos y remitir la documentación abajo señalada a la sede del CMR a más tardar el sábado 15 de septiembre de 2007. El proponente deberá incluir en su carta de propuesta los motivos de la misma y el *curriculum vitae* nominal del Reumatólogo propuesto.

Las propuestas podrán ser enviadas a través del servicio postal o mensajería a la calle de Atenor Sala 81, Col. Narvarte 03020 Benito Juárez, México. D.F., fax 55 19 94 89 o correo electrónico colegio@colmexreuma.org.mx.

En espera de sus propuestas, les presento la seguridad de mi más alta estima.

Dra. Leonor Adriana Barile Fabris
Coordinadora
Comité de Proposiciones Nominales del Colegio Mexicano de Reumatología, A.C.

Esculturas de terracota de Veracruz

Las ofrendas mortuorias de Mixtequilla, Veracruz, una zona que se extiende desde el Puerto de Alvarado, entre los ríos Papaloapan y río Blanco, se han caracterizado por sus extraordinarias figuritas de barro, en las que se distinguen las «caritas sonrientes», así como las representaciones en cerámica de deidades como Huehuetéotl, Mictlantecuhtli, y las cihuateteo, las cuales se pueden apreciar en el Museo de Antropología de Jalapa, Veracruz.

Las esculturas de terracota tienen una gran tradición en el estado jarocho, sobre todo en esta área del Zapotal, donde se han encontrado figuras de tamaño natural, pese a que el barro que se trabajaba era arenoso y de difícil cocción.

Las manos de la cabeza número 7 de San Lorenzo, una parte mutilada del cuerpo, se refieren al sacrificio, ritual típicamente mesoamericano. Los anillos sobre los ojos, de los que parten los dedos, son atributos divinos por excelencia. Probablemente lo que se representa es el retrato de un hombre que así manifiesta su cercanía e identificación con un dios.

Mictlantecuhtli. El Zapotal, Veracruz. Altura: 160 cm.

Llama la atención el vigor y la maestría con la que se representa a las figuras, sobre todo destacando aspectos del cuerpo humano, las cuales están impregnadas de un gran realismo.

En el Zapotal se encontró un adoratorio, en cuyo centro se encontraba Mictlantecuhtli, dios de la muerte, de aproximadamente 1.60 m, modelado en barro sin cocer, recubierto por varias capas de pintura. Es una figura de un varón sentado, con rostro y torso descarnados, apreciándose las prominencias óseas. Las piernas abiertas y los brazos apoyados sugieren dinamismo, como si pretendiera levantarse, dispuesto para alguna acción. Se le encontró rodeado de restos humanos y de ricas ofrendas, figuras antropométricas, braseros, animales, etc.

La cihuateteo es una figura con los ojos cerrados y la boca abierta, con el pecho desnudo, falda y cinturón que terminan con cabezas de serpientes en sus extremos, adornada con joyas en cuello y orejas, y portando un elemento ceremonial en la mano izquierda. Lo interesante de estas obras es que, dadas sus dimensiones, eran hechas de dos o tres piezas embonadas, formando una escultura perfecta.

También se pueden apreciar algunas figuras representando guerreros ataviados con extraños adornos, mascaras, rodilleras, tocados o cargando una gruesa cuerda en el cuello, etc.

En otro osario encontrado, de casi cinco metros de altura, destacan las representaciones de Huehuetéotl con ofrendas muy similares a las encontradas en la misma área.

Este será parte del entorno del XXXVI Congreso Mexicano de Reumatología 2008.

¡Veracruz les espera!

Figurilla sedente. Paso de Ovejas, Veracruz. 21.5 x 44 cm.

La Cihuateteo. El Zapotal, Veracruz.

Jaguar, ofrenda mortuoria. El Zapotal, Veracruz.

Figura masculina con tocado zoomorfo. El Zapotal, Veracruz. 44 x 19 cm.

Congreso EULAR 2007 Barcelona, España, 13-16 junio 2007

EULAR, la Liga Europea Contra el Reumatismo es la organización que representa a pacientes, profesionales de la salud y a las sociedades científicas de reumatología de todos los países asociados a la unión europea. EULAR fue creada para estimular, promover y apoyar estudios de investigación y para la prevención, el tratamiento y la rehabilitación de las enfermedades reumáticas.

EULAR define a la Reumatología como la especialidad que incluye a las enfermedades reumáticas del tejido conectivo, sistema locomotor y musculoesquelético. Su Congreso es un evento de intercambio científico, educativo y social de la más alta calidad.

Durante el Foro Europeo de Discapacidad, el organismo social de EULAR se encargó de colectar más de un millón de firmas de personas, demandando a la Unión Europea el combate hacia la discriminación contra las personas con alguna discapacidad. (PARE Manifiesto).

Congreso EULAR 2007

Número de participantes	12,430
Trabajos recibidos	3,346
Registro por países	
Estado Unidos	982
Inglaterra	978
Francia	974
Alemania	868
España	738
Italia	679
Suiza	587
Grecia	390
Netherlands	350
Turquía	323
México	29

Resúmenes de los trabajos mexicanos presentados en el Congreso EULAR 2007, en Barcelona, España

1. [2007] [SAT0261] SITE-SPECIFIC PREVALENCE OF OSTEOARTHRITIS IN TWO PREHISPANIC POPULATIONS OF MEXICO. A PALEOPATHOLOGIC STUDY

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Objectives: To determine the anatomic distribution and severity of OA in two prehispanic populations with different work-related physical activities: hunter-gatherers (HG) and agriculturalists (AG). **Methods:** A morphoscopic and descriptive analysis of two collections of human skeletal remains preserved at the Direction of Physical Anthropology of the National Museum of Anthropology in Mexico City. The HG skeletal materials were recovered from different sites in south region of Baja California whereas agrarian specimens came from the archeological site of Cuicuilco, Valley of Mexico. Their antiquity ranged from 600-150 BC (AG) and 1320-1420 AC (HG). A visual examination was performed on each skeleton to assess and categorize the occurrence of OA, defined as presence of osteophyte formation on articular surfaces. Age and gender determinations were made by standard anthropological techniques. Skeletons in which the preservation conditions limited its evaluation and those under 20-yr old were excluded. The areas evaluated were: shoulder, elbow, hip, knee, and axial skeleton. Each joint was coded for the presence and severity of OA according to the following key: 0- None: No signs of articular surface porosity (pitting), lipping, or eburnation, and intact articular surface. 1- Minor damage: Less than 1/3 pitting, minimal osteophyte formation, no lipping, and no eburnation. 2- Mild damage: Less than 1/3 articular surface porosity, and lipping of less than 1/3 of the circumference of joint edge. 3- Moderate damage: 1/3 or greater articular surface porosity, and lipping around 1/3 or greater of the joint circumference; no greater than 2/3 of porosity or lipping. 4- Severe damage: 2/3 or greater of articular surface porosity, lipping of 2/3 of the joint circumference, and eburnation present. Joints that scored 0 on the scale were considered normal. Joints with OA were further categorized as: 1 or 2, mild; 3, moderate; and 4, severe OA. **Results:** Both collections comprised a total of 231 skeletons, 130 were excluded; 101 specimens were included, 57 HG and 44 AG; 50% were male, 43% female, and 7% undetermined. The mean age was of 29.9-yr (SD ± 6.8) in HG and of 35.5-yr (SD ± 9.2) in AG ($p = 0.001$). Seventy eight specimens had OA, with a remarkable frequency at early ages in both populations (63.4% < 30 yr-old). The prevalence of OA was greater in AG specimens (93.2 *vs* 64.9% [$p = 0.001$]). The most commonly affected joints were: knees (72.5%), lumbar spine (68.1%), elbows (51.8%) and cervical spine (46%). There was a higher proportion of cervical spine OA in AG population (60.7 *vs* 27.3% [$p < 0.024$]). The male AG showed higher frequency of OA than HG ($p < 0.05$) in shoulders (61.5 *vs* 17.6%), hips (65.3 *vs* 25%) and cervical spine (72.7 *vs* 16.7%). There were no differences in a female sub-analysis. AG population showed greater OA severity. **Conclusion:** 1. We found a high prevalence of OA in prehispanic populations younger than 30 yr-old. 2. The occupational physical activity (biomechanically challenging work) and male gender in the AG population privileged the genesis and a greater severity of OA. 3. A unique site-specific prevalence (elbow and shoulder) distinguish prehispanic OA from contemporaneous OA pattern. **Osteoarthritis clinical aspects and treatment**

Citation: Ann Rheum Dis 2007;66(Suppl II):509

2. [2007] [SAT0422] COMPLEMENTARY AND ALTERNATIVE MEDICINE IN CHILDREN WITH RHEUMATIC DISEASES IN WESTERN MEXICO

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Objectives: To determine the frequency of use and types of complementary and alternative medicine (CAM) used by pediatric patients with lupus and chronic juvenile arthritis attending rheumatology departments in a tertiary care pediatric hospital and a general hospital in Western Mexico. **Methods:** In a cross-sectional survey, we included consecutive patients. The parents were interviewed and completed a questionnaire containing items on demographic data, types of CAM employed, factors related to their use and their perceived effectiveness. **Results:** Eighty five parents of 35 pediatric lupus (41%) and 50 chronic arthritis (59%) patients completed the survey. Sixty three percent were women; the mean age was 11 + 3 years, mean disease duration was 3 + 2 years. Sixty two patients (73%) had received CAM. The most common form in the arthritis group were the topical applications 33 (80%) meanwhile homeopathy predominated in the lupus group twelve patients (63%). The mean number of therapies was 2 + 1.1 (95% CI 1.59-2.12). In the arthritis group 16% discontinue their conventional treatment because of CAM, there were no discontinuations of treatment in lupus patients. Prior CAM use by the family was associated with its use in patients ($p = 0.006$) (OR 4.6, CI 95% 1.7 – 12.9), no significant differences were found with regard to age, sex, or parental educational level between groups. Perceived usefulness was reported in 66% of CAM users. Only 43% of the parents voluntarily communicated CAM use to their rheumatologist. **Conclusion:** CAM use in Mexican children with lupus and arthritis is common, most frequently topical for arthritis and homeopathy for lupus. The majority perceived benefits with its usage, but unfortunately in less than half of the cases the treating physician was informed about this practice. Physicians should systematically ask about CAM use, particularly because of possible complex interactions with conventional therapy. **Paediatric rheumatology**

Citation: Ann Rheum Dis 2007;66(Suppl II):557

3. [2007] [THU0338] CLINIMETRIC EVALUATION OF THE HEALTH ASSESSMENT QUESTIONNAIRE (HAQ) IN PATIENTS WITH GOUT

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Background: Gout is a disease that occurs concomitantly with arthritis, causing disability. However, the HAQ was administered but has not been validated for the group of patients with gout. **Objectives:** To perform a clinimetrical assessment of the HAQ in patients with gout. **Methods:** Patients were recruited from a multicenter cohort study designed to determine the economic impact of rheumatic diseases in Mexico. Only patients with a confirmed diagnosis of gout were included. All patients were examined clinically and completed the Short Form quality of life survey (SF-36) and the Health Assessment Questionnaire (HAQ) measuring functional status. Demographic variables were also recorded. **Results:** Two hundred and six patients were assessed; with 96.6% (199) males and mean age of 56.31 ± 12.35 years. Mean years of education was 10.58 ± 4.3. Mean disease progression was 9.27 ± 8.54 years. Of all subjects, 36.9% had tophi. Mean HAQ was 0.59 ± 0.77 (95% CI, 0.49 to 0.70). The consistency determined by using intraclass correlation coefficient was 0.76. Homogeneity had a Cronbach's alpha of 0.913 (95% CI, 0.881 to 0.920) between 8 categories, with appropriate sensitivity to change. We found a significant correlation of the HAQ score with the number of painful joints, swollen joints, joints with functional limitation, and the presence of tophi, as well as with all components of the SF-36. No correlation was found with age, gender, education level, or disease progression.

Table I. HAQ score with regard to the clinical variables.

Variable	HAQ X(SD) Yes	No	p
Tophi	1.01 (0.89)	0.35 (0.56)	0.000
Swollen joints	1.21 (0.92)	0.41 (0.61)	0.000
Painful joints	0.86 (0.87)	0.30 (0.50)	0.000
Joints with functional limitation	1.04 (0.87)	0.38 (0.61)	0.000
Sex	Male 0.58 (0.77)	Female 0.90 (0.79)	0.263

Conclusion: The HAQ is an appropriate instrument for measuring functional ability in gout patients.

Bone diseases other than osteoporosis, metabolic diseases and crystal diseases

Citation: Ann Rheum Dis 2007;66(Suppl II):230.

4. [2007] [THU0357] PERFORMANCE OF EULAR BASED RECOMMENDATIONS FOR DIAGNOSIS IN GOUT PATIENTS

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Background: Experts committee ESCISIT based in a Delphi consensus approach and evidence based medicine, proposed 10 key recommendations for gout diagnosis. They also reported sensitivity, specificity and LR for them. **Objectives:** To identify the performance of these recommendations in multicentric data base group of gout patients and how these variables perform in typical patients. **Methods:** We analyzed the data of 549 gout patients diagnosed by the clinical judgement of the participant rheumatologists, the data of each component of the Wallace criteria was recorded in the database. With these data we made a study of diagnostic test (pre-test probability, likihood ratio, post-test probability and ROC curves) and colineality tests. **Results:** Ninety six percent were males, mean age (SD) 50 (14.4) years, mean (SD) educational level of 7.5 (4.7) years. Mean (SD) duration of the disease was 12 (9.7) years. Eighty four percent of the patients fulfill the Wallace criteria for the diagnosis, only 15.1% of the patients had demonstration of urate crystals in synovial fluid or tophi, in the rest of the patients the study was not done. Based in ESCISIT recommendations, 73.7% had rapid articular pain and swelling, 47.9% of the patients had erythema plus the previous data, 37.5% when podagra was added, 33.7% plus hyperuricemia, 15.3% plus tophi, 10.9% of the patients had also radiographic changes and only 1.82% had all the previous data plus urate crystals demonstration. When we compared the clinical and laboratory variables among patients with urate crystals VS those in whom this study was not done, there were no significant differences among them. Post-test probability was 0.57 for acute pain and swelling until 4.9 when the 7 clinical and laboratory data were present. The other two variables from the Wallace criteria that demonstrated good pre and pot-test probabilities were tarsitis 1.56 and negative culture 2.62. **Conclusion:** Rheumatologists regularly diagnose gout in patients with some clinical and laboratory data included in the Eular recommendations, but the proposed composite diagnostic ladder has not high LR in the patients included in this study, perhaps the combination of these data in a different way could be more useful. Gout patients should always have urate crystal demonstration.
Bone diseases other than osteoporosis, metabolic diseases and crystal diseases
Citation: Ann Rheum Dis 2007;66(Suppl II):236.

5. [2007] [THU0329] CLINICAL, ENDOSCOPIC AND MANOMETRIC UPPER GASTRO-ESOPHAGEAL MANIFESTATIONS IN PATIENTS WITH SYSTEMIC SCLEROSIS

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Background: In the Systemic Sclerosis (SSc) gastrointestinal manifestations are present up to 90% and the esophagus is the most affected organ. Endoscopy and manometry allow us to evaluate structurally and functionally the esophagic derangements. **Objectives:** To investigate clinical, endoscopic and manometric upper gastro-esophageal manifestations in patients with SSc. **Methods:** From a cohort of 250 patients with SSc according to criteria from the American College of Rheumatology, 60 patients were studied (59 women and 1 man) with mean age of 38 ± 11 years and a mean disease evolution 11 ± 8 yrs. An endoscopy of gastro-esophageal tract and esophageal manometry were performed according to the Los Angeles Classification (LAC). **Results:** The most frequent clinical manifestations were: dysphagia 80%, pirosis and regurgitations 68%. Endoscopic findings were as follows: esophagitis 60% (according LAC: Grade A: 35%, grade B: 15%, grade C: 8% and grade D: 2%); hiatal hernia 65%, loose hiatus 15%; Barrett's esophagus 18%. Manometric findings were: hypotensive lower esophageal sphincter (LES) 95% and normal LES 5%. Motility alterations of esophageal body were found in 98% with aperistalsis in 41%, slight hypomotility in 30%, severe hypomotility 27% and normal motility in 2%. Gastric disturbances were observed in 80%; of these, 40% corresponds to nonerosive gastropathy, 30% to erosive gastropathy and 10% to nodular gastropathy. **Conclusion:** The most frequent endoscopic findings were esophagitis and hiatal hernia, and by manometry were aperistalsis and hypotensive LES. These alterations imply disorders of motility and dysfunction of LES. Barret's esophagus was always associated with hiatal hernia. **References:** 1. Rose S, Young MA, Reynolds JC. Gastrointestinal manifestations of scleroderma. *Gastroenterol Clin North Am* 1998; 27: 563-594. 2. Wipff J, Allanore Y, Soussi F, Terris B, Abitbol V, Raymond J, et al. Prevalence of Barrett's esophagus in systemic sclerosis. *Arthritis Rheum* 2005; 59: 2882-8. 3. Al-Amri SM. The pattern of esophageal manometry in progressive systemic sclerosis. *Saudi Med J* 2003; 24: 68-71. 4. Marie I. Gastrointestinal involvement in systemic sclerosis. *Presse Med* 2006; 35: 1952-65. 5. Ebert EC. Esophageal disease in scleroderma. *J Clin Gastroenterol* 2006; 40: 769-75.
Scleroderma, myositis and related syndromes
Citation: Ann Rheum Dis 2007;66(Suppl II):227

6. [2007] [FRI0350] TAKAYASU'S ARTERITIS IN A COHORT OF MEXICAN PATIENTS: CLINICAL MANIFESTATIONS, LABORATORY DATA AND THE CAUSE OF DEATH

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Background: Takayasu's arteritis (TA) is a chronic inflammatory disease of unknown etiology which involves the aorta and its major branches. **Objectives:** To investigate the clinical manifestations, laboratory data and the cause of death in patients with TA
Methods: 50 patients seen at the Hospital de Especialidades Centro Médico Nacional La Raza were studied in a retrospective way from 1980 to 2006 who presented more than 3 criteria of the ACR classification for TA and the clinical manifestations, angiographic findings and laboratory data were investigated. Antineutrophil cytoplasmic antibodies (ANCA) by ELISA was determined in 30 patients, anticardiolipin antibodies in 20 patients, HLA was performed in 30 patients and antinuclear antibodies (ANA) were measured in all patients, as well as the causes of death. **Results:** There were 48 women and 2 men with an average age at onset of TA of 26 ± 12 yrs. Present age of patients is 38 ± 14 yrs, with an average disease evolution of 16 ± 12. The main clinical manifestations were as follows: cardiovascular characterized by decrease and/or absence of pulses 47 (94%), claudication of extremities 46 (92%), vascular murmurs 40 (89%), arterial hypertension 25 (50%), aortic insufficiency 25 (50%), ischemic cardiopathy 8(16%): 4 patients with angina and 4 with myocardial infarction. Neurological manifestations: headache 40 (80%), dizziness 27(54%), cerebrovascular disease (CVD): 4 (8%), 3 infarctions and one hypertensive hemorrhage; ocular involvement: 15 (30%), blindness 4 (8%), transverse myelitis secondary to involvement of Adamkiewics artery 1 (2%). Skeletal-muscle manifestation: arthralgias 30(60%), myalgias 20 (40%). Cutaneous manifestations: erythema nodosum 3 (6%). The principal general symptoms were: asthenia and adynamia 40%. Laboratory findings: normocityc normocromic anemia 33%, erythrocyte sedimentation rate increased 92%, anticardiolipin antibodies 5 (25%) were positive at low titers, ANCA were negative; antinuclear antibodies were positive (30%) at low titer. The HLA most frequent HLA was B5. The classification by arteriography according to Moriwaki was as follows: Type 1 = 5, 2a = 5, 2b = 10, 3 = 10, 4 = 5 and 5 = 15. All patients were treated with steroids by the oral route; in addition 15 patients received methilprednisolone pulses (an average of 10 monthly pulses) with an adequate response demonstrated by clinical improvement and post treatment artheriography; other 5 patients received cyclophosphamide pulses and 10 patients received methotrexate as a maintenance treatment. We observed 5 deaths (10%): myocardial infarction 2, CVD: 2, postsurgical complications one
Conclusion: In this cohort of patients with TA, the main clinical manifestations and cause of mortality were cardiovascular and neurological. HLA B5 was the most frequent haplotype in mexican population. Methilprednisolone pulses were useful in the treatment of TA. **References:** 1. Johnston SL, Lock RJ, Gompels MM. Takayasu arteritis: a review. *J Clin Pathol* 2002; 55: 481-86. 2. Ringleb PA, Strittmatter EI, Loewer M, Hartmann M, Fiebach JB, Lichy C, et al Cerebrovascular manifestations of Takayasu arteritis in Europe. *Rheumatology* (Oxford). 2005; 44: 1012-5. Epub 2005 Apr 19.
Vasculitis
Citation: Ann Rheum Dis 2007;66(Suppl II):385

7. [2007] [SAT0359] LATENT TUBERCULOSIS (TB) IN CONNECTIVE TISSUE DISEASES (CTD). COMPARISON BETWEEN 2 «PROPHYLACTIC» THERAPIES

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Background: One third of the world population is infected with TB, 20,000 people contract active TB daily and 5,000 die for that reason. The prevalence of TB in CTD patients has increased, mainly due to reactivation of latent infection (LTB1). The CDC recommends screening for active TB with tuberculin skin test (TST) and chest radiography. In BCG+ population like Mexico, only 30% of RA and SLE patients are TST+, showing that is not a suitable test to identify active and latent TB, needing an adjustment to < 5 mm to identify CTD risk patients. **Objectives:** To compare rifampicin 600 mg/isoniacid 300 mg two times weekly during 12 weeks (G-1 3R/I) against isoniacid 300 mg daily during 6 months (G-2 6I), in CTD patients with TST > 5 mm on immunosuppressants (IS) and/or biologic therapy (BiT) to protect against active TB. **Methods:** Consecutive patients with CTD were randomly assigned. Use of DMARDs, IS, prednisone ≥ 7.5 mg/day and contact with active TB patients were recorded. Chest X rays and TST (5 IU, 23RD, Tubersol®, induration > 5 mm after 72 h = positive). In negative cases, a second TST dose was applied. Active TB was considered to isolation of M. tuberculosis from any sample. Drug schemes were orally self-administered, and compliance was defined as 90% of complete anti-LTB1 scheme. **Results:** We studied 159 CTD patients: 65 with SLE(mean age 36.2, range 20-62), 54 with RA (mean age 48.1 years, range 24-64), 13 with ankylosing spondylitis, 8 with Sjögren's syndrome, 6 with overlap syndrome, 5 with Takayasu's arteritis (TA), 4 with Wegener's, 3 with PAN and 1 relapsing polychondritis.

53 CTD patients were assigned to each group. After 1-year of follow-up, no TB case has been found in any of the 52 patients treated with R/I, as well as in 48 patients that completed 6H, compared with 2/53 patients without LTBI treatment (G-3), 1 case with TA and lymph-node TB, and 1 RA patient developed renal TB after 11 months on etanercept (p < 0.001). Regarding side-effects, asymptomatic AST increase (< 3 normal values) was found in 3 R/I patients and in 2 of 6H group(p NS), as well as nausea and diarrhoea in one case each. There was no evidence of toxicity or neuropathy secondary to vitamin defficiency. Regarding compliance, only 1/53 (2.3%) R/I patients withdrew therapy, against 5/53 (10%)of 6H patients that menctioned failure (1 week or more, p < 0.02). **Conclusion:** Both schemes 6I (CDC standard LTBI treatment) and 3R/I are safe and adequate to diminish TB in CTD, but 3R/I has better compliance and may avoid drug-resistance. In countries such as Mexico, similar to observed with anti-TNF therapy, LTBI therapy (better than «prophylactic» treatment), must be added in CTD patients with TST > 5 mm and IS or BiT, since TB reactivation is likely to occur and physicians must be aware. **Infection-related rheumatic diseases Citation:** Ann Rheum Dis 2007;66(Suppl II):538

8. [2007] [SAT0111] LACK OF SUBCLINICAL MYOCARDIAL ISCHAEMIA IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS WITHOUT TRADITIONAL RISK FACTORS FOR CORONARY ARTERY DISEASE

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Objectives: To analyze whether patients with systemic lupus erythematosus (SLE) without traditional risk factors for coronary artery disease (CAD) develop subclinical myocardial ischaemia in the first years after diagnosis. **Methods:** A cross-sectional analysis of a cohort of 200 female SLE patients was conducted. We selected those patients who fulfilled the American College of Rheumatology (ACR) SLE criteria and had no traditional risk factors for CAD, including diabetes mellitus, hypertension, obesity, hyperlipidemia, and smoking. After an initial clinical and laboratory examination, patients were evaluated using a baseline echocardiogram and a dobutamine and atropine stress echocardiogram to search for subclinical myocardial ischaemia. **Results:** Forty-one patients were included in the study. The mean age at the time of the study was 34.5 ± 9.56 years (mean ± SD). The mean age at diagnosis was 30.3 ± 9.39 years. The mean time from diagnosis was 3.9 ± 3.3 years. Baseline disease activity index (MEX-SLEDAI score) showed that 92.6% of patients had disease activity, although most patients had mild activity. A dobutamine and atropine stress echocardiogram was performed in 40 patients. All 40 patients had a negative tests for subclinical myocardial ischaemia. **Conclusion:** Patients without traditional risk factors for CAD do not have an increased risk for subclinical myocardial ischaemia in the first years after diagnosis. A longitudinal follow-up study of these patients is needed to confirm our findings and assess if additional non-traditional risk factors for CAD increase the risk for myocardial ischaemia.
SLE, Sjögren's and APS clinical aspects and treatment
Citation: Ann Rheum Dis 2007;66(Suppl II):463

9. [2007] [SAT0040] 6 WEEKS OF TREATMENT OF ACTIVE RHEUMATOID ARTHRITIS WITH AN ORALLY ACTIVE INHIBITOR OF JANUS KINASE 3, CP-690,550, IS ASSOCIATED WITH DOSE-DEPENDENT INCREASES IN REMISSION RATES AND IMPROVEMENT IN THE CDAI AND SDAI

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Background: This proof-of-concept study compared the efficacy, safety, tolerability and effects on health and functional status of 3 dose levels of CP-690,550 *vs* placebo, administered for 6 weeks with 6 weeks post-dosing follow-up, to subjects with moderate to severe active RA. **Objectives:** The primary efficacy endpoint, ACR20 response rates, and safety have been reported separately.[1] Secondary analyses of efficacy, including remission rates, are detailed here. **Methods:** Subjects enrolled had an inadequate response to methotrexate or a TNF inhibitor. Stable background NSAIDs, COX-2 inhibitors, low-dose glucocorticoids and analgesics were allowed. All subjects randomized 1:1:1:1 to placebo BID, CP 5 mg BID, 15 mg BID or 30 mg BID (n=264) received study medication. **Results:** At baseline, mean tender joint counts ranged from 26.7 - 32.3, mean swollen joint counts from 16.2 - 21.1, mean CRP from 2.2 - 3.1 mg/dL and mean DAS28-3(CRP) values from 5.7 - 6.2. Statistically significant increases in the DAS- and Joint-remission rates were seen in the 15 and 30 mg BID dose levels, compared to placebo, by week 2 and in the CDAI remission rates by week 4. Compared to placebo, changes from baseline in the SDAI and CDAI were statistically significant at all timepoints in all 3 CP-690,550 dose levels.

	N	Week 6 remission rates and mean changes from baseline to week 6 DAS remission	SDAI remission	CDAI remission	Joint remission	Jt + CRP remission	Change DAS	Change SDAI	Change CDAI
PBO	65	2.1%	0.0%	0.0%	0.0%	0.0%	-0.8	-14.1	-13.3
5 mg BID	61	12.2*	0.0	1.8	3.3	0.0	-1.7#	-38.6#	-25.5#
15 mg BID	69	30.4#	7.4*	12.1*	8.7*	5.3	-2.3#	-47.3#	-28.0#
30 mg BID	69	25.0*	7.6*	12.5*	13.2*	10.5*	-2.4#	-48.0#	-29.0#

Sample sizes (N) may differ across the endpoints. *p < 0.05 compared to placebo; #p < 0.0001 compared to placebo.

Conclusion: DAS Remission: value ≤ 2.6 of the DAS28-3(CRP); SDAI Remission: value < 3.3 of the Simple Disease Activity Index (SDAI); CDAI Remission: value < 2.8 of the Clinical Disease Activity Index (CDAI); Joint Remission: tender joint count = 0 AND swollen joint count = 0; Jt + CRP Remission: Joint Remission AND CRP ≤ 0.4 mg/dL. In this population with moderate to severe active RA, 15 and 30 mg CP-690,550 dosed BID for 6 weeks produced remission rates superior to placebo by multiple criteria, and 5 mg BID produced significantly higher DAS remission rates. Improvements in the SDAI and CDAI were seen in all 3 dose levels of CP-690,550 at all timepoints. CP-690,550 should be investigated in subjects with RA in studies of longer duration. **References:** 1. JM Kremer, et al. *Arthritis Rheum* 2006; 54: 4116.
RA non-biologic treatment
Citation: Ann Rheum Dis 2007;66(Suppl II):441

10. [2007] [FRI0307] GALECTIN-1 AND ANTI-GALECTIN-1 AUTOANTIBODIES IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Galectin-1 (Gal-1) is a member of a large family of mammalian lectins that have a special affinity for the N-acetyl-lactosamine residues on other glycoproteins. In the immune response, Gal-1 promotes the apoptosis of various cell types including T lymphocytes, being thus capable of regulating autorreactive clones and inflammation in Rheumatoid Arthritis (RA). Because of its high expression in the extracellular matrix, it has been suggested that it may represent a target for the synthesis of autoantibodies and these might have an influence on disease activity. **Objectives:** To measure Gal-1 serum levels and to establish the presence of anti-Gal-1 antibodies in the sera of patients with RA and to correlate their relationship with disease activity, comparing these results to those from controls. **Methods:** We included patients with RA classified according to the ACR 1987 criteria, excluding those with incomplete data. Disease activity was measured using the DAS28. Rheumatoid factor and Gal-1 as well as anti-Gal-1 IgG-antibodies were measured by indirect sandwich ELISA. Control sera was taken from gender matched controls from the local blood bank. Comparisons between groups were done using the Mann-Whitney U test and Spearman's correlation was employed to determine the relationship to disease activity. **Results:** For measurements of serum Gal-1, 60 patients and 50 controls were sampled. There were no statistically significant differences between groups (p = 0.114), nor was there any correlation with disease activity (p = 0.42). Anti-Gal-1 antibodies were determined in the samples of 94 controls and 114 patients. A significant difference (p < 0.05) was found when comparing the levels of anti-Gal-1 antibodies between controls and patients. There was also a statistically significant correlation between the presence of anti-Gal-1 antibodies and active disease (p < 0.05). **Conclusion:** In patient with RA, Gal-1 levels seem to be consistent with those measured in healthy controls. The presence of anti-Gal-1 IgG-antibodies is significantly higher in patients with RA than in controls and there is a statistically significant correlation with active disease. These findings could suggest a role of anti-Gal-1 antibodies downregulating T cell apoptosis induced by Gal-1 in RA patients.
RA other clinical aspects and comorbidity
Citation: Ann Rheum Dis 2007;66(Suppl II):372

11. [2007] [FRI0180] WORK COMPETENCY IN RHEUMATOID ARTHRITIS (RA) PATIENTS AND ITS LINK WITH PROGRESSION TIME AND TREATMENT PATTERNS

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Background: Work disability is a common and expensive consequence of RA, its related with the severity of the disease and results in lost income for the patients and less productivity for society. **Objectives:** To establish the employment status in a large

national cohort of RA patients. **Methods:** Using data from RACE study (Retrospective study for costs and epidemiology data of Rheumatoid Arthritis in Mexico), employment status was analyzed and correlated with course time, activity disease index (DAS 28), treatment and direct and indirect costs during the six months prior to the interview. Descriptive analysis and parametric tests were done. **Results:** A total of 2602 patients were included, 88.5% women and 11.45% men, with a 7,7:1 ratio, with an average age of 47.82 ± 13.82 years. Classified by mean evolution course: 261 (10.03%) were < 1 year, 921 (35.4%) were 1-5 years, 634 (24.3%) 5 to 10 years and 786 (30.21%) > 10 years. Medium DAS 28 value was 5.13 ± 1.75; when the population was categorized by DAS 28 51.04% had severe disease activity, 33.9% moderate, 7.03% low and 8.03% were in remission. The 95.16% were using any DMARD in their treatment and 13.26% were using a biologic drug therapy. A total of 1,174 (45.29%) had a paid work. Of the remaining 54.71%, a 37.34% attributed the absence of labor activity directly to RA. Indirect costs were significantly increased in patients without an employment activity, this difference increased in accordance with mean course time from 213.28 to 713.29 € in < 1 year patients *vs* 657.19 to 6616.75 € (0-116697.71 €) for those with more than 10 years with the disease. Inability working days raised also progressively with RA course time, fluctuating from 39.51 ± 44.03 days in patients with < 1 year, 41.68 ± 51.67 with 1 to 5 years; 46.16 ± 77.68 with 5-10 years and 54.08 ± 62.77 with more than 10 years. Remission was more frequently reached in patients that included any biological therapy, 12.17% *vs* 7.4% (p = 0.05), and when inability working costs between patients who reached it were compared, they fluctuated from 15 -133.93 €, in comparison with those with severe disease activity level which cost 105.77 to 503.15 €. The price of working absenteeism was 13.90 to 147.83 € *vs* 90.59 to 600.92 €, with a statistical significant difference p = 0.05. **Conclusion:** Rheumatoid Arthritis patients present important labor absenteeism, and combined with work disability, they generate high expenses. Work disability increases proportionally to evolution time. Treatment strategies must be designed to reach remission as long as possible in order to improve the labor status and prognoses in patients economically active. **References:** 1. Puolakka K, Kautiainen H, Möttönen T, et al. Predictors of productivity loss in early rheumatoid arthritis: a 5 year follow up study. *Ann Rheum Dis* 2005; 64: 130-3.

RA epidemiology, prognosis and predictors

Citation: Ann Rheum Dis 2007;66(Suppl II):334

12. [2007] [THU0428] IMPROVEMENTS IN PAIN, FUNCTION, AND HEALTH STATUS IN PATIENTS TAKING CP-690,550, AN ORALLY ACTIVE INHIBITOR OF JANUS KINASE 3 (JAK3I): RESULTS FROM A RANDOMIZED, DOUBLE-BLIND, PLACEBO-CONTROLLED TRIAL IN THE TREATMENT OF ACTIVE RHEUMATOID ARTHRITIS

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Objectives: CP-690,550 (CP), an orally active, moderately selective JAK3i has separately reported efficacy (ACR20 response rates) and safety for 3 oral dose levels of CP *vs* placebo, administered for 6 weeks, to subjects with moderate to severe RA. Secondary efficacy measures of pain, function, and health status are detailed here. *Methods:* Subjects enrolled had an inadequate response to methotrexate or a TNFi. Stable background NSAIDs, COX-2 inhibitors, low-dose glucocorticoids and analgesics were allowed. All subjects randomized 1:1:1:1 to placebo BID, CP 5 mg BID, 15 mg BID or 30 mg BID (n = 264) received study medication. At Baseline and Weeks 1, 2, 4, and 6, subjects completed the Patient's Assessment of Pain (Pain) and rated functional ability using the Health Assessment Questionnaire-Disability Index (HAQ-DI). At Baseline and Week 6, subjects rated their health status using the SF-36. **Results:** Mean change from Baseline in Pain improved statistically significantly compared to placebo at all weeks, with highly significant (p < 0.0001) changes in the 15 and 30 mg CP-BID groups at all weeks, and in the 5 mg CP-BID group at Weeks 4 and 6. Mean HAQ-DI scores decreased from Baseline over time and with increasing doses of CP, indicating improved functional status, and were statistically significant compared to placebo at all weeks, with highly significant (p < 0.0001) changes occurring in the 30 mg CP-BID group at all weeks, and in 5 and 15 mg CP-BID at Weeks 4 and 6. Rates of subjects achieving clinically meaningful reductions in the HAQ-DI (≥ 0.3 units) at Week 6 were 31% for placebo compared to 57%, 71% and 70% for 5, 15, and 30 mg CP-BID groups, respectively. The mean changes from Baseline to Week 6 in SF-36 scores are presented in the table.

Treatment	SF-36 Mean change from baseline to week 6 Placebo BID, N = 44	CP-5mg BID, N = 56	CP-15 mg BID, N = 55	CP-30 mg BID, N = 52
Physical function	2.48	5.79	6.57*	8.58**
Role-Physical	2.09	8.36**	7.50*	9.08***
Bodily pain	3.65	12.14***	13.62***	15.11***
General health	2.33	5.55*	5.83*	7.99**
Vitality	3.09	5.99	8.61*	11.84***
Social function	4.22	7.36	7.81	10.88*
Role-Emotional	1.06	6.07*	5.26	8.89**
Mental health	3.04	5.88	6.60	10.15**

* p < 0.05; ** p < 0.001; ***p < 0.0001; All p values comparing CP-690,550 groups to placebo.

Conclusion: All 3 dose levels of oral CP-690,550 were efficacious, compared to placebo, in improving the pain, function, and health status of subjects with moderate to severe RA, beginning at Week 1 and sustained through Week 6. **References:** JM Kremer, et al. *Arthritis Rheum* 54:4116;2006.

Health service and outcome research

Citation: Ann Rheum Dis 2007;66(Suppl II):257

13. [2007] [OP0113] UNDIFFERENTIATED CONNECTIVE TISSUE DISEASE (UCTD): BASAL CLINICAL AND SEROLOGICAL CHARACTERISTICS IN A GROUP OF 57 PATIENTS

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Background: UCTD involves widespread inflammation and generally comprise those patients with symptoms of a rheumatic disease who have systemic manifestations expressed by two or more specific entities but cannot be definitely diagnosed. **Objectives:** The aim of this study was to determine clinical and serological characteristics in a group of patients suffering of UCTD. **Methods:** Using retrospective data we included incident and prevalent consecutive active patients from our rheumatology clinic at Hospital General de Occidente according to the following criteria: a) clinical manifestations suggestive of a systemic rheumatic disease but not definitely diagnosed. b) Presence of antinuclear antibodies and/or rheumatoid factor. c) Follow-up of the patient of at least one year. d) Availability of the clinical file. At this basal stage we used retrospective data, and once included a prospective phase began including clinical data and serology at 3, 5 and 10 years of follow-up, in addition to the clinical care under the judgment of the physicians in charge. **Results:** We studied 57 patients. Basal clinical and serological features were: age (mean, median, and value min-max), 37, 36, 8 – 60 years; evolution time 2.2, 1, 1 – 12 years. Gender relation female/male was 54/3. Eighty-four percent had musculoskeletal symptoms (32% arthralgias, 26% arthritis, and 26% fibromyalgia); Raynaud's phenomenon in 19%; lympho/leukopenia in 16%; keratoconjunctivis sicca in 12%, xerostomia in 9%, oral ulcerations in 11% and photosensitivity in 5%. Immunological sera findings included positive antinuclear antibodies in 7%, positive rheumatoid factor in 11% and in 14% of the cases these both autoantibodies were positive at the same time. The follow-up time was at least the 3 years minimum in 25 cases. Progression to a defined systemic autoimmune disease was observed in 5/25 patients, three developed systemic lupus erythematosus, one scleroderma and one primary Sjögren's syndrome. **Conclusion:** In our study we remark fibromyalgia as a major basal manifestation, despite this cardinal clinical feature, the overall proportion of differentiation is comparable with other series. If patients with UCTD displaying fibromyalgia have a different progression rate to defined systemic autoimmune disease, is an issue that remains to become elucidated.

Undifferentiated connective tissue diseases and overlap syndromes

Citation: Ann Rheum Dis 2007;66(Suppl II):86

14. [2007] [SAT0121] PROLACTIN LEVELS ARE ASSOCIATED WITH LUPUS ACTIVITY, LUPUS ANTICOAGULANT AND POOR OUTCOME IN PREGNANCY

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Background: High prolactin (PRL) levels seem to be associated with active systemic lupus erythematosus (SLE) during pregnancy. However, the association of activity, using modified scales for SLE activity in pregnancy, lupus anticoagulant (LA) and poor outcome has not been analyzed. **Objectives:** The aim of this study was to investigate the association among serum PRL levels with SLE activity, LA, and outcome during pregnancy in SLE patients. **Methods:** We studied 15 SLE (ACR criteria) pregnant patients and 9 healthy pregnant women. All patients were evaluated monthly with the follow determinations: 1. SLE activity using m-SLAM (modified- systemic lupus activity measurement), 2. LA (by partial activated thromboplastine time) 3. PRL serum levels (Immunoradiometric assay).

Healthy controls were evaluated each trimester of pregnancy. Prematurity, fetal loss, low birth weight, preeclampsia/eclampsia, premature ruptures of membranes were evaluated. Statistical analysis included chi square test, Fisher exact test, Spearman correlation and odds ratio (OR). **Results:** The mean age of SLE patients was 30 ± 4.9 years and 27.1 ± 3.7 years of controls. Mean disease duration was 4.3 ± 2.8 years. All patients received low prednisone doses, (10 mg per day), only 4 patients received chloroquine (150 mg per day). High PRL levels were found during second and third trimester in SLE patients in comparison with controls (186.2 ± 54.02* *vs* 119.6 ± 31.1 and 177.4 ± 48.6 * *vs* 158.3 ± 31.5) ($p < 0.05$). We observed a significant linear correlation between PRL and m-SLAM from first to seventh month. This correlation was lost during eight and nine month and it was recuperated in postpartum. Nine patients had LA. From third month until partum, a direct association between high PRL levels (> 120 ng/ml) and LA was found. In addition, an association between LA and m-SLAM from fourth to sixth month was also found ($p < 0.05$). Relative risk (RR) of PRL levels, LA, and maternal-fetal outcome (premature birth, and low birth weight) are summarized in *table I*. Any patients had fetal loss.

Table I. PRL, LA and maternal-fetal outcome.

	Third month	Fourth month	Fifth month	Sixth month	Seven month
PRL p	0.013	0.005	0.027	0.012	0.015
RR	3.6	2.1	3.9	3.2	2.5
LA p	0.033	0.033	0.017	0.005	
RR	4.5	4.5	5.7	7.7	

Conclusion: Our study suggests a strong association among PRL, LA, SLE activity and pregnancy outcome. Pregnancy in these patients should be followed and treated in order to increase fetal and maternal survival and decrease poor outcome. **References:** 1. Tincani A, Bompane D, Danieli E, Doria A. Pregnancy, lupus and antiphospholipid syndrome (Hughes syndrome). *Lupus* 2006; 15: 156-60. 2. Dhar JP, Essenmacher LM, Ager JW, Sokol RJ. Pregnancy outcomes before and after a diagnosis of systemic lupus erythematosus. *Am J Obstet Gynecol* 2005; 193: 1444-55.
SLE, Sjögren's and APS clinical aspects and treatment
Citation: Ann Rheum Dis 2007;66(Suppl II):466

15. [2007] [SAT0118] RITUXIMAB FOR REFRACTORY HEMATOLOGICAL MANIFESTATIONS OF SYSTEMIC LUPUS ERYTHEMATOSUS AND ANTIPHOSPHOLIPID SYNDROME

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Background: Conventional treatment for thrombocytopenia (TP) and autoimmune hemolytic anemia (AHA) in systemic lupus erythematosus (SLE) includes corticosteroids, and/or cytotoxic drugs. However, almost 30% of patients are refractory to these treatments. Rituximab has a clinically useful therapeutic effect in SLE especially in lupus nephritis. Here we report our experience with rituximab on refractory thrombocytopenic and hemolytic anemia in SLE and antiphospholipid syndrome (APS). **Methods:** We studied 6 patients with SLE, mean age was 35.8 years (range 17-66) with disease duration was 7.3 yr (range 3-12) and hematological manifestations (5 patients had refractory thrombocytopenia and 1 hemolytic anemia), three of them with APS associated. All patients were refractory to conventional treatment defined as no previous response to high dose corticosteroids and at least 2 immunosuppressive drugs or previous splenectomy (Spl). Patients received rituximab at a dose of 375 mg/m^2 for a total of four doses. Therapeutic response for thrombocytopenia was defined as complete (≥ 100% baseline platelet count increase), partial (50-100%) and no response (< 50%) after 8 weeks (initial response) and 1 year of follow-up. **Results:** After 8 weeks of treatment 3 patients showed complete response, 2 partial and 1 had no response. After 1 year of follow up 3 patients with complete response continued with normal platelet counts, 1 patient with partial response and 1 with no response were underwent to splenectomy and both achieved complete response, 1 patient with partial response was lost to follow up. None of our patients showed adverse events *(Table I)*.

Age, gender	DX	Prior treatments	Response 8 week	Response 1 year	Treatment after Rituximab
39, F	TP-APS	Dan, Aza, spl	Complete	Complete	Prednisone
66, M	TP-APS	Dan, Aza, DDS	Complete	Complete	Prednisone
17, F	AHA	Dan, Aza, DDS	Partial	Lost	
32, F	TP	Dan, Aza	No	Comp after Spl	Prednisone, Dan
38, F	TP-APS	Dan, Aza, CYC CsA, Spl	Complete	Complete	Prednisone, CsA
32, F	TP	Dan, Aza, CYC	Partial	Comp after Spl	Prednisone

Dan danazole; Aza azathioprine; DDS dapsone; CYC cyclophosphamide; CsA cyclosporine A.
Conclusion: Rituximab seems to be effective in refractory hematological manifestations including in post-splenectomized patients.

SLE, Sjogren's and APS clinical aspects and treatment
Citation: Ann Rheum Dis 2007;66(Suppl II):465

16. [2007] [SAT0080] OMEGA 3, OMEGA 9 FATTY ACIDS, AND C VITAMIN IN PATIENTS WITH SEVERE LUPUS NEPHRITIS. A PILOT STUDY

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Background: Severe lupus nephritis is the more important complication of systemic lupus erythematosus (SLE). Despite the emergence of newer immunosuppressive and immunomodulatory treatments, cyclophosphamide (CYC) remains the first line of treatment for severe lupus nephritis. Nutrient supplementation omega 3, omega 9 fatty acids and C vitamin have anti-immune/inflammatory, and antioxidants action and it has been advocated as a potentially useful add-on therapy in severe lupus nephritis. **Objectives:** ωTo evaluate the beneficial effect of omega ( ) 9 fatty acids, and vitamin C, in severe lupus nephritis, during ω3, omega (treatment with CYC. **Methods:** From March 2006 to December 2006 a pilot clinical trial was performed. Patients from 18 to 65 years old, with severe lupus nephritis based on renal biopsy (III, IV, and V WHO class) were included. Disease activity was assessed using the SLEDAI score. At onset and to the end of study, we evaluated corporal composition with bioelectric impedance; laboratory parameters of renal function, plasma lipids, antinuclear antibodies (ELISA), anti-DNA (ELISA), and complement were performed. The treatment for lupus nephritis included CYC and prednisone at conventional doses. The experimental group received a diet of 30 to 35 kcals/day protein, plus 30 g of linseed in grain, 10 ml of olive's oil (extravirgen), and 500 mg of vitamin C during 16 weeks. Statistics data were analyzed using the SPSS program V12 and Wilcoxon's statistic test. **Results:** Eighteen patients with active SLE were included in the study. Both, corporal and biochemical composition were evaluated. The corporal composition with bioelectric impedance at onset and at the end of study showed: body weight: 66.93 ± 12.82 *vs* 67.19 12 ± 50 p = 0.10, fat mass (per kg) 19.69 ± 7.8 9 *vs* 20.26 ± 7.64, p = NS. Muscle mass (per kg) 47.02 + 8.85 *vs* 46.72 + 8.34, p = NS. Corporal water (per kg) 34.59 ± 7.00 *vs* 34.36 ± 6.68 p = NS. BMI: 26.8 + 4.97 *vs* 27.02 + 4.94, p = NS. *Table I* shows the effect of nutrient supplementation on severe lupus nephritis. Statistical significance were achieved in triglycerides (188.6 ± 87.04 *vs* 168.72 ± 60.78 mg/dl, $p < 0.05$) levels, and ANA (235.00 ± 327.21 and 56.47 ± 92.80 IU/ml, $p < 0.02$) titers.

	Basal	End	p
FERUM creatinine	0.84 ± 0.32	0.88 ± 0.38	0.34
FERUM urea	29.96 ± 13.89	28.05 ± 16.14.	0.19
Creatinine clearance	93.51 ± 41.87	86.22 ± 41.36	0.31
Proteinuria	0.71 ± 1.07	0.80 ± 1.32	0.86
Uric acid	9.58 ± 10.78	5.84 ± 7.60	0.47
Cholesterol	189.72 ± 39.89	185.61 ± 41.87	0.30
Triglycerides	188.61 ± 87.04	168.72 ± 60.78	0.05
Anti-dsDNA	16.47 ± 31.01	7.78 ± 20.74	0.13
ANA	235.00 ± 327.21	56.47 ± 92.80	0.02
C3	115.08 ± 41.91	111.61 ± 35.81	0.86
C4	20.98 ± 12.13	20.26 ± 9.4	0.86
SLEDAI	3.50 ± 2.83	2.28 ± 2.35	0.48

Conclusion: 9 fatty acids and antioxidants (vitamin ω3, ω The supplementation nutrient with C), decreased triglycerides and antinuclear antibodies in patients with severe lupus nephritis. Nutrient supplementation seems to be useful as complementary therapy in severe lupus nephritis.
SLE, Sjögren's and APS clinical aspects and treatment
Citation: Ann Rheum Dis 2007;66(Suppl II):454

17. [2007] [SAT0368] SYSTEMIC AUTOIMMUNE DISEASES COEXISTING WITH CHRONIC HEPATITIS C VIRUS INFECTION (THE HISPAMEC REGISTRY). CLINICAL CHARACTERIZATION AND GEOGRAPHICAL DISTRIBUTION OF 1,015 CASES

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Objectives: To describe the clinical and immunologic characteristics of a large series of patients with systemic autoimmune diseases (SAD) associated with chronic hepatitis C virus (HCV) infection. **Methods:** The HISPAMEC Registry is a multicenter international

study group dedicated to collecting data on patients diagnosed with SAD with serological evidence of chronic HCV infection. The information sources are cases reported by physicians of the HISPAMEC Study Group and periodic surveillance of reported cases by a Medline search updated up to December 31, 2006. **Results:** One thousand and fifteen patients are currently included in the Registry (73% female and 27% male, with a mean age at SAD diagnosis of 50 years). Patients have been reported from the following geographical areas: Southern Europe (61%), Northern Europe (8%), South America (0.2%), North America (15%), Asia (15%) and Africa (0%). All patients fulfilled the classification criteria for the following SAD: Sjögren's syndrome (n = 475, 47%), rheumatoid arthritis (RA) (n = 150, 15%), systemic lupus erythematosus (n = 130, 13%), polyarteritis nodosa (n = 81, 8%), antiphospholipid syndrome (n = 60, 6%), inflammatory myopathy (n = 40, 4%) and other SAD (n = 79). The main immunologic features were ANA in 65% of patients, RF in 63%, cryoglobulinemia in 55% and hypocomplementemia in 51%. The liver profile was abnormal in 61% of patients, mainly raised transaminases in 74%. Neoplasia was found in 80/641 (13%) patients, consisting principally of B-cell lymphoma in 50 cases and hepatocarcinoma in 18. Seven per cent of patients died during the follow-up. **Conclusion:** The SAD most commonly reported in association with chronic HCV infection are SS (nearly half the cases), RA and SLE. Nearly two thirds of SAD-HCV cases were reported from the Mediterranean area. This study confirms that, in these patients, ANA, RF and cryoglobulins are the predominant immunological features and B-cell lymphoma the most frequent neoplasia. This complex pattern of disease expression is generated by a chronic viral infection that induces both liver and autoimmune disease.
Infection-related rheumatic diseases
Citation: Ann Rheum Dis 2007;66(Suppl II):541

18. [2007] [SAT0417] DIAGNOSTIC FEATURES OF TAKAYASU ARTERITIS IN MEXICAN CHILDREN

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Background: Takayasu arteritis (TA) is a chronic vasculitis of unknown origin, affecting mainly the aorta and its main branches. Delay in diagnosis for TA is a common problem for children. Although early manifestations are nonspecific the clinical features that lead to diagnosis appear related to vascular involvement. **Objectives:** To describe the clinical features in children with Takayasu arteritis. **Methods:** Using a retrospective strategy we included incident and prevalent cases from our rheumatology clinic. We found four patients (girls) with an age range of 6 to 12 years during the analysis period of 4 years. All patient fulfill Takayasu arteritis criteria. Each patient had at last one year of follow-up. **Results:** All patients suffered from fatigue, intermittent fever and abdominal pain for a mean of 4 months (range 2 to 6). In three children high blood pressure was documented before the vascular symptoms and one girl suffer of myocardial inflammation without hypertension. In all patients we found an elevated acute phase reactants (ESR and CPR) and positive AAN, while ANCAs were negative. The imaging studies (US Doppler, angiography, and CT-scans) revealed changes of vascular involvement suggested Takayasu arteritis. Both thoracic and abdominal aorta and branches were involvement. One girl with hypertension and severe renal stenosis a stent was placed. All patients received corticosteroids followed by a combination of prednisone and methotrexate except in the girl with myocardial inflammation who received metilprednisolone and cyclophosphamide. At present the four patients are in good clinical control. **Conclusion:** Hypertension was a common clinical finding to suspect the diagnosis of Takayasu arteritis in children with nonspecific systemic manifestations. Corticosteroids followed by MTX have been effective and a safe treatment.
Paediatric rheumatology
Citation: Ann Rheum Dis 2007;66(Suppl II):556

19. [2007] [SAT0153] HEART CONDUCTION SYSTEM STATUS IN PRIMARY ANTIPHOSPHOLIPID SYNDROME

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Background: Rhythm and conduction disturbances are important manifestations of cardiac involvement in autoimmune rheumatic diseases and a possible cause of sudden death. An association between antiphospholipid antibodies (aPL) and cardiac abnormalities in patients with systemic lupus erythematosus has been described. In primary antiphospholipid syndrome (PAPS), the better characterized cardiovascular abnormalities have been echocardiographic findings. However, rhythm and conduction disturbances in PAPS have not yet been studied. **Objectives:** To assess the heart conduction system function in PAPS patients. **Methods:** 16 consecutive patients who fulfilled Sapporo criteria for PAPS were selected and underwent a 24-hour ECG Holter monitoring study. Patients with clinical evidence of previous heart disease were excluded, SLE-associated APS was also excluded. Descriptive statistics and correlations were performed. **Results:** 9 female and 7 male patients wit a mean age 39.9 ± 11.4 years were included. Mean duration of disease was 7.1 ± 3.5 years. All patients were receiving oral anticoagulants at the time of the study. 7 patients had history of venous thrombosis, 7 arterial and 2 both types. Holter findings were as follows: 100% of patients had sinusal rhythm, mean heart rate was 79.8 ± 5.9 beats/min, maximum heart rate 136.5 ± 10 beats/min and minimum heart rate 49.5 ± 8 beats/min. 12/16 patients (75%) had extrasystoles, 3 of them (25%) had only supraventricular extrasystoles, 4 (30%) only ventricular extrasystoles and 5 (41.6%) had both types of extrasystoles. The mean number of supraventricular extrasystoles was 30.37 (range 1-104) and 18.33 (range 1-83) for ventricular extrasystoles. We found no correlation between Holter findings and age, gender, duration of disease, type of thrombosis and number of thrombotic events. **Conclusion:** This is the first study of Holter findings in PAPS. Ventricular and supraventricular extrasystoles seem to be prevalent in asymptomatic patients and they do not seem to correlate with clinical status. The clinical relevance of rhythm and conduction disturbances in PAPS patients is not clear. Further studies are needed to confirm these findings.
SLE, Sjogren's and APS clinical aspects and treatment
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20. [2007] [SAT0148] FIBROMYALGIA IN MEXICAN PATIENTS WITH PRIMARY SJÖGREN'S SYNDROME. A CASE-CONTROL STUDY

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Background: The cause of fatigue and myofascial pain in primary Sjögren's syndrome (pSS) remains unclear and it is particularly relevant to consider the differential diagnosis of fibromyalgia (FM). Additionally, a focal sialoadenitis had been reported in this group of patients. **Objectives:** We determined the prevalence of fibromyalgia in 75 female's patients with pSS in which the differences of clinical, immunological and histopathology findings were examined. **Methods:** Retrospective case-control study was conducted. We enrolled incident and prevalent cases of outpatients from rheumatology department. All patients fulfilled at least 4 European criteria for pSS (modified for not readiness of image and glandular dynamics studies). Case definition was established if pSS fulfill the ACR criteria for FM and the opposite was used to define control. Focal sialoadenitis was expressed by the quotient number of focus/glandular tissue examined in 4 mm^2. **Results:** Mean values for age (years) and duration of disease (months) at the moment of study were 57.6 ± 10 and 70.6 ± 72.3 respectively. Sixty three (85.9%) patients presented subjective and seventy three (98.6%) objective ocular criteria. All patients were positive for oral criteria, and fifty one (83.6%) fulfilled histopathology criteria. Immunologic features were positive in sixty seven (89.3%). Fatigue was not a common feature and there were only small clinical differences between groups. Parotid inflammation, Raynaud's phenomenon, ANA and leucopenia was not frequent observed. Twenty two (29.3%) pSS patients fulfilled the ACR criteria for fibromyalgia and interestingly purpura, rheumatoid factor, anti-Ro/SSA and anti-La/SSB antibodies had lower frequencies with a borderline statistical tendency (p 0.05 with IC95% RM that included the unit). Lymphocyte infiltrate density in salivary gland biopsy failed to show statistical differences between case and controls, having a median of 0.40 and 0.38 respectively. **Conclusion:** Fibromyalgia was found higher than has been previously studies reported in patients with pSS. Future research in this field should look to identify the possible factors responsible for FM in pSS. Sialoadenitis density was not useful to differentiate these groups of patients.
SLE, Sjögren's and APS clinical aspects and treatment
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21. [2007] [SAT0143] THYROID DISEASE IN WOMEN WITH PRIMARY ANTIPHOSPHOLIPID SYNDROME

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Background: Primary Antiphospholipid syndrome(PAPS) is defined as vascular thrombosis and pregnancy morbidity associated with antiphospholipid antibodies. Few cases with endocrine abnormalities, such as adrenal insufficiency, hypopituitarism, autoimmune thyroid disease, have been reported. However, thyroid function abnormalities in PAPS have been little described. **Objectives:** To analyze thyroid function in PAPS. **Methods:** Patients with PAPS (Sapporo criteria) and healthy women as a control group were included. Thyroid evaluation in both groups included serum levels of T3, thyrotropin (TSH), free thyroxine (T4) levels, thyroglobulin, and anti-thyroglobulin (TgAb) (RIA/IRMA). We defined thyroid disease as any abnormalities in these hormones. We reviewed the files to obtain demographic and clinical data. The data were analyzed with Mann-Whitney U test. **Results:** We included 28 PAPS women and 20 healthy women as controls. Mean age of patients was 43.03 ± 9.07 years, controls 42.25 ± 11.4 years; disease evolution was 9.03 ± 4.4. Serum levels of T3, T4, thyroglobulin, and TgAb were not

different in patients and controls: T3, 108.8 ± 38.6 *vs* 126.4 ± 24.07 ng/dl (p = NS); T4: 1.93 ± 1.77 *vs* 1.5 ± 0.73 ng/dl (p = NS), respectively. A significant difference in mean TSH levels between patients and controls (8.7 *vs* 1.2 μUI/ml) (p = 0.02) was found. Eight patients (28%) had abnormalities in thyroid function: 3 patients (10.7%) had hipothyroidism, 4 sublinical hipothyroidism (14%) and one developed thyroiditis (T3 203.1 ng/dl). Only one patient showed high antithyroglobulin antibodies with normal thyroid profile. **Conclusion:** Abnormalities in thyroid profile are prevalent in women with PAPS, especially clinical and subclinical hipothyroidism. The relationship between antiphospholipid antibodies and thyroid disease remains to be investigated. **References:** Uthman I, Salti I, Khamashta M. Endocrinologic manifestations of antiphospholipid syndrome. *Lupus* 2006; 15(8): 485-9. Innocencio RM, Romaldini JH,Ward LS. Thyroid autoantibodies in autoimmune diseases. *Medicine* (B Aires) 2004; 64(3): 227-30.
SLE, Sjogren's and APS clinical aspects and treatment
Citation: Ann Rheum Dis 2007;66(Suppl II):472

22. [2007] [SAT0122] ANALYSIS OF SECOND PREGNANCY IN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS AND ANTIPHOSPHOLIPID SYNDROME. A COMPARATIVE STUDY

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Background: Pregnancies in systemic lupus erythematosus (SLE) patients are recognized to result in excessive fetal morbidity and mortality. The risk of maternal-fetal complications is increased in presence of antiphospholipid syndrome (APS) and treatment has resulted in a successful pregnancy in more patients. However, the outcome of pregnancy after a previous successful pregnancy in SLE and APS has not been analyzed. **Objectives:** To compare the course of second pregnancy in SLE and APS patients, after a successful pregnancy. **Methods:** We included SLE and APS patients with a second pregnancy after a previous successful pregnancy under treatment during the period 2002-2006, attending the outpatient clinic of pregnancy and autoimmune diseases. Patients were divided in two groups: APS (group 1) and SLE (group 2). All patients were managed with the same protocol treatment: low weight heparin plus aspirin for APS, and chloroquine plus steroids for SLE.The outcome considered weeks of gestation, birth weight, and delivery. The data were analyzed with chi-square test, T- Student's test, Mann-Whitney U test, and Kaplan-Meier method to estimate fetal survival. **Results:** We studied 30 patients. Group 1:13 APS patients and group 2:17 SLE patients. Mean age in group 1 was 32 ± 5.5 and in group 2, 29.3 ± 4.9 years. Mean disease duration was 6.7 ± 3.9 and 3.7 ± 1.9 years respectively. Mean weeks of gestation were 36.3 in APS *vs* 35.8 in SLE (p = NS). Mean birth weight was 2,729.5 g in APS and 2,584.7 g in SLE (p = NS). There was no fetal loss in both groups and pre-term birth was similar in both groups (38.4% in APS *vs* 47% in SLE). The Kaplan Meier analysis showed no differences in weeks of gestation and fetal survival. **Conclusion:** Second pregnancy in APS and SLE continues being considered as high risk pregnancy. Pregnancy in APS and SLE had similar maternal-fetal outcome. Treatment to prevent maternal-fetal complications is mandatory in SLE and APS in order to obtain another successful pregnancy. **References:** 1. Khamashta MA. Systemic lupus erythematosus and pregnancy. *Best Pract Res Clin Rheumatol* 2006; 20: 685-94. 2. Petri M, Qazi U. Management of antiphospholipid syndrome in pregnancy. *Rheum Dis Clin North Am* 2006; 32: 591-607.
SLE, Sjogren's and APS clinical aspects and treatment
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23. [2007] [FRI0053] SNPS OF E-SELECTIN (A561C), ICAM-1 (G721A) AND VCAM-1 (G1238C) IN RHEUMATOID ARTHRITIS. RELATIONSHIP WITH INFLAMMATORY STATUS AND LIPID PROFILE

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Background: Rheumatoid arthritis (RA) is a systemic inflammatory disease that mainly affects the diarthrodial joint with polygenic susceptibility. An inflamed synovium is central to the pathophysiology of RA. Adhesion molecules are thought to have a role in recruitment of inflammatory cells to the joints in RA. The presence of adhesion molecules, expressed in synovial lesions, in cells involved in the development and progression of the inflammation, undergoes striking alterations in cellular number and content. Thus, expression of adhesion molecules in synovial tissue probably represents a regulatory mechanism for recruitment and retention of leucocytes, the dysregulation of which might contribute to the RA. On the other hand, the high density lipoprotein (HDL) augments reverse cholesterol transport. Recent studies propose that signaling pathway HDL activation to prevent the inflammation in human endothelial cells. **Objectives:** The aim was to investigate the relationship between E-selectin, ICAM-1 and VCAM-1 polymorphisms with lipid profile, sE-selectin, sICAM and sVCAM in RA. **Methods:** Sixty RA patients classified according to 1987 ACR criteria and 60 unrelated healthy controls (HS) defined as Mexican-mestizo population, were included. The sE-selectin, sICAM-1 and sVCAM-1 were determined using ELISA kit. The lipid profile RF (rheumatoid factor), ESR (erythrocyte sedimentation rate) and C-reactive protein were measured by routine methods. The genotypes were characterized using the PCR-RFLPs technique. Statistical analysis was performed using SPSSv10.0. **Results:** RA x=284 and 481 ng/ml? group showed high levels of sICAM-1 and sVCAM-1 (respectively p = 0.002) *vs* HS. The significant correlations were: i) sICAM-1 and sVCAM-1 with cHDL (-0.433, -0.583 respectively); ii) ApoA-1 with sICAM-1 (-0.300). iii)sVCAM-1 with ESR (0.426), p < 0.05. The relationship obtained between the serum levels of total cholesterol and cLDL showed an association with A allele, ICAM-1 polymorphism (p = 0.036 and 0.022); and serum levels of total cholesterol, Apo A1 and Apo B showed an association with C allele, of VCAM-1 polymorphism (p < 0.05); and total cholesterol/cHDL and cLDL/cHDL with C allele, E-selectin polymorphism (p < 0.05). Concern, on behalf of ICAM-1-polymorphism the allele A721 (OR = 1.9[(95%) CI 1.02-3.65]) and phenotype A (G/A+A/A)721 OR = 2.3[(95%)IC 1.11-5.04] were associated with RA (p < 0.05). **Conclusion:** We suggest that cHDL coupled apoA-1 prevents endothelial cell inflammation. sVCAM-1 serum level may be used as a clinical marker to assess inflammation in RA. In addition, this study suggests that ICAM-1 polymorphism influence the susceptibility to RA from the west of Mexico. **References:** 1. Millar MA, et al. *Circulating soluble E- selectin levels and the Ser128Arg Polymorphism in individuals from different ethnic groups*. 2005; 15: 65-70. 2. Wenzel K, et. al. DNA polymorphisms in adhesion molecule genes- a new risk factor for early atherosclerosis. *Hum Genet* 1996; 97: 15-20. 3. Goronzy JJ, Weyand CM. Rheumatoid arthritis. *Immunol Rev* 2005; 204: 55-73. RA: etiology, pathogenesis and animal models
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24. [2007] [SAT0312] HISTOMORPHOMETRIC AND MICRO-CT ANALYSIS OF BONE BIOPSIES AFTER 3 ANNUAL INFUSIONS OF ZOLEDRONIC ACID 5 MG: EVIDENCE FOR PRESERVATION OF BONE STRUCTURE AND REMODELING CAPACITY

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Background: The HORIZON -Pivotal Fracture Trial in 7736 postmenopausal women demonstrated significant anti-fracture efficacy of 3 annual infusions of zoledronic acid (ZOL) 5 mg on vertebral, hip and non-vertebral fractures. **Objectives:** The purpose of this analysis was to assess the effects of ZOL 5 mg on bone structure and remodeling capacity. **Methods:** In this study, 153 individual bone biopsies were obtained at the final visit at month 36, 1 year after the last infusion. The biopsies were subjected to micro-CT (μCT) analysis to assess biopsy quality and bone structure, 143 biopsies (76 ZOL, 67 placebo) had at least one μCT parameter measured. Following micro-CT analysis the biopsies were sent for histomorphometry. A total of 152 (82 ZOL, 70 placebo) were available for qualitative analysis of tetracycline labeling by inspection and 111 for quantitative histomorphometry (59 ZOL, 52 placebo). **Results:** Micro-CT analysis of bone structure revealed higher trabecular bone volume (BV/TV) (median 16.6 *vs* 12.8%, P = 0.0200), higher trabecular number (Tb.N) (median 1.36 *vs* 1.22/mm, P = 0.0081), decreased trabecular spacing (Tb.Sp)(median 0.72 *vs* 0.80 mm, P = 0.0105), and a strong trend towards improvement in connectivity density (median 4.40 *vs* 3.30/mm^3, P = 0.062) in biopsies obtained from patients on ZOL indicating preservation of trabecular bone structure *vs* placebo. Tetracycline label was demonstrable in all but 1 of 82 biopsies obtained in patients treated with ZOL; the 1 biopsy without label was incomplete and fragmented. All 70 biopsies obtained from placebo patients had label. Biopsies obtained from patients treated with ZOL exhibited reduction in activation frequency (Ac.F) by 63% (median 0.10 *vs* 0.27/y, P < 0.0001), mineralizing surface (MS/BS) (median 0.45 *vs* 4.79%, P < 0.0001), volume referent bone formation rate (BFR/BV) (median 0.05 *vs* 0.15 mm^2/mm^2/y, P < 0.0001). Mineral appositional rate (MAR) was significantly higher in patients on active treatment (median 0.60 *vs* 0.53 μm/d, P = 0.0002), indicating increased activity of individual osteoblasts *vs* placebo. No woven bone formation, marrow fibrosis, or mineralizing defect was detected. In conclusion, yearly infusions of ZOL 5 mg over 3 years preserved trabecular bone structure as assessed by μCT in women with postmenopausal osteoporosis. Dynamic histomorphometry demonstrated a 63% reduction of bone turnover in ZOL patients compared to placebo, but increased formative activity at the level of individual osteoblasts. No sign of excessive suppression of bone turnover or other bone pathologies was detected. **Conclusion:** Annual treatment with ZOL 5 mg IV suppressed bone remodeling without causing oversuppression. Osteoporosis
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25. [2007] [SAT0095] SUB-CLINICAL CARDIAC ABNORMALITIES IN MEXICAN PATIENTS WITH SYSTEMIC LUPUS ERYTHEMATOSUS

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Background: Cardiac abnormalities are frequent in patients with systemic lupus erhytematosus (SLE), About 60% of patients develop any cardiac abnormality during their course of illness. **Objectives:** We performed a study to determine the frequency of cardiac abnormalities without clinical manifestations in patients with systemic lupus erhytematosus. **Methods:** We performed Doppler and M-mode transthoracic echocardiography and rheumatologic evaluations in 30 patients with systemic lupus erhytematosus. The echocardiographic findings were compared with 15 healthy volunteers. Data were expressed as mean ± standard deviation. Where appropriate, Student's unpaired t-test, chi-square test and Fisher exact test were used for statistical analysis. Statistical significance was assumed when the P value was < 0.05. **Results:** Compared with the control subjects, patients with lupus had an increased prevalence of echocardiographic abnormalities. These included posterior pericardial effusion (37%), concentric left ventricle hypertrophy (10%), right ventricular enlargement (17%), left ventricular enlargement (3%), mitral regurgitation (20%), tricuspid regurgitation (53%), aortic regurgitation (7%), pulmonary regurgitation (10%), diastolic dysfunction (10%), pulmonary arterial hypertension (67%), and abnormal ejection fraction (13%). Correlation between echocardiographic abnormalities and clinical parameters showed that pericardial effusion was associated with active disease (P < 0.03). **Conclusion:** There was a high prevalence of sub-clinical cardiac abnormalities, especially pericardial effusion, valvular lesions and pulmonary arterial hypertension in mexican patients with systemic lupus erhytematosus. Echocardiography is a very good non-invasive method to determine cardiac abnormalities and should be used routinely for cardiac evaluation of theses patients.
SLE, Sjögren's and APS clinical aspects and treatment
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26. [2007] [THU0039] THE A/A -844 PAI-1 PROMOTER POLYMORPHISM IS ASSOCIATE WITH MRNA EXPRESSION IN RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) is a chronic, inflammatory and autoimmune disease.[1] The plasminogen activator inhibitor type 1 (PAI-1) is the major regulator of the plasminogen activation to plasmin. The plasmin degrade directly cartilage and bone matrix proteins, or indirectly through the activation of matrix metalloproteinases (MMPs), and therefore the PAI-1 could be involved in the physiopathology of RA.[2,3] **Objectives:** To associate the -844 PAI-1 gene polymorphism with the PAI-1 gene mRNA expression in RA patients. **Methods:** Fifty RA patients and 50 healthy subjects (HS) were included as a control group. Genotypes were identified by the PCR-RFLP technique using Xho I restriction enzyme. The mRNA expression of PAI-1 gene was quantified by real-time PCR. Haematological parameters and biochemical were realized by conventional methods. Indexes of activity and disability (DAS28 and Spanish HAQ-DI) were applied in RA patients. Statistical analysis was performed using SPSS version 10.0 and STATGRAPHICS version 4.0. **Results:** DAS28 and Spanish HAQ-DI indexes demonstrated the activity of the disease and functional disability in RA patients. High levels of acute phase reactants (ESR, CRP and fibrinogen), WBC and PLT reflecting the inflammatory process in RA. In addition, the lipid profile reflect low levels in TG, TC, c-HDL and c-VLDL in RA (p < 0.05 vs healthy subjects). Our population was in Hardy-Weinberg equilibrium for the -844 PAI-1 gene polymorphism. In RA, the genotype frequency was: 46% (G/G), 48% (G/A) and 6% (A/A), whereas in healthy subjects was: 48% (G/G), 38% (G/A) and 14% (A/A). The G allele frequency in RA and healthy subjects was: 70% and 67% respectively, whereas for the A allele was: 30% and 33%, respectively. The RA group showed a highest mRNA expression of PAI-1 gene (p < 0.05 *vs* healthy subjects). In addition, A/A genotype carriers RA patients showed a increase of 3.1 fold in the mRNA expression respect to G/A and G/G genotype carriers (1.89 and 1.27, respectively) (p < 0.05). **Conclusion:** The A/A genotype is associated with an increase mRNA expression of PAI-1 gene in RA patients; however, no significant differences in genotype and allele frequencies between RA and healthy subjects were found. **References:** 1. Weyand CM. New insights into the pathogenesis of rheumatoid arthritis. *Rheumatology* 2000; 39(1): 3-8. 2. Lijnen HR. Pleiotropic functions of plasminogen activator inhibitor-1. *J Thromb Haemost* 2005; 3: 35-45. 3. Busso N, Pèclat V, So A, Sappino AP. Plasminogen activation in synovial tissues: differences between normal, osteoarthritis, and rheumatoid arthritis joints. *Ann Rheum Dis* 1997; 56: 550-557.
Genomics, genetic basis of disease and HLA/T cell recognition
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27. [2007] [SAT0030] INCIDENCE OF ANTI-NUCLEAR AND ANTI-DNA ANTIBODY SEROPOSITIVITY, AND IMMUNOGENICITY, IN PATIENTS WITH RHEUMATOID ARTHRITIS TREATED WITH ABATACEPT OR INFLIXIMAB

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Background: This multicenter, double-blind trial in patients (pts) with active RA was designed to investigate the magnitude of the treatment effect of abatacept (ABA) or infliximab (IFX) vs placebo (PBO), and to assess the efficacy and safety between ABA and IFX. **Objectives:** To examine the incidence of anti-nuclear (ANA) and anti-DNA antibodies and immunogenicity associated with ABA or IFX. **Methods:** Pts with active RA were randomized to receive ABA (~10 mg/kg every 4 wks), IFX (3 mg/kg every 8 wks) or PBO (every 4 wks) following standard loading dose protocols and using a double-dummy technique, plus MTX. Validated ELISAs assessed the immunogenicity of ABA (1 against the whole molecule, and 1 against the cytotoxic-lymphocyte antigen-4 [CTLA-4] portion alone). The immunogenicity of IFX was assessed using a human anti-chimeric antibody assay (Prometheus Laboratories Inc., CA, US). ANA and anti-DNA antibodies were evaluated using semi-quantitative immunofluorescence and radioimmunoassay, respectively (Quintiles Laboratories, GA, US). The incidence of positive response is presented at 6 and 12 months. **Results:** 156, 165 and 110 pts were randomized and treated with ABA, IFX and PBO, respectively. At randomization, demographic and clinical characteristics were similar across groups. The proportion of pts who developed ANA and anti-DNA antibodies was less in the ABA *vs* PBO group at Day 197 *(Table)*. At Days 197 and 365, the proportion of pts who developed ANA and anti-DNA antibodies was lower with ABA than IFX *(Table)*. Using the two different assays to detect immunogenicity, it was found that 0% of the ABA group developed antibodies to ABA (or the CTLA-4 portion), and 62% of the IFX group developed anti-IFX antibodies. Autoimmune symptoms/disorders were uncommon, occuring in ≤ 1.3% in each group through Day 365 (ABA group: 2 cases [vasculitis]; IFX group: 1 case [Sicca syndrome]; PBO group (Day 1–197): 1 case [leukocytoclastic vasculitis]). One additional case of keratoconjunctivitis sicca was reported in a patient who switched from PBO to ABA after Day 197.

n (%*)	Day 1–197			Day 1–365	
	ABA† (N = 156)	PBO† (N = 110)	IFX† (N = 165)	ABA† (N = 147)	IFX† (N = 152)
ANA seropositive	2 (1.7)	4 (4.9)	38 (32.2)	7 (6.5)	51 (47.7)
Anti-DNA seropositive	1 (0.8)	4 (4.3)	51 (38.6)	3 (2.4)	61 (47.7)

*% of patients who were negative at baseline, and seroconverted;†+MTX.
Conclusion: Through 1 year, the profile of ANA and anti-DNA antibody seropositivity was markedly different in IFX- *vs* ABA-treated pts, although this did not translate into an increase in autoimmune diseases in either group. Similarly, the immunogenicity profiles appear to be different for the 2 agents, although differences in assay type/sensitivity prevent a direct comparison. These data demonstrate that ABA and IFX (3 mg/kg every 8 wks) exhibit dramatically different characteristics in their propensity to elicit autoantibody seroconversion and immunogenicity.
RA other biologic treatment
Citation: Ann Rheum Dis 2007;66(Suppl II):437

28. [2007] [SAT0001] TOCILIZUMAB, A NOVEL MONOCLONAL ANTIBODY TARGETING IL-6 SIGNALLING, SIGNIFICANTLY IMPROVES QUALITY OF LIFE IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Background: Blockade of IL-6 signalling with tocilizumab, a new humanized anti-human interleukin-6 (IL-6) receptor monoclonal antibody, has shown promising results in reducing disease activity in rheumatoid arthritis (RA). **Objectives:** To investigate the influence of tocilizumab on health-related quality of life (HRQOL) and physical function

in patients with RA. **Methods:** In a randomized, parallel-group, double-blind, placebo-controlled trial, 623 patients with moderate to severe RA and inadequate response to methotrexate (MTX) were randomly allocated to 3 groups to receive tocilizumab 8 mg/kg, tocilizumab 4 mg/kg, or placebo i.v. every 4 weeks. Throughout the study, all groups received concomitant MTX (oral or parenteral) at their pre-study dose (10-25 mg weekly), with all other disease modifying anti-rheumatic drugs discontinued at study entry. Outcome measures including Health Assessment Questionnaire (HAQ) and Functional Assessment of Chronic Illness Therapy-Fatigue scale (FACIT-Fatigue) were performed every 4 weeks and Short Form 36 Health Survey (SF-36) was assessed at baseline, weeks 8, 16, and 24. **Results:** A significant improvement from baseline in HAQ was observed for patients treated with tocilizumab *vs* placebo at week 24 (baseline: tocilizumab 8 mg/kg 1.55; 4 mg/kg 1.64; placebo 1.55, see *Table*). At week 24, significant improvements in SF-36 were also observed in both tocilizumab groups *vs* placebo in the physical component score (baseline: tocilizumab 8 mg/kg 32.10; 4 mg/kg 31.53; placebo 32.29, see *Table*) and in the mental component score (baseline: tocilizumab 8 mg/kg 40.82; 4 mg/kg 40.13; placebo 39.08, see *Table*). FACIT-Fatigue scores at week 24 also showed a significant improvement in the tocilizumab 8 and 4 mg/kg treatment groups compared to placebo (baseline: tocilizumab 8 mg/kg 27.7; 4 mg/kg 27.0; placebo 26.7, see *Table*). In addition, change from baseline scores for tocilizumab was well above generally accepted thresholds for minimal clinically important difference (MCID) for these measures.

Table I.

Assessment	Tocilizumab 8 mg/kg	Tocilizumab 4 mg/kg	Placebo
HAQ score	-0.55, p = 0.0082	-0.52, p = 0.026	-0.34
SF-36 score (physical component)	9.5, p < 0.0001	9.7, p < 0.0001	5.0
SF-36 score (mental component)	7.3, p = 0.0012	5.7, p = 0.0394	2.7
FACIT-Fatigue score	8.60, p < 0.0001	7.29, p = 0.0063	4.01

Values are change from baseline at 24 weeks with all comparisons to placebo.
Conclusion: Tocilizumab showed statistically significant and clinically meaningful improvement in HRQOL and physical function in patients with rheumatoid arthritis. The results of this study demonstrate that targeted blockade of IL-6 signalling is a very promising approach to RA treatment.
RA other biologic treatment
Citation: Ann Rheum Dis 2007;66(Suppl II):428

29. [2007] [SAT0292] THE DIVA STUDY LONG-TERM EXTENSION: MAINTAINED EFFICACY WITH QUARTERLY INTRAVENOUS IBANDRONATE INJECTION

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Background: Oral bisphosphonates are standard treatment for postmenopausal osteoporosis but may be inappropriate for some patients due to gastrointestinal intolerance, oesophageal abnormalities or difficulty complying with dosing procedures. For these patients, an effective intravenous (i.v.) bisphosphonate is an attractive option. The randomized, double-blind phase III DIVA trial (n = 1,395),[1,2] showed that 2- or 3-monthly i.v. ibandronate injections (2 mg or 3 mg, respectively) were at least as effective as the established daily oral regimen (2.5 mg, with proven antifracture efficacy, 62% vertebral fracture risk reduction.[3] From per-protocol analyses, after 2 years of treatment, lumbar spine bone mineral density (BMD) increased by 6.4% and 6.3% in the 2- and 3-monthly i.v. groups, respectively, compared with 4.8% in the oral group ($p < 0.001$).[2] Total hip BMD increases were also significantly greater with the i.v. regimens compared with daily ($p < 0.001$). Serum concentrations of the bone resorption marker, CTX, were reduced from baseline by a similar extent in all groups (53.4-59.9%).[2] Measures of BMD and bone turnover allow some assessment of bone strength and hence indicate potential fracture resistance. An open-label long-term extension (LTE) study is now being conducted to determine the long-term efficacy and safety of i.v. ibandronate injections. **Methods:** Eligible patients in the DIVA study who enrolled into the LTE continued to receive i.v. ibandronate at their previous dose and regimen for a further 3 years. Eligible patients receiving daily oral ibandronate were re-randomized to i.v. treatment. **Results:** ITT population data from the first year of the DIVA study LTE are presented here. After 1 year of extension, patients receiving both 2- and 3-monthly i.v. ibandronate had further gains in lumbar spine and total hip BMD in addition to the gains shown after 2 years in DIVA. For patients in the 2-monthly arm (n = 365), mean lumbar spine BMD increased by a further 0.92% and total hip BMD by a further 0.48%. In the 3-monthly arm (n = 393), mean lumbar spine BMD increased by a further 0.95% and total hip BMD by a further 0.13%. The substantial reductions in serum CTX seen after 2 years in DIVA were maintained during the first year of the DIVA study LTE. Median peak serum CTX (month 6) decreased by 81.7% (2-monthly arm) and 85.7% (3-monthly arm), relative to the LTE study baseline, and median trough serum CTX (month 12) increased by 18.3% (2-monthly arm) and 9.8% (3-monthly arm). I.v. ibandronate continued to be well tolerated, with the pattern of adverse events similar to that seen in the 2 years of DIVA and with no evidence for late or cumulative toxicity. Treatment-related adverse events occurred in 20% (2-monthly) and 16% of patients (3-monthly). Only two serious adverse events were deemed treatment-related and only nine patients (all 2-monthly; 2.4%) withdrew due to adverse events. **Conclusion:** These data demonstrate the long-term safety and efficacy of quarterly i.v. ibandronate injections in terms of further gains in BMD and maintained reductions in serum CTX. **References:** 1. Delmas PD, et al. *Arthritis Rheum* 2006; 54: 1838-46. 2. Emkey R, et al. *Arthritis Rheum* 2005; 52: 4060 (Abst L8). 3. Chesnut CH, et al. *J Bone Miner Res* 2004; 19: 1241-9.
Osteoporosis
Citation: Ann Rheum Dis 2007;66(Suppl II):519

30. [2007] [THU0038] THE C/G HIND III PAI-1 POLYMORPHISM IS ASSOCIATED WITH PLASMA PAI-1 LEVELS IN RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) is an autoimmune, inflammatory and chronic disease of unknown etiology that mainly affect the diarthrodial joints.[1] The plasminogen activator inhibitor type 1 (PAI-1) regulates the plasminogen activation to plasmin. The plasmin degrades directly cartilage and bone matrix proteins or indirectly through the activation of matrix metalloproteinases (MMPs).[2] The Hind III PAI-1 gene polymorphism is associated with changes in the plasmatic levels of the PAI-1 protein.[3] Therefore PAI-1 can be indirectly involved in the degradation of cartilage and bone in RA. **Objectives:** The aim of this study was identify the Hind III PAI-1 gene polymorphism and the plasma PAI-1 levels in RA patients. **Methods:** Fifty RA patients and 50 healthy subjects (HS) were included as a control group. Genotypes were identified by the PCR-RFLP technique with the Hind III restriction enzyme. The PAI-1 protein was quantified using ELISA kit. Haematological parameters were realized by conventional methods. Indexes of activity and disability (DAS28 and Spanish HAQ-DI, respectively) were applied to the RA patients. Statistical analysis was performed using SPSS version 10.0 and STATGRAPHICS version 4.0. **Results:** DAS28 and Spanish HAQ-DI indexes demonstrated the disease activity and functional disability in RA patients. Elevated levels of erythrocyte sedimentation rate (ESR), C-reactive protein (CRP), fibrinogen, rheumatoid factor (RF), white blood cells (WBC) and platelet count (PLT) reflected the inflammatory process in RA ($p < 0.05$ *vs* HS). Our population was in Hardy-Weinberg equilibrium for the Hind III PAI-1 gene polymorphism. Genotype frequency for C/C, C/G and G/G in RA patients was 46%, 44% and 10% whereas in HS was 50%, 44% and 6%. Frequency for C allele in RA and HS was 68% and 72% whereas for G allele was 32% and 28%. The RA patients showed lower plasmatic levels of PAI-1 protein than HS (18.9 ± 12.9 *vs* 23.7 ± 23.4 ng/ml, respectively; NS). In addition, the carriers of C/G genotype in RA patients showed an increase of the PAI-1 protein (23.0 ± 13.8 ng/ml) respect to C/C and G/G genotype carriers (16.8 ± 11.9 and 10.5 ± 7.1 ng/ml, respectively) ($p < 0.05$). **Conclusion:** The C/G genotype is associated with an increase in the plasma PAI-1 levels in RA patients. However, not significant differences in genotype and allele frequencies between groups, were found. **References:** 1. Firestein GS. *Nature* 2003; 423(6937): 356-361. 2. Judex MO, et al. *Am J Pathol* 2005; 166(3): 645-7. 3. Dawson S, et al. *Arterioscler Thromb* 1991; 11(1): 183-190.
Genomics, genetic basis of disease and HLA/T cell recognition
Citation: Ann Rheum Dis 2007;66(Suppl II):137

31. [2007] [FRI0290] PREVALENCE AND FACTORS ASSOCIATED WITH CERVICAL HUMAN PAPILLOMAVIRUS INFECTION IN RHEUMATOID ARTHRITIS

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Background: Many patients with rheumatoid arthritis (RA) are treated with immunosuppressive drugs or anti-TNF therapy resulting in impairment in the response to viral infection. Although, human papillomavirus (HPV) is the main infection associated with cervical cancer, there is no information about the frequency of this infection in women with RA. **Objectives:** To evaluate the prevalence and factors associated with cervical HPV infection in women with RA. **Methods:** In a cross-sectional study, we included 250 Mexican women who were sent to cervical cytology. Sixty-one of them had RA according to the ACR criteria, these patients were compared with 189 healthy women. After obtaining an informed consent, all the patients were interviewed about socio-demographical, sexual behavior characteristics and other risk factors for sexually transmitted diseases. The cervical cytology was performed by the same researcher. All women were tested for HPV DNA using polymerase chain reaction (PCR) with specific primers in order to identify the types of HPV. The statistical analysis included a comparison in prevalence of infection between in groups. For patients with RA a logistic regression analysis was performed in order to evaluate factors associated with the presence of infection, adjusted odds ratios (OR) and their 95% confidence intervals (95%CI) were also computed. **Results:** From 61 women with RA, 18 (30%) had infection by HPV. This prevalence did not differ of the observed in controls (34%, p = 0.5). In RA, 94% of the patients had the types of virus 16, 58 and 18. All of these types are related with high risk for the development of cervical cancer. After, an adjusted analysis the main risk factors for HPV infection were to have 2 or more sexual partners (OR = 5.8, IC95% 1.1 to 31.1, p = 0.04), to perform 2 or more intercourses per week (OR=6.7, IC95% 0.9 a 51.6, p=0.06), and to have a male partner with circumcision (OR=9.0, IC95% 1.2 a 64.4, p = 0.02). **Conclusion:** There is a high prevalence of HPV infection in women with rheumatoid arthritis. Most of the infections are produced by the types of virus considered as «high risk» for cervical cancer. This issue needs to be considered in those patients who are users of drugs that decrease the immune response to this virus may facilitate the development of cervical cancer. Funding: FOFOI-IMSS FP2003/095 and Pfizer Scientific Institute.

RA other clinical aspects and comorbidity

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32. [2007] [FRI0203] RELATIONSHIP BETWEEN LEPTIN AND OTHER PROINFLAMMATORY CYTOKINES ON THE COURSE AND DISEASE ACTIVITY OF RHEUMATOID ARTHRITIS

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Background: Leptin is a polypeptide hormone derived from adypocytes that plays a key role in maintaining an adequate balance in the consumption and expenditure of energy. There is evidence that shows that Leptin also participates in the regulation and activation of cells of the innate and adaptive immune response during inflammatory processes. **Objectives:** To evaluate the difference that exist between levels of serum Leptin in patients with Rheumatoid Arthritis (RA) and controls, between early and established RA and its relationship with disease activity as well as to determine the relationship with other proinflammatory cytokines. **Methods:** Patients with RA (ACR 1987) were included, excluding those with incomplete files. Disease activity was measured using DAS28. Erythrosedimentation rate (Westerngren) was measured as well as serum Leptin, tumor necrosis factor (TNF-a), interleukin 1beta (IL-1b) and interferon gamma; (IFN-g) using indirect ELISA. Control serum was obtained from the local blood bank. Body Mass index (BMI) was calculated in both patients and controls. Early RA was defined as disease with a course of less than 2 years. Correlations were calculated using Spearman's rho; and the Mann Whitney U test was used for differences between groups. **Results:** Of 63 patients with RA, 57 were included (only one was male), 24 (42% with early RA. 98% received 10 mg or less of prednisone/day and 75% were treated with 10 mg/week or more of methotrexate. Control sera were obtained from 50 healthy blood donors (41 men, 9 women). There were no differences in BMI between groups but the patient group was significantly older. Leptin concentrations were higher in patients than controls ($p < 0.005$), and higher levels correlated positively with a longer disease course (rho 0.201) as well as a higher DAS28 (rho 0.030). TNFa levels were significantly higher in patients while no differences were observed for IFN-g and IL-1b. Serum Leptin levels were independent of BMI with no differences between patients and controls (28 ± 2.3 *vs* 29 ± 2.5 kg/cm^2, respectively). Though TNF-a levels remained stable in established RA, Leptin levels were higher in longer disease courses. Higher Leptin levels also correlated to higher concentrations of IL-1b and IFN-g. **Conclusion:** RA patients have significantly higher Leptin levels than controls and this is more evident in established disease than in early disease. Higher levels of Leptin also significantly correlate to a higher DAS28 in RA. Leptin behaves as a proinflammatory cytokine and its levels in RA patients keep climbing when other cytokines (eg. TBNF-a) have reached a stable level, which suggests a possible role in maintaining inflammatory activity in the long term.

RA epidemiology, prognosis and predictors

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33. [2007] [THU0037] A BRIDGE BETWEEN FAMILIAL MEDITERRANEAN FEVER AND SOME DISEASES

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Background: Familial Mediterranean Fever (FMF) - autosomal recessive disorder of inflammation in people of Mediterranean ancestry. FMF starts mostly in childhood, is characterized by recurrent attacks of fever, cerrosal membranes.[1,2] The frequent association of FMF with other disorders is remarkable and of great interest.[3,5-7] **Objectives:** The detection of risk factors for the development of FMF, the determination of noteworthy connections between FMF and other diseases, considering the family trees of FMF patients. **Methods:** The family trees were built using follow up data of 383 FMF patients (138 girls, 245 boys) in «Arabkir» Center. Patients' age varied from 6 months up to 18 years. Control group (CG) consisted from 169 practically healthy children from school #145 in Yerevan. **Results:** The analysis of all data from the genetic trees revealed the following: hiatus-50.2% (CG-28.3%); thyroid diseases-45.3% (CG-16,0%); diabetes mellitus-42.0% (CG-22.0%) primarily the second type of diabetes mellitus; cancers-35.5%, (CG-27.0%); bronchial asthma-27.0% (CG-14.0%); rheumatic diseases-25.0% (CG-10.0%); epilepsy-18.6% (CG-0.2%); stomach ulcer-18.0% (CG-13%); blepharitis-16.0% (CG-6.8%).All statistical data are exact, $p < 0.001$. **Conclusion:** There are a variety of disorders in family threes of FMF patients. From the data above we can assume that in the family trees of FMF patients prevail diseases affecting those organs, which in general have mesenchimal origins, and are rich with connective tissue. Also, the above mentioned diseases are considered to be polygenic disorders.[4,8] Therefore, it is possible that the inheritance and the development of these diseases takes place during morphogenesis as a result of damages of some cells of mesenchyma. The activation and repression of different types of genes of fetus leads to morphological and chemical changes within the same genomic cells. The commonality of FMF and above mentioned diseases is of histological origin. The development and manifestation of these diseases is stipulated by relationship of the genes, signal transduction, environmental factors, and pathological development of the connective tissue during the morphogenesis on the first place. Thus we conclude that all of these diseases contribute to the development of FMF, and are possible risk factors to take into account. **References:** 1. El-Shanti H, Majeed H, El-Khateeb Mohammed. Familial Mediterranean Fever in Arabs. *Lancet* 2006; 367: 1016-1024. 2. Padeh S. Periodic Fever Syndromes. *Pediatr Clin North Am* 2005; 52: 577-609. 3. Ehrnfeld M, Prass M, Shoenfeld Y. *Is FMF an autoimmune disease or an immune mediated condition*. 1st International Conference, September 7-11, 1997, Jerusalem, Israel.-P. 267-274. 4. Panayiotopoulos CP. *The epilepsies: seizures, syndromes and management.* (based on the ILAE classifications and practice guidelines), 2005: 541. 5. Livneh A, Aksetijevich I, Langevitz P, et al. A single mutated MEFV allele in a Israeli patients suffering from FMF and Behcet's disease. *Eur. Journal Hum Genet* 2001; (9): 191-196. 6. Cattan D, Notarnicola C, et al. Inflammatory bowel disease in non Askenazi Jews with FMF. *Lancet* 2000; 355: 378-379. 7. Tansu C, Ozbakis O, et al. Adrenal axis functions in patients with FMF. *Clinical Rheumatology* 2006; 25(4): 458-461. 8. Tusie-Luna MT. Departamento de Medicina, Universidad Nacional Autonoma de Mexico. Genetics of type 2 diabetes mellitus. *Rev Invest Clin* 2000; 52(3): 296-305.

Genomics, genetic basis of disease and HLA/T cell recognition

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34. [2007] [OP0118] EFFICACY OF ABATACEPT OR INFLIXIMAB TREATMENT IN RHEUMATOID ARTHRITIS PATIENTS WITH AN INADEQUATE RESPONSE TO METHOTREXATE: RESULTS FROM A 1-YEAR DOUBLE-BLIND, RANDOMIZED, PLACEBO-CONTROLLED TRIAL

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Background: This multicenter, double-blind (DB) trial in patients (pts) with active RA was designed to investigate the magnitude of the treatment effect of abatacept (ABA) or infliximab (IFX) *vs* placebo (PBO) at 6 months, and to assess the efficacy and safety of ABA and IFX at 1 year. Safety has been previously reported.[1] **Objectives:** To evaluate the efficacy of ABA and IFX by assessing disease activity and status (DAS28 [ESR] and EULAR criteria), physical function (Health Assessment Questionnaire [HAQ]) and quality of life (Short Form [SF]-36). **Methods:** RA pts with an inadequate response to MTX and no prior anti-TNF therapy were randomized to receive ABA (~10 mg/kg every 4 wks), IFX (3 mg/kg every 8 wks), or PBO (every 4 wks) following standard loading dose protocols and using a double-dummy technique, plus MTX. LDAS (DAS28 [ESR] $\leq$ 3.2), remission (DAS28 [ESR] < 2.6), EULAR response criteria (good and moderate),[2] HAQ responders

(≥ 0.3 unit improvement) and SF-36 scores were assessed. Statistical testing was performed on the efficacy measures comparing ABA and IFX with PBO at Day 197. The difference between ABA and IFX was summarized using 95% CIs at Day 365. **Results:** 156, 165 and 110 pts were randomized and treated with ABA, PBO and IFX, respectively. Pt demographics and clinical characteristics were similar across groups, with mean scores of ~1.7 for HAQ and 6.8 for DAS28 (ESR). At Day 197, all efficacy scores were higher with ABA vs PBO and IFX *vs* PBO *(Table)*. Mean changes in PCS and MCS were also greater with ABA *vs* PBO (8.4 *vs* 4.3, p < 0.001; 5.1 *vs* 1.6, p = 0.004) and IFX *vs* PBO (7.7 *vs* 4.3, p = 0.002; 4.3 *vs* 1.6, p = 0.027). At Day 365, LDAS (35.3 *vs* 22.4%, [difference of 12.9%, 95% CI = 2.1, 23.7]), remission (18.7 *vs* 12.2%, [difference of 6.5%, 95% CI = -2.2, 15.2]), mean change in PCS (9.5 *vs* 7.6 [difference of 1.93, 95% CI = 0.02, 3.84]) and MCS (6.0 *vs* 4.0 [difference of 1.92, 95% CI = -0.30, 4.15]), and HAQ responders (57.7 *vs* 52.7% [difference of 5.0%, 95% CI = -6.5, 16.5]) were higher with ABA *vs* IFX.

DAS28 (ESR)/ EULAR response	ABA*† (N = 156) n (%)	PBO*† (N = 110) n (%)	IFX*† (N = 165) n (%)	ABA*‡ (N = 156) n (%)	IFX*‡ (N = 165) n (%)
n	150	102	156	150	156
DAS28 ≤ 3.2 (LDAS)	31 (20.7)	11 (10.8)	40 (25.6)	53 (35.3)	35 (22.4)
DAS28 < 2.6 (remission)	17 (11.3)	3 (2.9)	20 (12.8)	28 (18.7)	19 (12.2)
Good EULAR response	30 (20.0)	11 (10.8)	36 (22.9)§	48 (32.0)	29 (18.5)§
Moderate EULAR response	85 (56.7)	45 (44.1)	67 (42.7)§	61 (40.7)	71 (45.2)§
HAQ responders	96 (61.5)**	45 (40.9)	97 (58.8)††	90 (57.7)	87 (52.7)

*+ MTX; †Day 197; ‡Day 365; §n = 157; **p = 0.001 vs PBO; ††p = 0.005 *vs* PBO. **Conclusion:** At Day 197, clinical benefits were similar with either ABA or IFX. At Day 365, the differences in mean scores/responders for the evaluated clinical efficacy measures were better for ABA than IFX. These data suggest that ABA exhibits a more durable response than IFX (3 mg/kg every 8 wks) through 1 year. **References:** 1. Schiff M, et al. *Arthritis Rheum* 2006; 54(Suppl 9): L43. 2. Fransen J, et al. *Clin Exp Rheumatol* 2005; 23(Suppl 39): 93-9.
Abstract Session: New biologics an update
Citation: Ann Rheum Dis 2007;66(Suppl II):88

35. [2007] [THU0236] RITUXIMAB, ALTERNATIVE TREATMENT IN REFRACTORY IDIOPATHIC INFLAMMATORY MYOPATHIES

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Background: Several studies have indicated a prominent role of steroids in the treatment of inflammatory myophaties (polymyositis and dermatomyositis). Nevertheless as in other autoimmune disorders, immune suppressor drugs have been used for no-steroid responders, but even more, there are patients non-responders to both drugs, and adverse event (AE) are frequently present. Blocking CD 20 (Rituximab) has been shown to effectively block in other autoimmune disorders with rapid and sustained clinical improvement. **Objectives:** To assess the safety profile and efficacy of rituximab in patients with polymyositis (PM) and dermatomyositis (DM) non-responders to conventional treatment. **Methods:** Mexican mestize patients with onset DM or PM according to the diagnostic criteria of Peter and Bohan, were enrolled in our clinic. All patients had been treated with corticosteroids and immune suppressive drugs prior to inclusion, defined as non-responder due to persisting clinical activity despite to the treatment. Rituximab was used in the fourth patients as an alternative therapy. Clinical variables and primary endpoint were reported (6 months), including: functional status (FS) I-IV, proximal muscular strength (PMS) and serum creatinkinase (CK). **Results:** Four patients have been registered, 3 females, mean age 35.7 years and mean duration of disease 6.9 yrs (range 3mon-16 yrs). Rituximab was administered i.v. 2 g as total dose in two periods of time (Primary and secondary infusion 15 days after). Clinical response was seen in all patients *(Table I)*. Non-serious adverse events were registered, but only one patient complaint of nausea during primary infusion.

Table I.

Patient	Basal PMS	Basal FS	Basal CK u/L	Endpoit PMS	Endpoit FS	Endpoit CK u/l
1	3/5	III	4,960	5/5	I	200
2	3/5	II	858	4/5	I	350
3	3/5	III	1,187	4/5	II	879
4	2/5	IV	492	4/5	II	1,567

Clinical response at 6 months endpoint.
Conclusion: Rituximab treatment does appear to have short term clinical benefit in patients with PM or DM non-responders to conventional treatment. The small number of patients in this study does not permit for conclusions about possible long-term efficacy of Rituximab in these patients. Safety profile of rituximab in PM-DM is similar to reported by others autoimmune diseases.
Scleroderma, myositis and related syndromes
Citation: Ann Rheum Dis 2007;66(Suppl II):199

Reseña del Tercer Encuentro Regional de la Correspondencia Noreste, en Cuatro Ciénagas, Coahuila

Durante el mes de marzo del presente se llevó a cabo el Tercer Encuentro Regional de la Correspondencia Noreste, teniendo como marco uno de los lugares considerado como reserva ecológica de nuestro país: Cuatro Ciénagas.

La llegada al lugar fue el día 23 de marzo por la noche, y debido a los efectos de la naturaleza la recepción se llevó a cabo a la luz de las velas, en una noche.

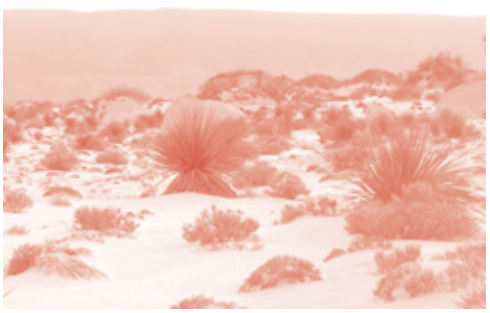
El 24 de marzo se inició formalmente el evento, y la Dra. Cassandra Skinner, Presidenta actual de la Correspondencia Noreste, dio una detallada introducción sobre el programa académico y algunos datos importantes del lugar sede. Posteriormente, el Dr. Rafael Herrera Esparza compartió importantes conocimientos sobre los aspectos comunes entre la antropología y la reumatología. Como parte cultural del evento, la Dra. Iris Colunga Pedraza impartió una interesante conferencia sobre Impresionismo. A continuación, el Dr. Juan Carlos Pozos y la Dra. Ángela Vicente presentaron el Programa *Progresar*, estableciéndose un compromiso entre ellos y los reumatólogos asistentes. La Dra. Skinner ilustró ampliamente sobre la Enfermedad de Lyme, un padecimiento reumático al cual se le ha prestado poca atención.

Ese mismo día, por la tarde, se hizo un recorrido turístico para conocer un poco más del bellísimo lugar. Entre las principales áreas que se visitaron se encuentran las Dunas de yeso, el Museo de mármol y la Poza azul. A la mañana siguiente, el Dr. Medina habló sobre la importante relación que existe entre las infecciones y enfermedades reumáticas, generando un amplio interés entre los asistentes, sobre todo al hablar del tan controvertido tema de la Tuberculosis y las novedosas terapias biológicas; en seguida, el Dr. Manuel Robles señaló las recomendaciones europeas vigentes con respecto al tratamiento de la artritis reumatoide temprana.

La Dra. Diana Flores participó con interesantes conceptos actuales sobre las Espondiloartropatías. Finalmente, se procedió a la entrega de reconocimientos a los asistentes, ofreciéndose, durante el acto de clausura, un especial agradecimiento a los Laboratorios Abbott por su gentil patrocinio.

El encuentro resultó muy exitoso en todos los aspectos con la complacencia de los asistentes.

Tercer Encuentro Regional de la Correspondencia Noreste, Cuatro Ciénagas, Coahuila



Cuatro Ciénagas, Coah. Sede del evento

Museo de Mármol

Dunas de Yeso

Dra. Ávalos. Dra. Ma. Luisa y Dr. Herrera

Asistentes al Tercer Encuentro Regional de la Correspondencia Noreste

Madrid/México, 03 de julio de 2007

Querido compañero:

Nos ponemos en contacto contigo para solicitar tu colaboración en la realización de un nuevo **«Documento de Consenso para el Uso de AINEs en Reumatología».**

La Sociedad Española de Reumatología y el Colegio Mexicano de Reumatología, con el fin de fomentar el estudio de las enfermedades reumáticas y atender los problemas relacionados con la especialidad, han considerado necesario y relevante unificar y actualizar la práctica clínica en relación con el uso de AINEs para disminuir la variabilidad existente, debida en gran parte a la rapidez de las innovaciones que se producen en ese campo.

Para elaborar este nuevo documento de consenso se está utilizando la siguiente metodología:

- En primer lugar se ha constituido un grupo de reumatólogos de ambos países, con experiencia y publicaciones previas en relación con el uso de AINEs, que ha elaborado una serie de recomendaciones.
- Estas recomendaciones, reformuladas como ítems, estarán disponibles en la web a modo de encuesta para que sean respondidas por todos los reumatólogos interesados en el tema.
- La Unidad de Investigación de la SER analizará los resultados de la encuesta, detectando los puntos en los que existan desacuerdos, opiniones contradictorias o confusión.
- En función de estos resultados se hará una revisión sistemática de la evidencia existente sobre los puntos conflictivos.
- Finalmente, el grupo de reumatólogos elaborará las recomendaciones finales del documento de consenso, que incluirán el grado de acuerdo obtenido en el delphi para cada recomendación y la evidencia que apoya a cada una de ellas según las revisiones.

Necesitamos **tu colaboración** completando la encuesta, **es muy importante**, ya que podrás puntuar tu grado de acuerdo con las recomendaciones propuestas, y de este modo contribuir a detectar los puntos sobre los que aún existen opiniones discrepantes o dudosas. De ese modo se podrán realizar revisiones sistemáticas de la evidencia sobre esos temas y mejorar nuestros conocimientos. Nuestro propósito es que el documento final de consenso resulte útil en la práctica clínica habitual.

El formulario de la encuesta lo encontrarás disponible en www.ser.es\aines desde el día 3 de julio hasta el 20 de agosto de 2007.

Si deseas tener más información sobre este estudio, puedes ponerte en contacto con la Unidad de Investigación de la SER, Milena Gobbo (milena@ser.es).

Esperando poder contar con tu colaboración, recibe un afectuoso saludo.

Joseph Blanch i Rubió
Presidente
Sociedad Española de Reumatología

Manuel Robles San Román
Presidente
Colegio Mexicano de Reumatología