Introduction

Second Mexican-Canadian Congress of Rheumatology
Cancun, Mexico, February 10–15, 2011

The Mexican College of Rheumatology and The Canadian Rheumatology Association held the 2nd Mexican-Canadian Congress of Rheumatology, the XXXIX Mexican Congress of Rheumatology and the 66th Annual Meeting of the Canadian Rheumatology Association, in Cancun, Quintana Roo, Mexico, from February 11 to 15, 2011. In this event we had the opportunity to analyze and discuss over 400 research papers from both countries, which were presented in plenary sessions, poster tours and posters, focusing on topics such as rheumatoid arthritis, systemic lupus erythematosus, systemic sclerosis, antiphospholipid syndrome, spondyloarthropathies, and rheumatic diseases in children, among others.

We had the participation of experts from Mexico, Canada, and other countries, who approached avant-garde topics in rheumatology, both clinical and basic keynote sessions, symposia, and pearls in rheumatology.

We were also honored with the presence of Dr. David G. Borenstein, president of the American College of Rheumatology, Dr. Antonio Ximenes, President of the Pan-American League Against Rheumatism (PANLAR), and Latin American rheumatologists who have been awarded the distinction of Master of the American College of Rheumatology.

This 2nd Mexican-Canadian Congress has strengthened our education and investigation bonds for the benefit of our patients, as well as the friendship ties between our 2 countries. We are proud to publish a selection of the best abstracts of this memorable meeting in The Journal of Rheumatology.

OLGA LIDIA VERA LASTRA, MD
President,
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The Canadian Rheumatology Association was very happy to participate in the 2nd Mexican-Canadian Congress of Rheumatology in February 2011. Members from both countries contributed to the excellent scientific content of the meeting and successfully covered a wide spectrum of rheumatology topics.

Graciously hosted by the Mexican College of Rheumatology in Cancun, the meeting was a great success. It was an opportunity to renew acquaintances, continue friendships, and foster collaborations between the 2 countries. We are proud to publish the abstracts of this meeting in The Journal of Rheumatology.

JAMIE HENDERSON, MD, FRCP
President,
Canadian Rheumatology Association

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Podium
01
Description of Patterns of Active Joint Count Trajectories in Juvenile Idiopathic Arthritis
Robert Berard (Sick Kids, Toronto); George Tomlinson (Toronto General Research Institute, Toronto); Xiuying Li (University Health Network, Toronto); Kimberly Oen (Health Sciences Centre, Arthritis Centre, Winnipeg); Alan Rosenberg (Royal University Hospital, Saskatoon); Brian Feldman (The Hospital for Sick Children, University of Toronto, Toronto); Rae Yeung (Sick Kids, Toronto); Claire Bombardier (University Health Network, Toronto)
Objective: To describe the patterns of longitudinal disease activity (active joint count [tender and swollen joints]) in juvenile idiopathic arthritis (JIA) and to examine the association of clinical and laboratory characteristics with these patterns.
Methods: A prospective cohort study at two Canadian centres was performed. The longitudinal patterns of active joint counts were described using latent variable growth modeling analysis. This method is ideally suited to a population whereby the underlying hypothesis is that the population is comprised of (unobserved) subpopulations. Latent variable growth modeling aims to classify individuals into statistically distinct groups based on individual response patterns so that individuals within a group are more similar than individuals between groups. The trajectory classes are each defined by a longitudinal growth curve. The association of baseline characteristics with class membership was examined using a multinomial logistic regression.
Results: Data were analyzed on 659 children diagnosed with JIA between 1990/03-2009/09. The median age at diagnosis was 10.00 (IQR 3.67–13.39), 61% (402/659) were female and 45% (286/629) were ANA positive. The distribution of the ILAR diagnoses were as follows: systemic (7%), oligoarthritis-persistent (34%), oligoarthritis-extended (6%), polyarthritis (RF negative) (15%), polyarthritis (RF positive) (4%), psoriatic arthritis (8%), enthesitis-related arthritis (22%) and undifferentiated (4%). A maximum of 10 years of follow-up data was included in the longitudinal analysis. The 659 patients were classified into 5 statistically different patterns of longitudinal active joint count (AJC) profiles using growth mixture modeling. 44% of patients were in group 1 characterized by a low initial AJC (mean 0.9) following by a decrease in joint count, 18% in group 2 — minimal to no active joint disease throughout course (mean 0.3), 19% in group 3 — persistent low AJC (mean 2.8), 10% in group 4 — initial mean AJC 4.9 followed by an increase in AJC at 5 years (mean 9.7) and finally 10% in group 5 characterized by an initial mild polyarthritis (mean 12.7) followed by a decline in AJC.
Conclusion: Using a novel longitudinal statistical method we were able to classify patients with JIA based on their pattern of active joint count over time. These results need to be interpreted in light of clinical significance. Examination of the association of baseline characteristics with each trajectory is ongoing. Identification of patterns of disease course is important in working towards the development of an outcome-based classification system in JIA.
02 Application of High-Resolution Peripheral Quantitative Computed Tomography (HR-pQCT) To Diagnose and Quantify Bony Damage in Rheumatoid Arthritis
Cynthia Barnabe (University of Calgary, Calgary); Lian Martin (University of Calgary, Calgary); Steven Boyd (University of Calgary, Calgary); Susan Barr (University of Calgary, Calgary)
Objective: (1) Determine the performance of high-resolution peripheral quantitative computed tomography (HR-pQCT) (isotropic voxel size of 82 µm) in the diagnosis of RA. (2) Provide quantitative assessment of joint space narrowing, erosions and peri-articular morphometric indices.
Methods: PIP and MCP joints of the dominant hand of 15 patients with established RA and their age- and sex-matched control patients were imaged by HR-pQCT (XtremeCT; Scanco Medical, Switzerland). Various models of erosion number and location were tested to determine the optimal diagnostic test performance for HR-pQCT compared to the clinical diagnosis of RA. Quantitative measures of bony damage were calculated from 3D images of the joints, reconstructed by a semi-automated segmentation program that identifies bone mineral based on changes in the gray-scale. The minimum joint space width was calculated by counting the number of voxels between articular surfaces (Image Processing Language). Standard morphometric indices were calculated for a predetermined region of interest for the MCP joints. The number and location of erosions were assessed visually from the two-dimensional images. Reproducibility was assessed by recontouring and segmenting a random sample of images.
Results: The best test performance for the clinical diagnosis of RA was determination of an erosion in MCP2 (sensitivity 76.9%, specificity 93.3%, ROC area 0.851, positive likelihood ratio 11.5 (95%CI 1.7–78.4)). Reproducibility was good for bone density parameters (all root mean square coefficients of variance < 1%), but less so for joint space measurements (17%), perhaps related to difficulties in contouring angulated joints. Joint space narrowing was detected in the MCP joints of RA patients compared to controls (relative difference for the 2nd MCP 131 µm; 3rd MCP 262 µm; 4th MCP 106 µm; 5th MCP 145 µm). There were no significant differences in morphometric indices between patients and controls. The majority of RA erosions occurred at the proximal bone surface, with a mean of 23.6 erosions over the 10 joints. Erosions were detected in some controls, mainly in the IP and PIP joints.
Conclusion: In this pilot study, HR-pQCT demonstrated good performance characteristics for RA diagnosis. Methods to provide quantitative measures of bony damage in established RA have been developed. Differences in joint space width are most pronounced at the MCP joints. A larger sample size may reveal detectable differences in morphometric indices between subjects with active inflammatory arthritis and those without. Erosions at MCP2 are highly specific for RA, but erosions were detected in controls unrelated to clinical disease.
03 Disease-free First-degree Relatives of RA Patients have a Serum Cytokine Profile that is Intermediate Between their Affected Relatives and Controls having no Family History of Autoimmunity
Hani El-Gabalawy (University of Manitoba, Winnipeg); David Robinson (University of Manitoba, Winnipeg); Irene Smolik (University of Manitoba, RR149-800 Sherbrook St.); Donna Hart (University of Manitoba, Winnipeg); Brenda Elias (University of Manitoba, Winnipeg); Keng Wong (University of Manitoba, Winnipeg); Carol Hitchon (University of Manitoba, Winnipeg); Charles Bernstein (University of Manitoba, Winnipeg); Marvin Fritzler (University of Calgary, Calgary)
Objective: RA is prevalent in North American Native (NAN) populations, with a high frequency of multi-case families. We have studied the first-degree relatives (FDR) of NAN RA probands and prospectively followed this cohort for the earliest evidence of disease onset. Previous data from studies of pre-clinical RA cohorts suggest that RA autoantibodies and serum cytokines can predict the onset of clinical disease. Thus, we sought to determine whether serum cytokine profiles can predict disease onset in healthy individuals belonging to high risk NAN families.
Methods: We studied NAN RA patients (n=105), their disease-free FDR (n=123), healthy NAN (NC) (n=100) and Caucasian controls (CC) (n=100) with no family history of autoimmune disease. Rheumatoid factors (RF) and anti-citrullinated protein antibodies (ACPA) were assessed using nephelometry and ELISA. We used a cytokine/chemokine 42-plex array to test serum samples from FDRs and Controls having no Family History of Autoimmunity (n=123) and healthy controls (n=100). We normalized and differences between groups were analyzed using ANOVA. Discriminant analysis was used to classify individuals based on 2 canonical functions generated from the transformed cytokine data.

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Objective: The major histocompatibility complex chain-related gene A (MICA) is located 47kb centromeric to HLA-B. MICA alleles can be classified into high and low-affinity binders of the natural killer/T-cell receptor NKG2D, based on a functional polymorphism at amino acid 129 (Met/Val). Our aim was to determine whether the high affinity MICA-129 Met allele is increased in psoriatic arthritis patients compared to patients with psoriasis without arthritis and controls.

Methods: 248 unrelated Caucasian psoriatic arthritis patients, 250 psoriasis subjects without arthritis, and 249 healthy controls were allelic typed for MICA-129 Met/Val genotypes were assigned from allelic typing using DNA sequences available from the IMGT/HLA database (release 3.1.0). Univariate logistic regressions and chi squared tests were performed to determine the effect of MICA-129 genotype on group membership. Multivariate logistic regressions were also performed using the Val/Val genotype as the reference category, to adjust for the presence of HLA-B^*13, B^*27, B^*38, B^*57, C^*01, C^*02, C^*06, and C^*12.

Results: Univariate analyses showed that the presence of a Met allele significantly increased the risk of developing psoriatic disease (OR=1.6, p=1.5x10^-3), psoriasis without arthritis (OR=1.7, p=5.3x10^-3), and psoriatic arthritis (OR=1.6, p=7.7x10^-4). Multivariate analyses showed that after adjustment for significant HLA-B and C alleles, homozygosity for the Met allele (genotype Met/Met) significantly increased risk of psoriatic disease (OR=3.8, p=1.0x10^-4), psoriasis without arthritis (OR = 2.8, p= 6.1x10^-3), and psoriatic arthritis (OR = 2.4, p= 2.7x10^-4). Heterozygosity (Met/Val) did not affect risk. There were no significant differences in MICA genotypes between patients with psoriatic arthritis and psoriasis without arthritis.

Conclusion: Individuals with a high-affinity Met residue at MICA-129, particularly those who are homozygous for the Met allele (Met/Met), have an increased risk of developing psoriatic disease, psoriasis without arthritis, and psoriatic arthritis independently of the presence of HLA-B and C risk alleles.
physical function. There is no literature available on common predictors for these three important aspects, that is, disease activity score (DAS); physical function, which is health assessment questionnaire (HAQ) and radiographic damage (Sharp Score). The purpose of this study is to demonstrate the use of longitudinal trivariate model and address the issue of longitudinally relationship between DAS28, HAQ and Sharp score and identify the significant common predictors for three of them.

**Methods:** 994 Patients diagnosed as having new onset RA (symptoms ≥3 but ≤12 months) by a board-certified rheumatologist were recruited from 98 rheumatology practices. Clinical, laboratory, X-ray and health questionnaire data were collected by the enrolling rheumatologist at baseline, year 1 and year 2. A trivariate longitudinal model of DAS28, HAQ and Sharp score was constructed and estimated using pooled cross sections for two years period, adjusting the significant predictors from the univariate analysis at the same time allowing for the latent individual-level effect. Different covariance structures were tested for the assumptions among these three outcomes in the model.

**Results:** The mean age of patients was 53 years (SD, 14.8), with 72% female and 90% Caucasian. The mean RA symptom duration was 170 days (180). The DAS28, HAQ and Sharp score were 4.4(1.32), 1(0.73) and 5.01 (7.28) at baseline, 3.4(1.38), 0.82(0.71) and 6.19(8.73) at year 1, 3.2(1.34), 0.77(0.72) and 6.39(9.25) at year 2, respectively. Partial correlation adjusting for time point showed that DAS, HAQ and Sharp score are significantly correlated (all p-values < 0.001). The longitudinal trivariate model showed that only higher baseline DAS, HAQ or Sharp Score value (P< 0.0001), higher 28 swollen joint count (P<0.0001), longer disease duration (P=0.002) and lower house hold income (P=0.015) were significant predictors for these three combined outcomes.

**Conclusion:** This innovative method identified the significant common predictors for three outcomes which related to the different aspects of RA patients. This method can help us better understand the longitudinally complex relationship between different aspects from a broader view of the disease. These identified factors can help rheumatologists to identify the patients who are at greater risk of worse disease, physical function and radiographic damage and make treatment decisions for RA patients at the early stage.

**07 The Prevalence of Systemic Autoimmune Rheumatic Diseases in Canadian Pediatric Populations: Administrative Database Estimates**

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**Objective:** Administrative healthcare databases offer interesting possibilities for national disease surveillance in Canada. Our aim was to use provincial administrative data to estimate pediatric-onset systemic autoimmune rheumatic disease (SARD) prevalence in Quebec (1994–2003), Alberta (1994–2007), and Manitoba (1995 to 2009).

**Methods:** We studied all health care beneficiaries aged 18 or younger. Data included all physician billing claims, and hospitalizations where discharge diagnoses indicate a systemic autoimmune rheumatic disease. We used three definitions: the first algorithm defined a case of SARDs on the basis of a hospitalization indicating a discharge diagnosis (primary or non-primary) for any SARD (including systemic lupus, scleroderma, or inflammatory myopathies). The second algorithm, using billing data, required two or more physician visits for these SARDs. (The visits had to occur at least two months apart, but within a two-year span.) In the third algorithm, cases were defined on the basis of one or more relevant billing code contributed by a rheumatologist. A subject was included in our prevalence estimates if they met one or more of these three algorithms, and were aged < 18 as of the end of the study interval in each province. We stratified our results by sex, and using postal code information also stratified by urban residence (defined as a census metropolitan area) versus rural residence.

**Results:** Pooling the data across provinces, the pediatric SARDs prevalence estimate was 18.9 cases per 100,000 (95% confidence interval, CI, 17.4, 20.6). Stratifying by sex, the SARDs rate was, as expected, higher in females (26.7 cases per 100,000 95% CI 24.0, 29.6) than males (11.5 cases per 100,000, 95% CI 9.8, 13.4). We found similar rates in SARDs in residents of rural areas (17.0 cases per 100,000, 95% CI 14.6, 19.7) and urban areas (20.1 cases per 100,000, 95% CI 18.1, 22.4).

**Conclusion:** In our work, prevalence estimates had fairly good face validity and potentially provide useful information about potential regional and demographic variations. Our results suggest that surveillance of some rheumatic diseases using administrative data may indeed be feasible.

**08 Pathogenicity of Anti-Citrullinated Protein Antibodies (ACP A) from Unaffected First Degree Relatives (FDRs) of Rheumatoid Arthritis Patients in a Population of North American Natives (NAN)**

Lillian Barra (University of Western Ontario, London); Mathias Scinocca (The University of Western Ontario, London); Elizabeth Wilson (The University of Western Ontario, London); David Bell (University of Western Ontario, London); Ewa Cairns (The University of Western Ontario, London); Hani El-Gabalawy (University of Manitoba, Winnipeg)

**Objective:** The prevalence of RA in NAN is approximately twice that of Caucasian populations. NAN also have a higher frequency of the Shared Epitope (SE), which is a major risk factor for RA and associated with ACPA. The rate of ACPA-positivity in unaffected FDR of NAN is 17%, much higher than in Caucasians (2%). We have previously reported that ACPA from RA patients injected intra-peritoneally (ip) into FcγRIIB-deficient mice induced inflammatory arthritis (IA); whereas, ip injections of IgG devoid of ACPA from the same RA patients did not. The objective of this study is to determine whether transferring ACPA from unaffected siblings of NAN RA patients into FcγRIIB-deficient mice induces inflammatory arthritis.

**Methods:** Patients were self-reported NAN recruited from the University of Manitoba Arthritis Centre Clinics and community health clinics on reserves in Manitoba and Saskatchewan. All patients met ACR criteria for RA and were positive for anti-CCP2. FDRs were deemed unaffected after assessment by a rheumatologist. ACPA was affinity purified using a synthetic citrullinated peptide (JED) and administered ip to FcγRIIB-deficient mice. ACPA were measured by ELISA; Rheumatoid Factor (RF) by nephelometry.

**Results:** Serum was obtained from 5 FDRs. Anti-CCP titres ranged from 7.7 to 138.9 RU/ml (mean 42.7). 2/5 were positive for anti-JED and anti-Modified Citrullinated Vimentin, 5/5 for anti-citrullinated Fibrinogen and 3/5 for RF. Both anti-JED positive FDRs were females (ages 30 and 38), current smokers and positive for SE. During the course of the study, one of these FDRs developed RA. The other FDR remained unaffected despite very high titre of anti-JED. Ip transfer of serum and ACPA from the FDR recently diagnosed with RA induced IA; whereas this subject’s IgG devoid of ACPA did not ( ankle widths 0.40, 0.39, 0.0625 mm respectively; P=0.001, P=0.002). Interestingly, the serum and ACPA from the unaffected FDR also induced IA ( ankle widths 0.40 and 0.37 mm, respectively, vs. 0.005 mm in the IgG devoid of ACPA-injected mice; P=0.009, P=0.008).

**Conclusion:** Unaffected FDRs of RA patients of NAN ethnicity have a high prevalence of ACPA; although presence of anti-CCP2 does not necessarily correlate with positivity of other ACPA. Transfer of ACPA and sera from both affected and unaffected FDRs induced IA in a mouse model, suggesting a directly pathogenic role of ACPA in RA. Future work will involve recruiting more subjects and studying mechanisms by which unaffected ACPA-positive individuals develop RA.

**09 Pregnancy and Rheumatoid Arthritis (RA): Observations in a Fertile Population**

CRA Abstracts
First Nations Population at High Risk for RA Development
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Objective: Previous studies have suggested correlations between RA risk and pregnancy history. First Nations (FN) Canadians have a high risk of RA, develop disease at a younger age, and have a high birth rate. We compared the pregnancy history of FN RA patients and controls to Caucasian (Cau) RA patients and controls.

Methods: We examined pregnancy history and RA risk using results from females enrolled in a study of RA in FN RA patients (n=141) and their unaffected 1st degree relatives (n=197); and FN (n=46) and Cau (n=120) RA patients and healthy controls (FN=238; Cau=190) enrolled in a study of autoimmunity in FN populations. All participants were interviewed using identical questionnaires detailing reproductive history. RA patients with onset before menarche were excluded. Only those pregnancies occurring prior to the diagnosis of RA were included. Age was defined as age at RA onset for RA patients, and age at study enrolment for controls.

Results: RA patients (n=307) and controls (n=625) were overall similar in age, number of pregnancies and age at first pregnancy, but RA patients had a later age at menarche (13 vs. 12.7 years; p=0.002). Thirty-two percent of RA patients and 28% of controls were smokers. FN participants were younger (36 vs. 42 years; p <0.001), had a higher number of children (54% ≥4 births vs. 23%; p<0.001) a younger age at first birth (62% < age 20 vs. 13%; p<0.001), were more likely to smoke (49% vs. 21%), and had a similar age at menarche compared to Cau. In regression analysis, after adjusting for ethnicity, age, smoking status and education, odds of RA were less than half for women with ≥4 births compared to nulliparous women (OR=0.39, 95% CI 0.22–0.68); and odds of RA were 1/3 (OR=0.32, 95% CI 0.18–0.58) for women aged ≥24 years compared to those aged < 20 at the time of first birth, while a later age at menarche significantly increased the odds of RA (OR = 1.2, 95% CI 1.05 – 1.32).

Conclusion: We found strong correlations between RA risk, an earlier age at menarche, a delayed first pregnancy and greater parity in this study; however any RA-protective mechanism is unclear. Unknown confounders may play a role in the age of menarche as well as age of first pregnancy, while a protective effect of greater parity on the evolution of RA may result from the repeated immunosuppressive effects of multiple pregnancies.

Gene Silencing of ERAP1 and ERAP2 Displays Differential Effects on Intracellular Free Heavy Chain Accumulation and Peptide Presentation in AS-Associated compared to Non-Associated B27 Subtypes
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Objective: HLA subtypes B*2704 and *2705 are associated with AS while *2706 and *2709 are not. We investigated the interaction of 2 novel AS associated genes ERAP1 and ERAP2 with HLA B*27 subtypes.

Methods: CIIR cells stably transfected with the respective B*27 subtypes (B*2704, *2705, *2706 and *2709) were used. For gene silencing, two duplexes each of Stealth RNAi™ for ERAP1 and ERAP2 and a negative control (NC) siRNA were nucleofected. For flow cytometry, ME1, HC10, W6/32 and MARB4 antibodies were used respectively for intact B27, MHC-I free heavy chains (FHC), intact MHC-I and B27 presenting abnormally long peptides (B27_LP). For intracellular FHC (IFHC) HC10 was used after cell permeabilization. The change in MFI was calculated as a ratio of the MFI with specific siRNA to NC for each antibody. Western blot showed more than 80% suppression of ERAP with specific siRNAs but not with NC.

Results: Silencing of ERAP1/2 was associated with a significant increase in IFHC in B*2704 and *2705 cells compared to *2706 and *2709 cells (p=0.002). The median (IQR) increase in IFHC (∆IFHC) in the B*2704 and *2705 cells was 2.5 (1.8, 4.2) compared to 1.3 (1.1, 1.5) in the *2706 and *2709 cells. There was no significant difference in the level of surface FHC, B27 or MHC-I expression. The median ∆B27_LP expression with ERAP1/2 silencing in B*2704 and *2705 cells was 1.2 (1.1, 1.4) and was significantly higher (p=0.03) than the median ∆B27_LP of 0.9 (0.8, 1.0) in *2706 and *2709 cells. There was no significant difference in the results whether ERAP1 or ERAP2 was suppressed.

Conclusion: ERAP1/2 silencing causes accumulation of more IFHC and higher B27_LP in AS-associated B*27 subtypes cells compared to non-associated subtypes. This is the first report suggesting that ERAP1/2 could be the missing link in the conundrum of B27 subtype specificity in AS.

Biologic Therapy in Juvenile Idiopathic Arthritis (JIA) at One ReACCh-Out Centre: A Pilot Study
Tommy Gerschman (BC Children’s Hospital, Vancouver); Jaime Guzman (BC’s Children Hospital, Vancouver); Victor Espinosa (Child and Family Research Institute, Vancouver); Ciaran Duffy (Montreal Children’s Hospital, Montreal); Rae Yeung ( Sick Kids, Toronto); Kiem Oen (Health Sciences Centre, Arthritis Centre, Winnipeg); Lori Tucker (BC’s Children Hospital, Vancouver)

Objective: To describe the use of biologic medications in Canadian children with JIA and determine factors associated with earlier use.

Methods: We analyzed patients from one centre of the Research on Arthritis in Canadian Children Emphasizing Outcomes (ReACCh-Out) inception cohort to refine methods that can then be applied to the complete cohort. Patients given any biologic medication were described with clinical and laboratory characteristics at study entry and at the visit prior to initiation of biologics. Children receiving early biologics (within 18mo from diagnosis) were compared to controls who did not receive biologics (matched follow-up), and to patients receiving late biologics (after 18mo). Univariate analysis was used to evaluate factors associated with early biologics. Multivariate logistic regression was conducted to explore baseline characteristics that predict early biologic use.

Results: 29/254 Vancouver ReACCh-Out participants (11.4%) used a biologic agent. Median age was 11.3y (1.6–15.6) and 41% male: 48.3% Caucasian, 10.5% Asian, and 17.2% Aboriginal. Thirteen patients (45%) had polyarticular disease, five (17%) ERA, six (21%) systemic-onset, and two (7%) oligoarticular. Two were given biologics for uveitis and two for IBD. Median time from diagnosis to start of biologics was 17.67mo (range 0.2–50). Fourteen children (48%) received early biologics at median 9.5mo (0.2–17.7). At baseline, they had median 5 active joints (0–32) and baseline physician global VAS 4.4 (0–7.7), compared to 2 (0–35) active joints and VAS 3.2 (0–8.2) for matched controls, and 12 active joints (1–51) and VAS 6.3 (2.8–7.6) for late biologics. At the visit prior to starting biologic, early biologics had a MD global VAS 4.5 (0–8.2) versus 0.35 (0–5.4) for controls and 3.3 (0.6–7.6) for late biologic. They had 12.5 (2–22) active joints versus 0 (0–18) for controls and 6 (0–26) for late biologic. Methotrexate was used by 86% of early biologic, 52% controls, and 100% late biologics. Two or more DMARDs were used before starting biologics by 29% early biologic, 3.7% controls, and 31% late biologic. Prednisone was used by 86% of early biologic, 35.8% controls, and 60% late biologic. We are currently exploring the logistic regression models.

Conclusion: Children with systemic-onset and polyarticular disease are prescribed biologics more frequently. Aboriginal children have a high proportion of biologic use, which may reflect more severe disease in this population. The full ReACCh-Out cohort may allow us to predict who will require early biologic so that we can better plan and inform families.

Fracture Risk Assessment and Hip Structural Analysis in Canadian Females Living with Systemic Lupus Erythematosus (SLE)
Jennifer Lee (University Health Network, Toronto); Angela Cheung (The University Health Network, Toronto); Ellie Aghdassi (The University
Objective: In women with Systemic Lupus Erythematosus (SLE), to determine: 1) prevalence of osteoporosis (OP) and low bone mass (LBM) in women ages 50 and <50, 2) fracture risk using the Canadian Fracture Risk Assessment Tool (FRAX) in women>40, 3) bone quality by Hip Structural Analysis (HSA), and 4) correlations between FRAX and HSA with SLE/OP risk factors.

Methods: Demographic data including age, SLE duration, OP risk factors, and medications were collected from 271 participants without prior OP fractures. Bone mineral densities (BMD) at the hip, spine, and femoral neck were determined using DXA. OP was determined using WHO definitions for females>50 (32.8%) and LBM was defined as z-scores <−2 for those <50. For those>40 (63.5%), the 10-year probabilities of a major fracture (FRAX-Major) and hip fracture (FRAX-Hip) were calculated. High fracture risk is FRAX-Major>20% or FRAX-Hip>3% and low risk is FRAX-Major<10% or FRAX-Hip<1%. HSA was completed in 81 participants and included section modulus (SM, bending strength) and buckling ratio (BR, cortical stability) at the narrow neck of the femur. BR>10% is considered high fracture risk.

Results: Subjects had a mean (SD) age of 43.8 (13.0) years, SLE duration of 11.6 (10.4) years, 38% were postmenopausal, 13% had a prior non-OP fracture, 24% were on corticosteroids>7.5mg, and 41% used corticosteroids for>3 months. Calcium and vitamin D were used by 46% and 39%, respectively. Overall, OP and LBM were diagnosed in 14.6% and 8.8%, respectively. Significant but low correlations were found between femoral neck BMD (r=−0.31, p<0.001) and hip BMD (r=−0.41, p<0.01) with corticosteroid use. The mean (SD) FRAX-Major was 10.2% (6.3) and FRAX-Hip was 1.9% (3.3). FRAX-Major>20% or FRAX-Hip>3% was seen in 12 patients with 7 treated. FRAX-Hip>3% was seen in 27 patients with 18 treated. Treatment was given to 19.4% and 14.6% who had FRAX-Major<10% and FRAX-Hip<1% respectively. FRAX-Major correlated significantly with: corticosteroid duration (r=0.33, p=0.008) and age (r=0.21, p=0.01). FRAX-Hip correlated significantly with: corticosteroid duration (r=0.35, p=0.03), age (r=0.23, p=0.02), and SLE duration (r=0.20, p=0.01). The mean (SD) BR was 9.5 (2.2). BR>10% was seen in 43.2%. BR significantly correlated with: FRAX-Major (r=0.58, p<0.01), FRAX-Hip (r=0.59, p<0.01), age (r=0.23, p=0.037), SLE duration (r=0.435, p<0.01), and corticosteroid duration (r=0.285, p=0.026). No associations were found between SM with FRAX or SLE/OP risk factors.

Conclusion: OP and LBM are prevalent in SLE women. FRAX and HSA provide insight to fracture risk by deriving fracture risk probabilities useful for prescribing treatment or assessing bone structure non-invasively.

13 Access To Care For Arthritis In Three First Nations Communities: Results Of A Mixed-Methods Study

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Objective: Aboriginal people in Canada are believed to have a high prevalence of arthritis, yet limited research has examined access to care. Our objectives were to: 1) evaluate access to healthcare services for arthritis among three First Nations communities and 2) examine the perceptions of First Nations people regarding the arthritis care received and barriers experienced.

Methods: We used a mixed-methods approach. An interview-administered household survey of all adults living in three on-reserve communities was performed to identify people who reported having received an arthritis diagnosis by a health professional, or who reported having chronic pain in the neck, back, or joints, and related functional limitations. All adults identified as such were then asked about their access to arthritis care services and barriers to care. Semi-structured interviews were conducted with a subsample of participants to further explore their perceptions of care received and barriers to care. Interviews were tape recorded for transcription. Descriptive analyses of the household survey and content analysis of interview data were conducted.

Results: Of 536 residents, 402 (75%) completed the household survey. Participants’ mean age was 46 years, 52% were female, and 61% were married. Thirty-percent (n=119/402) reported a health professional diagnosis of arthritis (excluding fibromyalgia). In comparison, non-age adjusted prevalence estimates reported in national surveys using the same question was 19% for off-reserve Aboriginal people and 16% for non-Aboriginal people. Chronic joint neck, or back pain and functional limitations were reported by 41% (166/402). Of these 166 individuals, 140 reported at least one healthcare professional visit for their problem: family doctor=75%; physical therapist=28%; occupational therapist=20%; rheumatologist=16%; and, traditional healer=15%. Only 8% had participated in an arthritis/chronic disease self-management program. Difficulties obtaining care in the past 12 months were reported by 28% (n=47/166), including long wait lists (n=20), difficult access to rheumatologists (n=19), poor transportation availability/high costs (n=16), lack of awareness of health professional to see (n=12), high treatment costs (n=11), and perceived inadequate/culturally inappropri- piate care (n=10). Subsequent in-depth interviews (n=11) revealed additional barriers to care: the need for flexibility in the time/location of services, culturally sensitive care, and family involvement in care plans.

Conclusion: The burden of arthritis was high among the participating First Nations’ communities. The prevalence of reporting an arthritis diagnosis exceeded that reported in national surveys for off-reserve Aboriginal and non-Aboriginal people. Culturally specific care challenges included the need for culturally safe care and a desire for greater family involvement in care.

14 Comparison of Patients with Systemic Lupus Erythematosus with and without Peripheral Nervous System Involvement

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Objective: To determine in SLE patients: 1) the prevalence and the clinical course of peripheral neuropathies (PN), 2) characterize the clinical features and sub-classes of the PN, 3) whether PN was related to SLE or to other comorbid conditions and, 4) whether there is an association between any of the features of SLE and PN.

Methods: Patients who met at least 4 of the ACR classification criteria and the ACR case definition criteria for peripheral neuropsychiatric syndromes in SLE were selected from the University of Toronto Lupus Clinic database registry. PN found as exclusions and associations were analyzed but considered non-SLE related. Demographic data including age, gender, SLE duration, SLE-related clinical and laboratory data and the outcomes were extracted. Health-related quality of life was assessed using the mental (MCS) and physical (PCS) component summary score of the SF-36 questionnaire. In a nested case-control study, SLE patients with PN were matched by SLE duration to SLE patients without PN and were compared. Chart review was performed to confirm clinical findings and determine the contributing factors to PN. Data were analyzed using SAS statistical program.

Results: Out of 1553 patients in the database, 207 (13.5%) with a mean

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CRA Abstracts
Objective: Post-hoc analysis of clinical trial data has demonstrated that AS patients who have extensive spinal ankylosis on radiographs experience clinical improvement with adalimumab that is similar to patients without extensive ankylosis. This benefit has been documented by patient self-report and not objectively using imaging data. We aimed to assess the impact of treatment in AS patients where both radiographs and MR scans were available to analyze the fate of vertebral corner inflammatory lesions (CIL) that demonstrated syndesmophytes and ankylosis on the baseline radiograph.

Methods: MRI scans were performed at baseline, 12, and 52 weeks while radiographs were done at baseline and 104 weeks in 76 AS patients randomized to receive either adalimumab (ADA) 40 mg every other week or placebo (PBO) for 24 weeks in a, double-blind, Phase III study of active AS with an inadequate response to at least one NSAID or DMARD. After the week 12 assessment, patients not achieving an ASAS20 response were eligible for early escape therapy with ADA and after 24 weeks all patients received ADA. The anterior vertebral corners (VC) of the cervical (C2 lower to T1 upper) and lumbar (T12 lower to S1 upper) spine were examined for syndesmophytes and ankylosis on lateral radiographs of the cervical and lumbar spine by 2 readers scoring independently. Anonymized MR scans were read independently by 2 readers who recorded the presence/absence of both typical CIL (Type A) and complex CIL (dimorphic) at the same anterior VC that were assessed by radiography. The primary analysis was based on concordant radiographic and MRI data. A CIL was defined as being persistent if it was recorded as being present on each MRI scan (baseline, 12, and 52 weeks) and as being completely resolved if either the baseline or 12 week MR scan showed a CIL that was no longer present at the 52 week final MRI examination.

Results: Ankylosis across the disc space was recorded on the baseline radiograph at 248 of 1736 (14.3%) VC that were assessed by both radiography and MRI. A syndesmophyte was recorded in 137 (7.9%) VC at baseline. A CIL was observed significantly more frequently at VC without either ankylosis or syndesmophytes (212/1351 (15.7%)) as compared to those with ankylosis (13/248 (5.2%), p < 0.0001) on baseline radiographs. Over half of CIL at VC with ankylosis at baseline resolved completely (7/13 (53.8%)) as compared to 157/212 (74.1%) of CIL at those VC without syndesmophytes/ankylosis at baseline (P = NS). For VC with baseline ankylosis, complete resolution was observed for almost all Type A CIL (5/6) but in only 2/7 dimorphic CIL.

Conclusion: Our data provide objective evidence for ongoing inflammation at sites of complete spinal ankylosis that can resolve completely with adalimumab, and that complete resolution of inflammation is observed more often in those CIL with a typical configuration than in more complex, dimorphic inflammatory lesions.

17 Neuropsychiatric Lupus: The Prevalence and Autoantibody Associations Depend on the Definition: Results from the 1000 Faces of Lupus Cohort

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Objective: The prevalence of neuropsychiatric systemic lupus erythematosus (NPSLE) varies widely depending on the definition used. We determined the prevalence of NPSLE in 1000 Faces of Lupus, a large multicentre Canadian cohort.

Methods: Adults who satisfied the ACR classification for SLE were included. NPSLE was defined as: (i) NPSLE by ACR classification criteria (seizures or psychosis), (ii) ACR, SLEDAI (seizure, psychosis, organic brain syndrome, cranial nerve disorder, headache and CVA), SLAM (CVA, seizure, cortical dysfunction and headache) and SLICC (cognitive impairment, psychosis seizures, CVA, cranial or peripheral neuropathy and trans-
verse myelitis) with and (iiii) without minor nonspecific NPSLE manifestations (including mild depression, mild cognitive impairment and EMG-negative neuropathies, and (iv) by ACR and SLEDAI NP indices alone. Factors associated with NPSLE were explored using regression models.

Results: 1253 were enrolled with mean disease 12±10 years, age 41±6 years and 86% female. Subgroup size was dependent on the specific definition of NPSLE. Prevalence of NPSLE was: 6.4% in Group (i); 38.6% in Group (ii); 28.7% in Group (iii); and 10.2% in Group (iv). In univariate analysis, Aboriginals had increased frequency of NPSLE in all groups (nearly two-fold) with ethnicity being significant in group (i) (p=0.04). Education level was not associated with NPSLE (p=0.32) and income was only significant in group (i) (p=0.03). Anti-Ro was significantly associated in groups (i) and (iv) and antiphospholipid (aPL) was increased groups (i), (ii) and (iii); however, aPL+ lost significance when thrombomembolic events were excluded from SLICC, SLEDAI, and SLAM indices. In group (iv) absence of anti-Sm was significant. In multivariate analysis, anti-Ro and aPL (i) and anti-Ro+ and lack of anti Sm (iv) were significant. NPSLE was not increased in those with + anti-DNA, anti-La, or anti-RNP. Total number of ACR criteria, SLAM, age at diagnosis, disease duration and gender were not associated with NPSLE.

Conclusion: The prevalence and factors associated with NPSLE varied depending on the definition used and was highest in the Aboriginals, and may be higher if +anti-Ro or aPL. SLAM and SLICC include mild subjective disease manifestations, which contributed to a 10% higher prevalence of NPSLE compared to a more strict definition. NPSLE may be less in this database than other publications as it may be decreasing, or selection bias of entry into an observational cohort. NPSLE was associated with aPL and often anti-Ro and varied by ethnicity but Aboriginals had higher aPL which was associated with some definitions of NPSLE.

18 The Pharmacist Initiated Intervention Trial in Osteoarthritis (PhIT-OA): Clinical Outcomes

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Objective: Osteoarthritis (OA) is the leading cause of disability and a cause of intensive health resource use in North America. This study determined the cost-effectiveness of a pharmacist-initiated intervention trial in OA (PhIT-OA).

Methods: The incremental cost per quality adjusted life year (QALY) gained was calculated using utility measures (i.e., PAT5D and HUI3) collected in the PhIT-OA trial. Cost-effectiveness analysis was done from the government and societal perspectives by excluding and including patient out-of-pocket expenses, respectively. Incremental cost effectiveness ratios (ICERs) were defined as incremental cost per additional QALY between intervention and usual care. Uncertainty in costs and effectiveness estimates were modeled by the combination of imputation and non-parametric bootstrapping.

Results: From the government perspective, the average patient in the intervention group generated CAN$129 in costs compared with $115 for usual care. From the societal perspective, these costs were $575 and $319, respectively. With QALYs calculated using HUI3 utility values, compared with usual care the intervention resulted in ICERs of $582 per QALY gained from the government perspective and $11,877 per QALY gained from the societal perspective; using PAT5D values, ICERs were $629 and $11,090, respectively.

Conclusion: Using the conventional effectiveness value of $50 000 per QALY, the multidisciplinary intervention initiated by pharmacists was cost-effective both from the government and societal perspectives. Results from this analysis may inform health service planning using pharmacists for OA care.

Poster Tour

20 Environment and Genetic Contributions to Disease Severity in First Nations with Early Inflammatory Arthritis

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Objective: First Nations (FN) populations present with severe inflammatory arthritis at an early age. We sought to determine the influence of genetic predisposition as reflected by HLA DRB1 alleles and environmental factors such as smoking and socioeconomic status on the development and outcome of early inflammatory arthritis (EIA) in this group.

Methods: Patients with EIA (less than 1 year symptom duration: First
Results: PN were more likely to be current smokers (14/25 (56%) vs 53/216 (25%) p<0.001), less likely to use alcohol (7/18 (38%) vs 127/182 (70%) p<0.008) and had less formal education (7.9 vs 12.7 years p<0.0001). There was no significant difference between FN and non-FN in reported exposure to vaccines (3/12 vs 22/104), flu-like illness (3/12 vs 29/102), bacterial illness (2/12 vs 15/100) travel (2/12 vs 46/105) or trauma (1/11 vs 20/100). PN were more likely to have any SE (30/39 (77%) vs 124/225 (55%) p<0.01) and less likely to have DERAA protective alleles (1/19 (3%) vs 40/225 (18%) p<0.015) than PN. In linear regression models predicting baseline DAS28CRP (included variables: years of school, smoking, any SE and DERAA ) SE (B=0.05 p=0.02) and years of school (B=0.05 p=0.002) were significant. At one year PN were less likely to be in remission (6/26(23%) vs 83/174 (48%) p<0.02).In multivariate models including ethnic group, smoking, education, and SE and DERAA, DERRA were associated with remission (OR 2.4 p<0.05).

Conclusion: In this cohort, environmental factors especially socioeconomic status as reflected by years of education is an important contributor to baseline disease activity. The presence of protective DERAA alleles is associated with a better clinical outcome.

21 Pathogenesis and Prevalence of Anti-Citrullinated Protein Antibodies (ACPAs) in Unaffected Siblings of ACPA-Positive Rheumatoid Arthritis Patients

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Objective: We previously reported that ACPA from RA patients injected intra-peritoneally (ip) into FcRRIIB-deficient mice induced inflammatory arthritis (IA); whereas, ip injections of IgG devoid of ACPA from the same RA patients did not. ACPA has been shown to be positive in some unaffected first degree relatives of patients with RA. The objective is to determine whether unaffected siblings of ACPA-positive RA probands have RA features and whether their ACPA induces IA experimentally.

Methods: Patients met ACR criteria for RA and had anti-CCP2>5; RA-unaffected siblings were confirmed by a physician. ACPA (affinity purified from patient sera using a synthetic citrullinated peptide (JED)) and sera was administered ip to FcRRIIB-deficient mice. ACPA were measured by ELISA, Rheumatoid Factor (RF) by nephelometry. All subjects were tested for the presence of the SE and cytokine levels were determined by Lumixin®.

Results: 13 families and 33 unaffected siblings were included; there were three monozygotic twins discordant for RA. All subjects were Caucasian. Mean age of probands was 60, age of disease onset was 44, 85% were smokers, and 85% were in remission. Mean age of siblings was 51 and 50% were smokers (p=0.024). The SE was present in 86% of RA patients and 61% of unaffected siblings (p=0.014). Of the probands, 85% were positive for IgG anti-JED, 54% IgM anti-JED, 77% anti-citrullinated Fibrinogen (cFib), 100% anti-Modified Citrullinated Vimentin (MCV) and 62% RF. One unaffected sibling was IgG anti-JED, anti-CCP2, anti-cFib and anti-MCV positive, 32% of siblings were IgM anti-JED positive and 21% had low titre anti-MCV. Normals (n=9) were negative for ACPA. The monozygotic twins were discordant for the presence of ACPA. Pro-inflammatory cytokines were elevated in RA patients compared to siblings and normals. Siblings compared to normals had significantly lower levels of IL-4, IL-7, IL-17, IFN and higher levels of IL-8, IL-10 and MCP-1. Purified ACPA and serum ip mouse transfers from a twin proband induced IA; whereas IgG devoid of ACPA and sera from the ACPA-negative unaffected twin did not.

Conclusion: Siblings of ACPA positive RA probands had an increase in IgM anti-JED, but rarely had IgG anti-JED, IgG anti-CCP2, or anti-c-Fib and lacked the elevation of pro-inflammatory cytokines characteristic of RA. Monozygotic twins discordant for RA were also discordant for ACPA. Sera from unaffected twins, negative for ACPA did not induce IA in a mouse model. Future work involves determining whether ACPA from unaffected siblings will induce IA in this model.

22 Validation of the 2010 Criteria to Diagnose RA in a Canadian Multicenter Cohort Of Patients with New Onset Inflammatory Arthritis

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Objective: The 2010 ACR/EULAR criteria for RA identify patients likely to have persistent and/or erosive inflammatory arthritis (IA). They have not been validated in North American patients or shown to identify patients eligible for clinical trials recruiting patients with a DAS28 of ≥3.2. We aimed to determine what proportion of patients with early IA of <1 year duration the 2010 ACR/EULAR criteria newly identify as having RA and if these newly identified patients would be eligible for clinical trials in early RA.

Methods: Baseline (BL) data collected from patients (n=1146) enrolled into the Canadian Early Arthritis Cohort (CATCH) study, a multi-centre observational prospective “real world” cohort of patients with early IA recruited since July 2007 were analysed for this study. Inclusion Criteria: age >16, symptom duration 6–52 weeks of persistent synovitis, ≥2 effused joints or 1 swollen MCP/PIP + ≥1 of: + RF, +anti-CCP, AM stiffness >45 minutes, response to NSAIDs, or painful MTP squeeze test. The 2010 criteria were applied to determine what proportion of patients with EIA fulfilled new criteria at BL. Patients were treatment naive or had received a few weeks of DMARDs. Patients newly identified as RA by the new criteria were evaluated for disease activity and the proportion of patients with a DAS28 ≥3.2 were considered as potentially being eligible treatment of for an early RA clinical trial.

Results: BL characteristics were: mean age 52±16 years, 73% female, median symptom duration 5.5 months, mean DAS28 ESR 4.9±1.6; 27% initially treated with oral glucocorticoids, 50% treated with MTX, 26% (226/874) had erosions at BL, 57% (N=648) of patients were eligible for this analysis. Of the remaining 648 patients, 68% (N=441) met 1987 ACR criteria for RA at BL. 31% (N=201) had undifferentiated IA (UIA). Of these 80% (N=518) had a score of ≥ 6 on the new criteria. Of the 68% of 441 who met old criteria, 87% (N=384) met new criteria. Of 201 UIA patients remaining, 66% (N=133) could now be diagnosed with RA using the new criteria. These patients had a mean of (DAS28=4.0). 78% of UIA patients now meeting the new criteria had a DAS28 of ≥3.2.

Conclusion: Based on data from a Canadian cohort, revised ACR/EULAR 2010 criteria identify a substantial number of UIA patients as having RA. The majority of patients would be eligible for clinical trials in ERA. Most patients who fulfill the 1987 ACR criteria also fulfill the 2010 criteria.

23 Prevalence of Risk factors for Rheumatoid Arthritis in a North American Native Community
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**Objective:** The etiology of RA remains unknown. Gene-environment interactions have been proposed to play a major role in disease susceptibility. Specific alleles of the HLA-DRB1 locus collectively known as shared epitope (SE) alleles are associated with disease risk. Environmental risk factors thought to contribute to RA development include smoking and periodontal disease (PD). We have recently shown that antibodies against the oral pathogen porphyromonas gingivalis (anti-PG) are associated with the presence of anti-citrullinated protein antibodies (ACPA), these being the hallmark of RA autoimmunity. Since North American Native (NAN) have high rates of RA, we tested hypotheses regarding disease risk in a genetically and environmentally homogeneous Northern Manitoba NAN community.

**Methods:** A random community sample of 172 participants from St Theresa Point with a mean age of 34 years, 53% of whom were females, answered questionnaires regarding joint and periodontal symptoms, as well as oral health related behaviors and smoking. The participants underwent a joint exam by a rheumatologist and were evaluated for periodontitis by a dental hygienist who generated a 0–4 score using a validated instrument, the Periodontal Screening Record (PSR). The participants had their serum tested for rheumatoid factor (RF) and ACPA, as well as anti-PG. HLA DRB1 testing was undertaken using sequence specific primers (n=106).

**Results:** Four participants with established RA had their data censored. Of the remaining 168 RA-free individuals, 42% reported hand symptoms of pain, stiffness, or swelling, while 10% were found to have joint tenderness or minimal swelling on exam. Current smoking was reported by 87% of subjects. The median PSR score was 3, and 81% had scores of either 3 or 4 (4=most severe). PSR scores correlated strongly with subjective symptoms of bleeding gums. In total, 7% were RF positive, and 2% were ACPA positive, in both cases titers generally being low, while 44% were anti-PG positive based on an arbitrary cutoff level. SE prevalence was 88% and 40% had 2 SE copies. There was no significant association between PSR score, joint symptoms or RA autoantibodies.

**Conclusion:** There is a high prevalence of both genetic and environmental risk factors for RA development in this Northern Manitoba First Nations community. However, there was no clear association between PD or anti-PG with either non-specific joint symptoms and signs suggestive of early RA or with RA autoantibodies, although the sample size and data distribution may have precluded a demonstration of such an association.

**24**

**A Population-Based Assessment of Live Births in Women with SLE**

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**Objective:** There is a general notion that live births are not decreased in women with SLE compared to healthy women. However, there is little evidence to support this; in fact, several disease-related factors may limit the number of children borne to women with SLE. Therefore, we calculated live births in women with SLE, and compared this with general population rates.

**Methods:** We identified women with SLE using Quebec administrative databases (1994/01/01 to 2003/12/31), which cover all health care beneficiaries. Incident SLE cases were women with ≥1 hospitalization with either a primary or secondary diagnosis of SLE, or ≥2 physicians’ claims for SLE within any 2-year period (at least 8 weeks apart), with no prior diagnosis of SLE in the 5 years preceding the interval. Only women aged ≤35 on within any 2-year period (at least 8 weeks apart), with no prior diagnosis of SLE, or ≥2 physicians’ claims for SLE were included. We determined the number of live births during the interval, as defined by procedure codes or physicians’ claims for delivery. We applied age-specific and relevant calendar-period birth rates to the observed years of follow-up to determine the expected number of live births. We then calculated the standardized incidence ratio (SIR) of observed to expected live births. We also performed multivariate analyses to explore potential predictors of live births in women with SLE.

**Results:** 1334 women with SLE were identified. Mean age at diagnosis was 28.9 years (standard deviation, 8.0). Most births occurred before or at SLE diagnosis date (respectively 41% and 15%), while 45% were observed after diagnosis. Overall, the number of live births over the interval (559) was below that which would be expected (708) (SIR 0.79; 95% CI 0.73–0.86). Compared with the general population, live births were substantially lower after SLE diagnosis (SIR 0.62; 95% CI 0.55–0.70) compared to before diagnosis (SIR 1.01; 95% CI 0.90–1.13). In multivariate analyses, prior hospitalization for SLE (RR 0.52; 95% CI 0.37–0.73) was associated with markedly decreased live births. There were trends for fewer live births in women with disease duration ≥5 years (RR 0.86; 95% CI 0.65–1.14) and in those living in rural regions (RR 0.79; 95% CI 0.60–1.06). We did not definitively establish a decrease in live births independently attributable to antiphospholipid syndrome (RR 0.90; 95% CI 0.65–1.25) or renal disease (RR 0.89; 95% CI 0.63–2.39).

**Conclusion:** After diagnosis, women with SLE have substantially fewer live births compared with the general population. Prior hospitalization for SLE was the most important predictor of live birth (after diagnosis) in our sample.
abnormal FMD. Assessment of FMD in SLE may identify a subgroup of patients with endothelial dysfunction not identified by FRS. Following these patients prospectively may help to determine their actual CVD risk.

26 Patterns and Determinants of Leisure-time Physical Activity in Women with Systemic Lupus Erythematosus

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Objective: To describe leisure-time physical activity (LTPA) patterns of women with systemic lupus erythematosus (SLE) and to identify demographic, psychosocial, disease related and physiological factors associated with LTPA levels.

Methods: Two hundred and seventy-eight women completed standardized questionnaires assessing LTPA, psychological distress, self-efficacy and health status. A clinical examination determined lupus disease activity and cumulative damage. Demographics and clinical variables, which include systemic inflammation factors (C-reactive protein (CRP) and homocysteine) were also collected. Sufficient and insufficient patterns of LTPA were identified and the association between these patterns with Health related quality of life (HRQoL) and other determinants were examined.

Results: Fifty percent (n=139) of the participants were meeting recommendations for achieving at least 7.5 metabolic equivalent hours per week (MET-hr/wk) of LTPA, 26.2% (n=73) were insufficiently active (< 7.5 MET-hr/wk of LTPA) and 23.7% (n=66) were sedentary. Walking was the preferred form of LTPA, reported by participants who were sufficiently (62%) and insufficiently active (79.5%). Participants who were sufficiently active scored significantly better in 7 of the 8 HRQoL domains compared to the less active and sedentary groups, including: physical functioning, role limitations due to physical health problems, bodily pain, vitality, and social functioning. Univariate analysis showed overall levels of psychological distress to be lower in sufficiently active individuals when compared to sedentary and insufficiently active patients. Physiological data shows systemic inflammation to be similar between activity groups with a decreasing trend in CRP values in active individuals. Along with similar values in disease activity and disease damage between the activity groups, this suggests exercise does not exacerbate symptoms of SLE. Multivariable logistic regression revealed that being sufficiently active was significantly associated with lower BMI (OR = .69, 95% CI = 0.49–0.99) and higher physical component summary scores (OR = 1.04, 95% CI = 1.01–1.08).

Conclusion: Patients with systemic lupus erythematosus who exercised regularly were found to have significantly higher HRQoL as well as lower psychological distress. These benefits are present in the absence of exacerbations of the disease. Future studies looking at the effects of exercise on patients with SLE should combine longitudinal monitoring of patients with a comprehensive exercise and lifestyle changing program.

27 Is There an Advantage for a Lupus Specific Quality of Life Measure over SF-36?

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Objective: We aimed to assess whether the LupusQoL contributed additional information not obtained using the SF-36 and to compare the responsiveness of both questionnaires over time in patients who changed clinically.

Methods: 41 patients seen at a single centre were followed at monthly intervals for 12 months. Both questionnaires were co-administered monthly. Lupus activity was determined by SLEDAI-2K 30 days. We compared the mean scores for the 4 comparable domains in both questionnaires in all patient-visits. For the 4 non-comparable domains of the LupusQoL, we determined the correlation between each domain with the Physical Component Score (PCS) and the Mental Component Score (MCS) of the SF-36. The effect size (ES) and the standardized response mean (SRM) were used to compare the responsiveness of both questionnaires in patient-visits with lupus flare (SLEDAI-2K≥4), improvement (reduction in SLEDAI-2K≥3) and remission (SLEDAI-2K=0) from previous visit.

Results: The mean age at SLE diagnosis was 30.5±10.3 years. At study visit the mean age was 45.3±13.2 and disease duration 14.8±10.3 years. SLEDAI-2K 2.59±2.41 and SDI 2.12±2.48. 376 patients-visits were recorded. Quality of life assessed by both questionnaires is low among patients. There was no statistically significant difference between the mean scores of comparable domains; Physical Health/Physical Functioning, Emotional Health/Mental Health, Pain/Bodily Pain and Fatigue/Vitality. For the 4 non-comparable domains of the LupusQoL, there was a correlation between Body Image/MCS-SF-36, Planning/MCS-SF-36, Intimate Relationships/PCS-SF-36, and Burden to Others/MCS-SF-36. Both questionnaires displayed responsiveness as determined by SE and SRM among patients who flared (SF-36: SRM moderate effect 0.64 Role Physical, small effect 0.42 Social Functioning and 0.30 PCS; LupusQoL: SRM moderate effect 0.67 Fatigue and small effect 0.49 Burden to others) and improved (SF-36: SRM moderate effect 0.60 MCS and small effect 0.43 Mental Health, 0.40 General Health, 0.30 Vitality, 0.30 Role Physical, 0.24 Social Functioning and 0.23 Physical Functioning; LupusQoL: SRM moderate effect 0.73 Pain, 0.53 Fatigue and 0.51 Physical Health, and small effect 0.45 Emotional Health, 0.39 Body Image, 0.37 Burden to others and 0.36 Planning) but not among patients in remission when compared to previous visit. There was no significant difference in the responsiveness of both questionnaires in patients with lupus flare and improvement when compared to previous visit.

Conclusion: There is no superiority of LupusQoL over SF-36 in assessing lupus patient’s quality of life. Both questionnaires are responsive instruments of lupus quality of life in patients with flare and improvement.

28 Differences in Clinical Manifestations between Childhood-Onset Lupus and Adult-Onset Lupus: A Meta-Analysis

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Objective: In SLE, it is known that age at disease onset impacts the clinical course and outcome; however, the precise differences in the prevalence of SLE manifestations are debated. The objective of this study was to conduct a systematic literature review and meta-analysis of all studies comparing childhood-onset to adult-onset lupus and determine which clinical manifestations vary with age at disease onset.

Methods: A search of MEDLINE/PubMed, EMBASE, CINAHL, and SCOPUS databases was conducted to identify relevant articles. Clinical manifestation event rates were extracted. Pooled odds ratios were calculated using the random effects method and heterogeneity and study quality were assessed.

Results: Of the 484 studies identified by the search strategy, 16 were included (905 children, 5993 adults). Mean quality was 16 out of 32 ranging from 8 to 29. Malar rash (OR 1.9), ulcers/mucocutaneous involvement (OR 1.4), renal involvement (1.6), seizures (OR 2.3), thrombocytopenia (OR 1.3), hemolytic anemia (1.9), fever (1.5), and lymphadenopathy(3.7) were more common in childhood-onset SLE (all P< 0.05). Raynaud’s, pleuritis, and sicca are more common in adult-onset SLE (P< 0.05; OR 4 to 0.7 comparing children to adults or approximately 50% more common in adults). Autoantibodies including ANA, anti-DNA and ENA had no difference in prevalence in adults vs. children. However, antiphospholipid antibodies were more common in childhood-onset SLE (p< 0.05). Other manifestations were not significantly different in adults vs children such as discoid rash, photosensitivity, alopecia, arthritis, psychosis, stroke, thrombosis, pericarditis, serositis, lung and heart involvement, leucopenia and lymphopenia. Limitations include: biases in case selection, inconsistent defining...
tions of cSLE ranging from less than 13 to 18. The strength is large numbers and data from several continents which improves the generalizability of the results.

Conclusion: Several manifestations of lupus are different in cSLE and aSLE. It is not surprising that lymphadenopathy, fevers and seizures were more common in cSLE as they are more common in children than adults and likewise, Sjögren’s seems to increase with age of onset of SLE and sicca is increased in older people. However, despite more antiphospholipid antibodies in children, there was no difference in CVA but other risk factors for stroke increase with age such as hypertension. Children had more renal involvement despite similar autoantibodies (ANA, anti-DNA, ENA) but there could be detection bias in that more severe SLE is detected in children as SLE is rarer in children compared to adults.

29 Health-related Quality of Life in Children with Primary CNS Vasculitis and Juvenile Spondyloarthritis

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Objective: To identify and compare the characteristic patterns of health-related quality of life (HRQOL) in children with two distinct rheumatic diseases: childhood Primary Angiitis of the Central Nervous System (cPACNS) and Juvenile Spondyloarthritits (JSpA). HRQOL is an important health outcome in children with rheumatic diseases. cPACNS is an inflammatory disease of the brain and spine. Children with cPACNS have neurological deficits which interfere with participation. JSpA is an inflammatory arthritis affecting the lower limbs (joint and entheses) and spine resulting in physical limitation. The physical limitations can equally interfere with the child’s ability to ambulate and interact with peers. Systemic manifestations of both the diseases may result in fatigue and sleep disturbances. Currently, there is very little information available on the impact of cPACNS and JSpA on HRQOL.

Methods: A single-center cross-sectional study of children with CNS vasculitis (cPACNS by Calabrese criteria) and JSpA (ILAR criteria for enthesitis-related) was performed. Data collection: clinical assessment, inflammatory markers and imaging. HRQOL was assessed using the PedsQL 4.0, a 23-item questionnaire rated by both parent and child and completed at their child’s regularly scheduled clinic visit. Disease activity was determined using Pediatric Global Assessment scales, BASDAI, BASFI and PSOM. Results were calculated comparing descriptive statistics and compared in parametric and non-parametric tests, when applicable.

Results: Twenty-six children (21 males, 5 females) diagnosed with a JSpA and their parents and 58 cPACNS patients (33 M: 25 F) and their parents participated in this study. Children were aged 4.6–16.5 years (mean 8.0). Mean duration of illness was 19 months in cPACNS and 34 months in JSpA. Overall child-reported HRQOL was higher in JSpA (M=82, SD12) than cPACNS (M = 74, SD17). Patients reported significantly higher HRQOL than parents (p =0.004). Differences were found for all domains: 1) psychosocial: JSpA M=85 (SD13), cPACNS M=60 (SD17), 2) physical: JSpA M=86 (SD16), cPACNS M = 91 (SD17), 3) emotional JSpA M=85 (SD12); cPACNS M=72 (SD12), 4) social: JSpA M=86, (SD14), cPACNS M=76 (SD15) and 5) school JSpA M=82, (SD17), cPACNS M=71 (SD14).

Conclusion: Childhood rheumatic diseases impact on HRQOL. CNS vasculitis and JSpA affect HRQOL distinctly differently. Children with JSpA had lower physical domain scores. In contrast, CNS vasculitis patients scored significantly lower on psychosocial, emotional and school-related domains. Comprehensive care for children with rheumatic diseases has to target these specific areas of impaired HRQOL.

30 Uveitis Screening in Juvenile Idiopathic Arthritis (JIA): A Quality Improvement Project

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Objective: Juvenile idiopathic arthritis (JIA) is the most common rheumatic disease in children; uveitis is the most severe extra-articular involvement. JIA accounts for 75% of all pediatric anterior uveitis cases in North America and Europe. A positive anti-nuclear antibody (ANA) increases the risk for uveitis in JIA > three fold. Thresholds for considering a titer positive remain undefined. The aims of the study were: 1) To determine, which ANA titer pediatric rheumatologists consistently consider positive, 2) to explore, how the obtained ANA titer information is translated into clinical practice when applying the Uveitis Screening Guidelines and 3) to determine how satisfied pediatric rheumatologists are with the current guidelines.

Methods: A single center quality improvement project was conducted and included all 23 pediatric rheumatologists (fellows and staff). A case based 14-question electronic survey including four hypothetical case scenarios was constructed using surveymonkey software. It explored the domains of 1) consistency of considering an ANA titer positive, 2) knowledge and application of the 2006 American Academy of Pediatrics (AAP) Uveitis Screening Guidelines, 3) satisfaction with guidelines. Results were summarized and compared using descriptive statistics, case-based knowledge and application of guidelines was compared using paired t-tests.

Results: A total of 20/23 (87%) pediatric rheumatologists completed the survey. ANA was considered an important risk factor for uveitis in JIA by 95%. There was inconsistency in the threshold for ANA positivity: 50% considered a titre of ≥ 1:40 to be positive, 45% selected ≥ 1:80, and 5% chose ≥ 1:160. A total of 85% of responders stated they were familiar with the AAP Uveitis Screening Guidelines; 85% reported to apply them “very frequently” or “all the time.” When provided with two cases with unani- mously positive ANA titres, before and after being shown the AAP screening guidelines, only 60% of respondents chose the uveitis screening frequency corresponding to the screening guidelines correctly. The reported satisfaction with the guidelines was low at 60%.

Conclusion: Thresholds for positive ANA titres in JIA amongst pediatric rheumatologists were found to be inconsistent. Knowledge and correct application of the Uveitis Screening Guidelines was limited and satisfaction with the guidelines was low. A data based approach is required to determine the risk of developing uveitis at different ANA titers. It will allow for evidence-based, consistent judgement of test positivity with the goal of decreasing variability and improving standard of care for JIA patients.

31 Musculoskeletal Examination Skills of Pediatric Residents

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Objective: Good musculoskeletal (MSK) examination skills are crucial for accurate assessment of a child with suspected rheumatic disease. It was our perception that pediatric residents do not demonstrate sufficient skills in this regard. Objective of this study was to assess whether pediatric residents feel confident performing a MSK exam focusing on assessment of the presence of inflammatory changes in joints

Methods: Study group: all pediatric residents attending Academic Half Day at the Children’s Hospital of Eastern Ontario. Assessment: A self-assessment questionnaire was handed out to all residents to assess their level of confidence in examining specific joints. Responses were scored using a five-point Likert scale (1=not confident, 5=very confident). After completion of questionnaires, the residents participated in a 2-hour teaching module on joint examination techniques with a practical hands-on compo-
Objective: The majority of AS patients who have elevated disease activity and back pain respond to anti-TNF therapy while few respond to continued conventional therapy. Younger patients and patients without peripheral enthesitis receiving anti-TNF therapy demonstrate an improved response. CRP, functionality and HLA-B27 measurements can help in assessing which patients will respond and subsequently achieve an improved disease state and who might therefore be a better candidate for anti-TNF therapy.

34 Response to the First Biologic in Patients with Ankylosing Spondylitis: a Real World Experience

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Objective: Biological therapy has brought a paradigm shift in the care of patients that are candidates for anti-TNF based on the predicted response / remission rates.

Methods: The ASSERT and GO-RAISE trial data were analyzed and matrix models developed to predict probability for achieving response or remission after initiating anti-TNF therapy or continuing conventional AS therapy. Univariate analyses identified possible baseline predictors for 50% improvement in BASDAI50 at wk 12 and ASAS partial remission at wk 24. Individual variable associations were explored using Spearman correlation analysis. A stepwise selection procedure using multivariate regression, ROC analysis and Spearman correlation was used to select predictors for the final model. Variables are represented as dichotomous or trichotomous parameters and logistic regression was used to calculate the predicted probability of achieving a BASDAI50 response and ASAS partial remission state respective to combined selected predictors at baseline.

Results: 479 AS patients treated with anti-TNF and 156 patients treated with placebo with continued conventional therapy, with BASDAI and spinal pain assessment ≤ 4 were included. Age (mean 39.5, SD 11.3 yrs), BASFI (mean 5.4; SD 2.2 cm), Berlin enthesis-score (mean 2.4; SD 2.9), therapy (anti-TNF or conventional), CRP (mean 2.1; SD 2.4 mg/dL) and HLA-B27 genotype ([+] or [-]) were included as predictors. After categorization of age (≤40 vs. >40 yrs), enthesitis (score = 0 vs. >0 units), CRP (≥0.6, >0.6 ≤2.0, >2.0 mg/dL) and BASFI (≥4.5, >4.5 ≤6.5, >6.5 cm), the AUC of the combined dataset prediction model was 80% for BASDAI50 response and 77% for ASAS partial remission suggesting a good prediction model according to the academic point system. A matrix model was developed and organized to represent increasing proportion of BASDAI50 response (range 1% to 80%) and ASAS partial remission (range 0% to 55%) respective to the characteristic at baseline. Only 2% of patients who did not have BASDAI50 response at week 12 did have ASAS partial remission at week 24.
patients with spondyloarthritis. However, the response to these medications is not uniform and data on predictors of response are available only from controlled conditions like drug trials. We present a real world experience of biologic use and response in patients with ankylosing spondylitis (AS).

**Methods:** Patients with AS (modified New York criteria) and who have been on at least one anti-TNF agent were selected for the study. Patients who stopped a biologic due to lack of response were considered failures. Patients who continued on the same agent or stopped due to low disease activity state were considered responders. Baseline demographic features including age and gender, HLA B27 status, disease duration, gap between diagnosis and initiation of biologic agent, disease activity measures including BASDAI, CRP and ESR, BASFI, BASG and hemogram were noted. The presence of peripheral arthritis, colitis, psoriasis, iritis and concomitant use of DMARDS were compared between the responders and non-responders. Univariate, followed by multivariate logistic regression analysis was performed. Student T test and Fischer’s Exact test were done where relevant.

**Results:** Out of a total of 230 patients with spondyloarthritis attending the clinic over a total of 654 visits, 193 patients had AS and detailed data on biologic use was available on 185 patients who were included in the study. The mean (±SD) age (38.5±13 vs 37.5±12) and disease duration (15±11 vs16±11) were comparable between the responder and non-responder groups. The age of onset of AS, delay in diagnosis or delay in starting biologic after diagnosis was not different between the two groups. The responders had lower BASDAI at baseline compared to non-responders (5±2.5 vs5.8±1.8; p=0.03). None of the other clinical or laboratory parameters were significantly different. More non-responders were on DMARDS compared to responders (88% vs 64%; p=0.04). In logistic regression analysis, the only predictor of anti-TNF response was leukocyte count with an OR of 0.83 (p=0.03). The area under curve of a model predicting anti-TNF response with leukocyte count alone was 0.668. Adding HLA B27, gender, BASDAI, CRP and other clinical variables did not improve the prediction model.

**Conclusion:** In a real life setting, prediction of biologic response can be different from a controlled setting like a drug trial. Patients who responded to the first anti-TNF agent had lower disease activity and a lower leukocyte count was predictive of response.

35 Cocaine-Induced Pseudovasculitis: a Case Series of 8 Patients

Nataliya Milman (University of Ottawa, Ottawa); C. Douglas Smith (The Ottawa Hosp, Ottawa)

**Case Report:** Over the previous year, eight patients who use cocaine presented to the Ottawa Hospital with features suggesting cutaneous vasculitis. Clinically, all patients had a mixture of cutaneous and oral ulcers of variable depth and size, purpuric and hemorrhagic lesions, and areas of skin necrosis. Most had prominent weight loss, 6 had arthritis, 1 had diffuse lines clinical features and a distinctive profile of laboratory investigations were noted. In 7/8 patients who were seen on more than one occasion, the course of disease was chronic, with relative improvement after hospital admissions and then recurrent exacerbations, often temporally related to cocaine use. One patient died due to multi-drug overdose. This report outlines clinical features and a distinctive profile of laboratory investigations that when present in the right clinical setting should prompt consideration of cocaine-induced pseudovasculitis.

36 Giant Cell Arteritis and Coexisting Inflammatory Arthritis

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**Objective:** The coexistence of Giant Cell Arteritis (GCA) and other inflammatory arthritis conditions is felt to be unusual. Prior studies have shown up to 15% of GCA patients may have synovitis; however they lacked the ability to test for anti-cyclic citrullinated peptide (CCP). We investigated the number of patients with GCA who were identified with inflammatory arthritis and were CCP positive.

**Methods:** Pathology records of all positive temporal artery biopsies performed in the Edmonton area over a 4-year period (2006–2010) were obtained. The University of Alberta Rheumatology Division, internal database was also reviewed for patients with GCA.

**Results:** Twenty-five biopsy-positive patients were identified, and their charts were reviewed for the presence of any inflammatory arthritis, as well as the specialty of the physician managing their temporal arteritis. Two patients with biopsy-confirmed GCA were subsequently diagnosed with inflammatory arthritis; one patient with rheumatoid arthritis (RA) the other with psoriatic arthritis (PsA). The patient with RA was CCP positive; the patient with PsA was CCP negative. Of the 25 patients, only 14 patients (56%) were managed by rheumatology. Of the remainder, 10 (40%) were managed by Ophthalmology alone, and one was followed by family medicine.

**Conclusion:** We present two patients with biopsy-confirmed GCA who were subsequently diagnosed with inflammatory arthritis, one with rheumatoid arthritis (RA) and one with psoriatic arthritis (PsA). The presence of CCP testing is beneficial in patients who have inflammatory symptoms. A significant number of our patients were managed by non-Rheumatologists (44%). This may lead to an underestimation of the incidence of inflammatory arthritis in this population.

37 Lower Education as a Proxy for Socioeconomic Status (SES) is not associated with Poor Outcomes in Systemic Sclerosis (SSc): Data from a Large SSc Cohort (CSRG)

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**Objective:** It is unknown what the effect of SES is on outcomes in SSc. SES is often measured by income and education. In SSc, highest education would be attained often decades prior to disease onset whereas current income could be low due to SSc, confounding interpretation of effect of SES on SSc. SES can modify outcomes by altering timing of access to care and adherence. Thus education is a proxy of SES.

**Methods:** The Canadian Scleroderma Research Group (CSRG) collects detailed data annually on more than 1000 SSc patients. For measuring SES we used education: did not complete high school or completed high school (HS). Linear regressions were used to assess the education effect on disease outcome as measured by severity score, global physician scores and sur-
vival (time from onset of scleroderma till death). Logistic regressions were done to detect any effect of education on mortality, presence of Class III pulmonary artery hypertension (PAH), interstitial lung disease (ILD) [total lung capacity (TLC) less or more than 70%], renal failure (serum creatinine level less or more than 150 μmol/L). Data were subdivided into limited and diffuse cutaneous SSc.

**Results:** The study included 1145 with mean of 8 years duration of SSc. Eighty six percent of the patients were females (986 females) with a mean age of 55.4 years. Approximately a quarter did not complete high school. Less than high school education was significantly more common in older age (p<0.000), males (p=0.01), lower income (p=0.000), unemployed (p=0.000), higher ESR (p=0.02) and those more likely to have died in follow up (p=0.02). Linear regressions did not show any statistically significant association between education level and ILD, PAH, and SRC. Education was not predictive of worse outcomes of scleroderma when usual risk factors (Gender, age, ESR, Hbg, ANA and SCL70) were entered into the model. Although, % deceased was significantly related to education by bivariate analysis, regression after adjusting for significant risk factors was no longer significant.

**Conclusion:** Unlike SLE in SSc education is not associated with worse outcomes when adjusting for usual risk factors. Education may not affect disease course in those with an aggressive disease.

### 38 Clinical Correlates of Oral Health Status in Systemic Sclerosis

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**Objective:** The manifestations of systemic sclerosis (SSc) are heterogeneous and include orofacial abnormalities. The purpose of our study was to identify the oral and disease-related correlates of oral health-related quality of life (HRQoL) in SSc.

**Methods:** In a cross-sectional study, SSc patients from the Canadian Scleroderma Research Group Registry were randomly recruited from 7 centers. Oral HRQoL was assessed with the Oral Health Impact Profile (OHIP), a validated self-reported measure of dysfunction, discomfort and disability attributed to oral conditions. The OHIP is composed of 7 subscales (functional limitation, physical pain, psychological discomfort, physical disability, psychological disability, social disability and handicap). Each subscale is scored separately from 0 to 40 (with 0 representing better oral health). Other disease-related manifestations that could potentially influence oral HRQoL in SSc. Oral findings of interest included interincisor distance, subjective feeling of oral dryness (feeling of dry mouth, difficulty swallowing dry food or swollen salivary glands), salivary flow per minute, and presence of full dentures. Disease-related manifestations included severity of Raynaud’s phenomenon, severity of finger ulcers, hand contractions, gastroesophageal reflux and global measures of disease activity and damage. The relationship between the OHIP and each oral and disease-related variable was investigated in separate multivariate models, adjusting for age, gender, education, current smoking and disease duration.

**Results:** There were 151 patients in the study: mean age 56.5 years, 90.1% female, 52.1% with more than high school education, 9.7% current smokers and mean disease duration 13.8 years. Intercisor distance was 37.6 mm, 63% reported a subjective feeling of oral dryness, mean saliva production per minute was 1.47 gm, and 11.3% had full dentures. The mean OHIP score was 8.67. Objective and subjective measures of oral dryness and full dentures were independent predictors of several OHIP subscales as well as the overall OHIP (p<0.05). Interincisor distance was an independent predictor of functional subscales of the OHIP, but not of the OHIP overall. No other disease-related manifestation tested was an independent predictor of the OHIP.

**Conclusion:** This is the first study to systematically assess the full spectrum of SSc-related manifestations on oral HRQoL. Oral dryness and reduced mouth opening are independent predictors of oral HRQoL. These findings should help researches to plan further prevention and intervention studies to improve oral HRQoL in SSc patients.

### 39 Joint Space Narrowing has a Stronger Impact on Physical Function Than Joint Erosion: Results From 8-year Longitudinal Analyses

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**Objective:** Structural damage, assessed by the modified Total Sharp Score (mTSS), has been shown to be related to physical function. Thus far, it remains unclear to what extent the individual components of the mTSS contribute to long-term physical function. The objective of this analysis was to characterize the longitudinal relationship between physical function and Joint Space Narrowing (JSN) or Joint Erosion (JE) in patients with advanced RA.

**Methods:** DE019 was a 52-week, phase 3, randomized, placebo-controlled trial for the treatment of moderate to severe advanced RA, in which patients with an inadequate response to methotrexate (MTX) were randomized to weekly placebo, weekly adalimumab (ADA) 20 mg, or ADA 40 mg every other week (ew), alongside concomitant MTX therapy. Patients completing the double-blind study were eligible to receive open-label ADA 40 mg ew + MTX for an additional 7 years. This post hoc analysis evaluated the 8-year completors cohort with radiographs available at baseline and years 5, 6, and 8. 28-joint Disease Activity Score (DAS28) was used to assess clinical levels of disease activity. Physical function was assessed through the Health Assessment Questionnaire (HAQ). Radiographic damage was assessed using the modified Total Sharp Score (mTSS). Longitudinal generalized linear modeling was used to characterize the dependence of the HAQ on concurrent DAS28, total mTSS, JSN, and JE values, following adjustment for baseline age and gender and for concurrent CRP.

**Results:** Over time, DAS28 was linearly associated with the HAQ (P < 0.001). Similarly, the mTSS was significantly associated with the HAQ throughout treatment duration (P < 0.001). A unit increase in DAS28 and a 20 unit increase in mTSS were associated with 0.22 and 0.044 increases in the HAQ, respectively. A breakdown of mTSS into the individual components revealed that JSN more strongly impacted the HAQ over time than JE, although both were significant determinants (P < 0.001 for both). A 20 unit increase in JSN and JE were associated with 0.1 and 0.06 increases in the HAQ, respectively. Interestingly, negative changes in mTSS trended towards lower HAQ values over time.

**Conclusion:** For patients with advanced disease, long-term physical functioning is associated with both the level of disease activity (DAS28) and the extent of radiographic damage (mTSS). Of the contributors to the mTSS, JSN had a greater impact on the HAQ over time than JE, suggesting that therapies with high potency for inhibiting both the progression of JSN and JE should be considered.

### 40 Defining the Smallest Detectable Change for the SPARC Spine and Sacroiliac Joint MRI Index for Ankylosing Spondylitis

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**Objective:** The Spondyloarthritides Research Consortium of Canada (SPAR-
CC magnetic resonance imaging (MRI) index is a scoring method for spinal and sacroiliac joint (SIJ) inflammation in ankylosing spondylitis (AS). The objective of this analysis was to define the cut-off for the smallest detectable change (SDC) on the SIJ and spine SPARCC MRI index.

Methods: Spine and SI J MRIs were performed at baseline (BL), Week 12, and Week 52 in AS patients randomized to adalimumab 40 mg every other week (eow) or placebo for a 24-week double-blind period, followed by an 80-week open-label period (adalimumab 40 mg eow). Two independent, blinded readers scored the MRIs using the SPARCC index and a global evaluation of change (much worse, worse, no change, better, or much better) for visit comparisons. Change categories were pooled. Mean change in absolute SPARCC scores and 95% confidence intervals (95% CIs) were determined. Receiver operating characteristic (ROC) curves and Youden indices were generated, and sensitivity and specificity of the category change reported as functions of absolute change in SPARCC score.

Results: A total of 82 patients were enrolled. Reader agreement on the evaluation of change was 77%–83% for the SIJ and 66%–74% for the spine. For the global evaluation category of change and no change, the 95% CIs of absolute change in SPARCC scores showed comparability between treatments and visit comparisons. Therefore, all cases were combined across treatment groups and visit comparisons. The ROC curves demonstrate that absolute change in SPARCC score is significantly associated with global evaluation of change (area under the curves: 0.960, SI joints; 0.839, spine). The Youden index reached maximum, separating change from no change at 2.0 for SI joints and 4.0 for the spine.

Conclusion: We propose that changes of 2.0 and 4.0 for the SIJ and spine, respectively, define the numerical cut-off for SDC on the SPARCC MRI index for AS.

41 Articular Tophus Burden by Dual Energy Computed Tomography and Health-Related Quality of Life
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Objective: Dual Energy Computed Tomography (DECT) provides specific colour-coded differential displays between uric acid and other materials, and is a potentially useful tool to diagnose and determine the articular burden of uric acid deposition (tophi) associated with gout. The specific objective of this study was to examine whether associations exist among the number of bony regions with tophi and both the physical (PCS) and mental (MCS) health components of the Medical Outcomes Study Short-36 Version 2 (SF-36v2) as these data would help to establish the clinical validity of DECT outcomes.

Methods: Our study sample consisted of 20 monosodium urate crystal-proven gout patients recruited from rheumatology offices in the Vancouver area, who prospectively underwent DECT scans at the Vancouver General Hospital and completed the SF-36v2. DECT scans were performed on all peripheral joints (hands/wrists, elbows, knees, feet/ankles) using a color-coding protocol that specifically assessed the chemical composition of the material (i.e. uric acid coloured in red, calcium coloured in blue). We examined the age- and BMI-adjusted relationships among the number of sites with tophi and the SF-36v2 component scores using linear regression analyses.

Results: The study sample was predominantly male (90%). The mean age of the study participants was 65.05 (SD=4.28) years. The average number of tophi sites per participant was 7.3 (range=0–25, median=8.0). The mean PCS score was 41.66 (SD=11.59), and mean MCS score was 49.62 (SD=11.23). The number of sites showing tophi correlated well with the physical component of SF-36v2 (Pearson’s r=0.56, p<0.02). Age- and BMI-adjusted linear regression showed that for every additional site with presence of tophi, the PCS increased by 0.95 (p=0.02). There was no correlation observed with the MCS scores. When we limited our analyses to men only, our results did not change materially.

Conclusion: The number of sites with tophi detected on DECT correlates well with the physical component of SF-36v2 among patients with crystall-proven gout. These data help to establish the clinical validity of DECT outcomes, which is of interest to practicing rheumatologists, investigators, and patients with gout and hyperuricemia.

42 LMP2 and ERAP1 Variants are Associated With Radiographic Severity in Ankylosing Spondylitis in the SPARCC Cohort
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Objective: Endoplasmic reticulum aminopeptidase 1 (ERAP1) and LMP2 polymorphisms are associated with AS. However, it is not known if they influence radiographic severity in AS. As part of a SPARCC initiative, we investigated the influence of genetic variants in components of the antigen processing pathway on radiographic progression in AS.

Methods: Caucasian AS patients from Edmonton and Toronto, diagnosed by the modified New York criteria, and having at least two sets of x-rays for scoring severity (mSASSS) were included in the study. All AS patients in the SPARCC registry are followed annually with a standardized protocol. Patients with a baseline mSASSS score of 65 or higher were excluded from the study. Progressors were identified as those patients who had an increase of at least 1 mSASSS unit per year. DNA was prepared from the peripheral blood of AS patients and genotyped for a panel of 13 coding-region SNPs in the ERAP1, LMP2, LMP7, TAP2 and TAP7 genes. Only SNPs with a minimum of 5% patients who were homozygous for the minor allele were included in the final analysis (4 SNPs in ERAP1 and 1 SNP each in LMP2 and TAP2). Regression analysis was done to identify predictors of baseline radiographic severity as well as progressors on follow up.

Results: A total of 241 patients (81% males and 82% HLA B27-positive) were followed up for a mean (± SD) duration of 2.4 (± 0.8) years. Baseline mSASSS scores were associated with gender, age, the ERAP1 SNP rs30187 and the LMP2 SNP rs17587. Patients with the major allele of the ERAP1 SNP rs30187 (CC/CT) and those homozygous for the minor allele of the LMP2 SNP rs17587 (AA) had significantly higher mSASSS at baseline. In multivariate analysis with the forward conditional method, adjusted for duration of disease and gender, the LMP2 SNP rs17587 were significantly (B=14.3; p<0.04) associated with the baseline mSASSS. In multivariate analysis of progressors, baseline mSASSS and the ERAP1 SNP rs27044 were significant predictors. This model correctly identified progressors and non-progressors in 75% of cases. After controlling for all variables included in the analysis, patients homozygous for the minor allele of rs27044 (GG) were more likely to progress compared to those with the minor allele, with an OR of 8.2 (CI: 1.8 to 38.5; p<1 x 10^-2).

Conclusion: Genetic variants of ERAP1 and LMP2 are associated with radiographic severity in AS.
Experience with Accelerated Rituximab Infusion for Rheumatoid Arthritis in a Single Community Practice

Rafat Farawi (McMaster University, Kitchener); Kelly Roth (McMaster University, Kitchener) Objective: Background: Rituximab, a chimeric monoclonal anti-CD20 antibody for treatment of NHL, CLL and RA, is administered as a slow infusion (255 minutes [4.25 hours]), due to the potential for infusion reactions, which is greatest with the initial infusion. However, the long infusion duration is resource intensive. Recently, short-infusion protocols (60 & 90 min) have been shown to be well tolerated in the oncology setting. Little data are available on short infusions in rheumatology. Objectives: To evaluate the practicality, safety and tolerability of a rapid-infusion rituximab protocol in RA patients.

Methods: RA patients meeting the criteria for rituximab treatment were recruited to participate in evaluation of the rapid-infusion protocol. Each treatment course consisted of 2 rituximab 1000-mg infusions, 2 weeks apart. The first infusion followed the recommended schedule (255 min). Second and subsequent infusions were administered over 120 min (2 hr) as follows: 0–30 min: 100 mg; 30–60 min: 200 mg; 60–90 min: 300 mg; 90–120 min: 400 mg. Premedication for all infusions consisted of acetaminophen 1000 mg, diphenhydramine 50 mg, and methylprednisolone 100 mg. Vital signs were recorded at baseline and at 15, 30, 60, 90 and 120 min.

Results: To date, 10 patients have been recruited and 36 infusions administered over 22 patients. The mean DAS was 5.9 at the first rituximab infusion. The average duration between rituximab infusion courses was 9.2 months. The rapid infusion was safe and well tolerated by all patients. One patient experienced a minor infusion reaction (headache, chest tightness, and shortness of breath), which resolved during the infusion. No infections were reported.

Conclusion: An accelerated rituximab infusion is safe and well tolerated in the community setting. The accelerated protocol optimizes patient, nurse and physician time, and all patients were satisfied with the short infusion duration. Rapid rituximab infusion is a practical option in a community setting.

45 A Canadian Survey Regarding Musculoskeletal Imaging for Rheumatology Residents

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Objective: Rheumatology residents must be proficient at interpreting musculoskeletal radiographs as stipulated by the Royal College of Physicians and Surgeons of Canada. It is unclear if, or how these skills are acquired. The purpose of this study was to survey Rheumatology program directors (PD) and residents (RR) regarding their perceived educational needs in radiology, types of training received, perceived adequacy of training, as well as acceptability of an on-line module.

Methods: All Canadian PD and RR were invited to participate in a voluntary online survey. The survey consisted of a total of 14 questions exploring the perceived importance of MSK radiology reading skills, present resident skill level, teaching methods, effectiveness, suggestions for improvement, need for web-based teaching tools and questions regarding its content. Results were reported as percentage of applicants selecting a response or the mean of applicant responses on a 5-point Likert scale.

Results: Completion rates were 12/14 (85.7%) for PD and 20/28 (71.4%) for RR. Over 85% of PD and RR felt that the ability to read plain MSK films was extremely important. The types of films that residents should be able to interpret (1 = no, 3 = neutral, 5 = yes) included plain film (5.0 PD and RR), CT scan (3.58 PD, 3.59 RR), MRI (3.25 PD, 3.7 RE), bone scan (3.25 PD, 3.35 RR) and ultrasound (3.08 PD, 3.89 RR). About half the PD (58.3%) and RR (50%) reported the confidence of residents as “a little confident” in their present ability to read films. The following percentage of those surveyed reported that present skill acquisition involved: formal didactic sessions (50% RR, 75% PD), learning by reviewing patient’s films (85% RR, 100% PD) and web-based material (10% RR, 25% PD). Very few reported the present system of instruction as effective (16.7% PD and 25% RR) and none considered it extremely effective. All PD and 85% of RR felt a web-based teaching module would be valuable.

Conclusion: Program directors and residents agree that the interpretation of musculoskeletal plain films is an essential skill for Rheumatologists. Present instructional modalities include primarily learning through patient care, didactic sessions, and electives in radiology. These are perceived as minimally effective which provides support for a more formal curriculum, which could include a web-based training tool specifically tailored for Rheumatology trainees.

Can Body Mass Index Be Considered a Differentiating Factor when Diagnosing Systemic Sclerosis?

Steven Katz (University of Alberta, Edmonton); Alex Yan (University of Alberta, Edmonton); Muneeb Ilyas (University of Alberta, Edmonton) Objective: We previously reported Body Mass Index was lower in a retrospective cohort of long standing scleroderma patients compared to the overall population. It remains unknown if BMI could be a useful clue to diagnose a prospective cohort of rheumatology patients referred for initial assessment of possible systemic sclerosis.

Methods: In this single rheumatologic practice prospective study, we examined all patients referred for assessment of scleroderma over 5 years...
between 2005 and 2010 and who had a weight and height recorded from their first physician visit. Gender, final diagnosis, and BMI were recorded. Patients were then stratified and compared based on final diagnosis. **Results:** 47 patients were referred for possible sclerodermia, with 10 excluded as no BMI was recorded and 4 excluded without a final diagnosis recorded. Of the remaining 33, 20 were diagnosed with sclerodermia (Scl+), 19 females, with an average age of 51. Diagnoses of the other 13 (Median age: 60, 10 Female) included: 6 primary Raynaud’s disease, 2 rheumatoid arthritis, 1 systemic lupus, 1 mechanical back pain, 1 rotator cuff tendinopathy, 1 diabetes, and 1 atherosclerosis. The average BMI was 23.7 kg/m² for the Scl+ group and 28.01 kg/m² for the Scl- group (p=0.038). Only 1 Scl+ patient had a BMI greater than 30, compared to 5/13 in the Scl- group (p=0.0248).

**Conclusion:** For the rheumatologist who is presented with a first time patient with a question of sclerodermia, a higher BMI may be a useful differentiating factor. Further study is necessary with a larger cohort and more physician experience.

### 47 Sex Differences in Pain Level and Location in Inflammatory Arthritis: A Systematic Review and Meta-Analysis

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**Objective:** Patient sex may influence the disease experience for patients with inflammatory arthritis (rheumatoid arthritis (RA), ankylosing spondylitis (AS), psoriatic arthritis (PsA) and spondyloarthropathy (SpA)), with implications for treatment expectations and predicted response. Our objective was to determine if there are differences in pain level or location reported by females and males in inflammatory arthritis studies.

**Methods:** A search of PubMed (1950 to April 2010) and EMBASE (1980 to April 2010) was supplemented by manual searches of conference abstracts. We identified studies reporting sex-stratified pain measures (visual analogue scale (VAS), bodily pain component of the 36-item Short Form Health Survey (SF-36BP)) or pain location, in biologic naïve populations. Effects analyzed were a) standardized mean difference (SMD) for pain measures (cross-sectional analyses), b) percentage improvement in pain measure (longitudinal analyses), and c) proportion reporting pain at a particular location. The systematic review for pain measures included 26 cohorts and 1 randomized controlled trial (23 in RA, 1 inflammatory polyarthritids, 1 AS and 1 PsA), and for pain location includes 12 publications (9 in AS, 2 PsA and 1 SpA). The meta-analysis for pain measures includes 16 cohorts reporting pain by VAS and 3 cohorts reporting pain by SF-36BP (all RA).

**Results:** Meta-analysis revealed a significant difference in the SMD in pain levels measured by VAS in RA (SMD 0.21 (95%CI 0.16–0.26), p<0.001), likely of modest clinical significance. This difference held when stratified by disease duration at measurement (RA < 1 year SMD 0.30 (95%CI 0.15–0.45), established RA SMD 0.20 (95%CI 0.14–0.25)). The SMD for SF-36BP was not significant (SMD 0.14 (95%CI 0.49–0.20), p=0.411). In longitudinal studies, pain levels in females with RA improved to a greater degree than in males, but were still higher at any time point. In AS, PsA and SpA, males experienced more inflammatory back pain at any time point during their disease (66% vs 51%) and females experienced more pain due to peripheral arthritis (69% vs 51%).

**Conclusion:** Females with RA experience overall higher pain levels than males, but do have a greater degree of improvement with treatment. Although this analysis does not explore confounding factors to explain this, clinicians should be aware of sex differences in pain when managing inflammatory arthritis. In AS, PsA and SpA, females will develop peripheral arthritis more frequently, with fewer manifestations of inflammatory back pain. This may have diagnostic implications in the clinical setting.

### 48 Patient Sex Does Not Influence Pain Levels in Early Inflammatory Arthritis

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**Objective:** Pain levels in established RA are on average higher in women than men. We sought to determine if patient sex influences pain levels in a prospective multicohort of early inflammatory arthritis patients treated to remission.

**Methods:** As of May 2010, 819 females and 307 males were recruited to the Canadian Arthritis CoHort (CATCH). Patients enrolled are over the age of 16 with ≥ 2 swollen joints or 1 swollen MCP orPIP, with symptom duration of 6 weeks to 12 months, and ≥1 of: positive RF, anti-CCP, morning stiffness, response to NSAID or painful MTP squeeze test. Patients are treated at the discretion of their rheumatologists. Sex-stratified analysis of pain measures recorded in CATCH, including the Visual Analogue Scale (VAS), Patient Global Assessment (PGA) and pain components of the Rheumatoid Arthritis Disease Activity Index (RADA1), was performed to identify differences in pain levels between females and males.

**Results:** The cohort includes patients with a mean disease duration of 6 months at first visit, with a mean (SD) baseline DAS28 of 4.85 (1.50) in females and 4.97 (1.80) in males. Females and males had similar levels of disease activity by DAS28 and RADA1 at all assessments, and a similar proportion achieved DAS28 remission. No significant differences were found in pain measures between females and males at baseline, year 1 or year 2 assessments. The mean (SD) VAS at baseline for females and males respectively was 5.40 (2.79) vs 5.49 (2.93); year 1: 2.81 (2.57) vs 2.87 (2.67); and year 2: 2.64 (2.64) vs 2.58 (2.66). The mean (SD) PGA at baseline for females and males respectively was 5.80 (2.90) vs 5.54 (3.08); year 1: 2.85 (2.66) vs 2.93 (2.83); and year 2: 2.73 (2.71) vs 2.26 (2.45). The mean (SD) total joint score of the RADA1 at baseline for females and males respectively was 2.58 (1.91) vs 2.78 (1.99); year 1: 1.30 (1.42) vs 1.27 (1.34); and year 2: 1.16 (1.47) vs 1.19 (1.58).

**Conclusion:** Sex does not influence pain perception in this multinational cohort of early inflammatory arthritis patients. This suggests that differences seen in established RA in other studies may have been influenced by disease duration and other factors.

### 49 Seasonal Variation in Vitamin D Levels in Patients with Psoriatic Arthritis from Northern and Southern Latitudes and its Association with Clinical Outcomes

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**Objective:** We aimed to determine the prevalence of vitamin D deficiency/insufficiency in patients with psoriatic arthritis (PsA), its seasonal and geographic variation, association with demographic and lifestyle characteristics, and with disease activity.

**Methods:** This study was conducted in a center in a northern geographic area (North) and a center in a subtropical region (South), from March 2009 to August 2009. Most subjects were assessed in both winter and summer. Patients completed a vitamin D questionnaire developed to assess lifestyle determinants of vitamin D levels. Demographic, clinical data, skin type ( Fitzpatrick classification), serum 25(OH) vitamin D, creatinine, calcium, phosphorus and liver enzymes were determined. Vitamin D levels were categorized as deficient < 30, insufficient 30– 74 and adequate >75 ng/mL. A multivariate linear mixed model that included demographic/lifestyle and

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Objective: We have shown that in a North American Native (NAN) population in Central Canada, the prevalence of RA is 2–3 times higher than that seen in most other populations, with a high frequency of familial disease. There is also a high prevalence of anti-citrullinated protein antibodies (ACPA) and rheumatoid factor (RF) in the first-degree relatives (FDR) of RA patients. We sought to get a better understanding of the relationship between joint symptoms and RA autoantibodies in disease-free FDR who may be at risk for developing future RA.

Methods: The prevalence of joint symptoms was compared in three distinct groups: 1) FDR of NAN RA patients (n=306), 2) NAN controls (NC, n=330), and 3) Caucasian controls (CC, n=293). The two control groups had no family history of RA or related autoimmune diseases. Study subjects completed a questionnaire which included demographic data, health-related habits, family health history, and six questions probing into whether they experience pain, swelling, or stiffness of the hands or of other joints. Anti-CCP2 antibodies were tested by ELISA and RF by nephelometry.

Results: The mean age of FDRs was 35±13, NCs 33±11, CCs 42±13, p<0.0001. The percentage of females was FDR=69%, NC=63%, and CC=63%, p<0.05. The mean prevalence of RF in FDR was 4.5%, NC was 1%, and CC was 1%, p<0.0001. Logistic regression demonstrated that age and FDR status were strong independent predictors of joint symptoms (p<0.0001 for both), while gender, RF, and ACPA status were not.

Conclusion: RA-like joint symptoms are more common in the FDR of NAN RA patients than they are in either NAN or Caucasian controls having no family history of RA. This finding is not explained by a higher prevalence of ACPA and RF in FDR. These data suggest that pre-clinical joint symptoms, based on biological or psychosocial factors, may be part of the risk profile for developing future disease in high risk individuals.
never progressed, progressed at year 1 only, progressed at year 2 only and progressed at both year 1 and year 2. Demographic and clinical characteristics were compared across these four patterns using ANOVA for continuous outcomes and Chi-square test for categorical outcomes.

**Results:** Among these four patterns, 86% subjects never had radiographic progression, 3.4% progressed in the first year only, 7.6% progressed in the second year only and 2.6% progressed in both year 1 and year 2. There were significant differences between the patterns, for swollen joint count, baseline HAQ score, sharp score, CRP and anti-CCP positive. Subjects who had no radiographic progression in two years were those who are younger, had less swollen joint counts, lower DAS score, lower sharp score, lower CRP, anti-CCP negative and RF negative at baseline.

**Conclusion:** Majority of the early RA subjects do not have radiographic progression within first two years of the disease. Very few subjects continuously progressed within 2-year period. Baseline sharp score is the best indicator of whether the subject will progress or not. Then it is baseline anti-CCP positive, CRP and swollen joint count. These identified indicators can help clinicians to identify the subjects who are at high risk of continuous radiographic progression.

53 Scleroderma prevalence in Alberta: A population-based assessment.

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**Objective:** To estimate the prevalence of systemic sclerosis (SSc) using population-based administrative data, and to compare First Nation (FN) versus non-FN prevalence rates.

**Methods:** We ascertained SSc cases from provincial physician billing and hospitalization databases in Alberta (covering over 3.7 million individuals). Three case definitions were used; >1 billing codes by a rheumatologist; or >2 billing codes by any physician, >8 weeks apart but within 2 years; or a hospitalization diagnosis. The Alberta Health and Wellness registry file was used to determine FN status, as well as rural and urban residence (by postal code). To account for imperfect case ascertainment, we employed a hierarchical Bayesian latent class regression model that accounted for possible between-test dependency conditional on disease status, and potential differences in case ascertainment sensitivity and specificity based on patient characteristics (age, sex, and rural-versus-urban residence). Cases were ascertained from 1994–2007, and prevalence estimates based on those who were still alive as of 2007.

**Results:** Accounting for error inherent in both the billing and the hospitalization data, the estimated overall SSc prevalence in Alberta as of 2007, is 57.7 cases per 100,000 females (95% credible interval, CRl 51.3–65.3) and 9.8 cases per 100,000 males (95% CRl 7.2–13.6). Prevalence was higher for individuals aged>45, particularly in rural women (140.2 cases per 100,000, 95% CRl 118.7–166.3). Although the overall prevalence of SSc in FN was similar to that of non-FN, interesting trends were seen for a higher prevalence of SSc in women of FN status (64.6 cases per 100,000; 95% CRl 43.4–94.0) compared to non-FN women (57.2 cases per 100,000; 95% CRl 50.4–65.3). This was particularly marked for females aged>45 living in rural areas, where the prevalence was 264.8 cases per 100,000 in FN (95% CRl 157.0–422.9) and 135.8 in non-FN (95% CRl 113.6–164.4). For females aged>45 living in urban areas, the prevalence was 207.3 cases per 100,000 in FN (95% CRl 157.0–391.7) and 124.6 in non-FN (95% CRl 106.8–146.0). The prevalence of SSc in subjects aged < 45 were similar in FN and non-FN groups, in both rural and urban areas.

**Conclusion:** We demonstrated differences in SSc prevalence according to age, sex, and region. Though the over-all prevalence of SSc in Alberta was similar for FN and non-FN, we saw a trend towards more cases in FN females aged >45.

54 Sleep Evaluation Before and After Initiation of Anti-Tumour Necrosis Factor Therapy in Rheumatoid Arthritis

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**Objective:** To evaluate sleep before and after anti-TNF-α (tumor necrosis factor) therapy initiation in rheumatoid arthritis (RA) patients.

**Methods:** This was a prospective evaluation of RA patients with poor sleep (abnormal Epworth Sleepiness Scale (ESS) and/or Pittsburgh Sleep Quality Index (PSQI) score) who were to initiate anti-TNF-α therapy. This study utilized overnight polysomnography (PSG) and questionnaire data including: pain, fatigue, global function, modified Health Assessment Questionnaire (mHAQ), depression, stress, SF-36 scores, Rheumatoid Arthritis Disease Activity Index (RADA1), ESS, PSQI, Berlin score for obstructive sleep apnea, and International Restless Legs Syndrome Study Group (IRLSSG) diagnostic criteria. Study patients underwent two PSGs and questionnaires; prior to starting anti-TNF-α therapy and again after initiation. A referent group of RA patients with normal ESS and PSQI scores participated in the baseline evaluation.

**Results:** Twelve RA patients met inclusion criteria, of which ten initiated anti-TNF-α therapy and underwent repeat PSG and questionnaire studies. Following anti-TNF-α therapy initiation improvements were apparent in the pain, fatigue, mHAQ, RADA1 scores. No change in ESS, PSQI, Berlin scores were evident. A trend towards improvement was observed for sleep efficiency (p = 0.031), sleep latency (p > 0.05), and ‘awakening after sleep onset’ time (p = 0.048).

**Conclusion:** Improvement in sleep efficiency, sleep latency and ‘awakening after sleep onset’ time were observed following initiation of anti-TNF-α therapy.

55 Detecting Latent Tuberculosis Infection during Anti-Tumour Necrosis Factor Therapy

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**Objective:** To evaluate the reliability of repeat tuberculin skin tests (TSTs) and Interferon Gamma Release Assays (IGRAs) in detecting latent tuberculosis infection (LTBI) in people on anti-Tumor Necrosis Factor (TNF) medication.

**Methods:** We conducted a prospective, observational study of patients referred to the Saskatoon Tuberculosis (TB) clinic prior to starting anti-TNF medication. A chest x-ray (CXR), 2-step TST and IGRA were performed at baseline. Those patients with a positive TST > 5 mm and/or a positive IGRA were followed with a clinic visit, CXR, TST and IGRA at 3 and 6 months after starting anti-TNF medication.

**Results:** Of 106 potential patients, 91 consented to participate. Twenty-eight patients had a positive TST or IGRA at baseline. Twelve patients started and stayed on anti-TNF medication during the 6-month follow-up and had all testing done. The baseline mean TST measurement for the 12 participants was 13.92 mm (SD 11.35), this increased to a mean of 16.83 mm (SD 9.32) post-booster. At 3 months post-anti-TNF initiation, there was an overall decrease in TST measurement (mean=10.00 mm; SD 9.32; p=0.013). By the 6-month TST, a response recovery was observed with a mean TST measurement of 14.50 mm (SD: 7.65). The IGRA was unchanged throughout the study period in all patients. The overall agreement between TST and IGRA was poor (kappa coefficient = 0.160, p = 0.033).

**Conclusion:** We demonstrated a transient but significant decrease in TST response in the first six months of anti-TNF therapy.
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Efficacy and Safety of Febuxostat and Allopurinol in Women with Gout, An Older Subset With Increased Comorbidity

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Objective: Literature confirms that women with gout have a later onset than men (averaging a decade or more after menopause) and suggests that the frequent comorbidities (renal impairment, cardiovascular disease, metabolic syndrome components, diuretic use) accompanying hyperuricemia/gout in men may be more common in women. We report on the efficacy and safety of febuxostat and allopurinol in the subset of women from 3 randomized controlled trials.

Methods: 4101 subjects (3875 men/226 women) participated in the 12-month FACT or the 6-month APER or CONFIRMS trials. This post-hoc subset analysis focuses on women with gout and baseline serum urate levels (sUA ≥ 8.0 mg/dL, who were randomized to daily placebo (n=11), febuxostat (n=139), or allopurinol (n=76). Baseline renal status was assessed by eCLcr using the Cockcroft-Gault formula. Urate-lowering efficacy (sUA < 6.0 mg/dL) is reported by drug and dose and stratified by baseline renal function.

Results: Women had a mean age of 62 years (vs 52 years for men), and 74% had BMI ≥ 30 kg/m2 (62% men). Comorbid history (women vs men) was significant for hypertension (81% vs 48%), diabetes (26% vs 10%), hyperlipidemia (46% vs 37%), and renal impairment (64% eCLcr < 60 mL/min vs 13%). Gout history: 19% of women and 21% of men had tophi; 86% and 85%, respectively, had experienced a gout flare in the prior year, and mean disease duration was 8 years for women and 12 years for men. Mean sUA at baseline was 9.7 mg/dL for both. In women with the most severe renal impairment (eCLcr 17–59 mL/min), sUA < 6.0 was achieved with: placebo (0%), febuxostat 40 mg (44%), febuxostat 80 mg (83%), febuxostat 120 mg (80%), febuxostat 240 mg (100%), and allopurinol ≤ 300 mg (44%). The most frequently reported AEs among women were: URI (16%), diarrhea (11%), and musculoskeletal/connective tissue disorders (11%). The majority of AEs were transient and resolved while on treatment. The most common serious AEs were cardiac disorders: febuxostat (all doses 2%) and allopurinol (4%).

Conclusion: Women with gout are a group with significant comorbidities (including advanced renal impairment) exceeding those of gouty men. In women with gout, urate-lowering to sUA to < 6.0 mg/dL was achieved with: placebo to ≤ 6.0 mg/dL with febuxostat 80 mg was superior to that of allopurinol at recommended renally adjusted doses (p<0.05) and was well tolerated.

57 Time to and Level of Initial DAS28 Change With Certolizumab Pegol Predicts the Likelihood of Having Low Disease Activity at Years 1 and 2 in Patients With Rheumatoid Arthritis

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Objective: To evaluate the sustainability of improvements in rheumatoid arthritis (RA), inhibition of joint damage progression and tolerability of CZP + MTX over 3 years in patients who completed 24 weeks of double-blind treatment with CZP 200 mg or 400 mg EOW+MTX (completers) in RAPID 2 and entered an open-label extension (OLE) of CZP 400 mg EOW+MTX.

Methods: ACR responses, DAS28(ESR), HAQ-DI, pain VAS (0–100-mm scale) are shown over 3 years (148 weeks) from the RAPID 2 baseline (BL) for CZP completers who entered the OLE; modified Total Sharp Scores (mTSS) are shown over 2.5 years (128 weeks). Patients who withdrew from the OLE for any reason or took rescue medication in the OLE had data imputed from that time point onwards. For mTSS, linear extrapolation (Lin ext) was used. For DAS28, HAQ-DI and pain VAS, last observation carried forward (LOCF) was used for any missing data. For ACR responses, both non-responder imputation (NRI) and observed data are reported. AEs were assessed at each visit (after first study drug administration) from the RAPID 2 BL. Safety analyses were based on the ITT population. AEs and serious AEs (SAEs)/100 patient-years are presented for all pts who received ≥ 1 CZP dose.

Results: Of 494 patients treated with CZP + MTX, 355 completed RAPID 2; of these, 342 (96%) entered the OLE. Completers entering the OLE had high disease activity at the RAPID 2 BL (mean: DAS28: 6.8; HAQ-DI: 1.6; pain VAS: 60.7); mean mTSS at the RAPID 2 BL was 33.6. After 3 years, 79% of CZP completers continued to receive OL CZP; only 2 patients withdrew due to lack of efficacy. ACR responses and improvements in DAS28, HAQ-DI and pain from BL were sustained in the OLE to 3 years in CZP completers. Inhibition of progression of structural damage observed during the placebo-controlled phase was sustained up to the last X-ray evaluation at 2.5 years. The incidence of AEs by Week 148 was 86.0% and 85%, respectively, had experienced a gout flare in the prior year, and mean disease duration was 8 years for women and 12 years for men.

Conclusion: Of the 783 patients randomized to CZP + MTX, 670 patients entered the OLE; of these, 96 patients withdrew and 574 remained in the OLE at Year 2. 98% of randomized patients had DAS28 ≥5.1 at BL (mean BL DAS28 was 6.9). 86.0% of patients had a 1.2 DAS28 response by Week 12. LDA was achieved by 35.2% of the original CZP ITT population at Year 2. Failure to achieve LDA at both Years 1 and 2 was dependent on the level of DAS28 change up to Week 12. Patients with DAS28 changes < 0.3 by Week 4, < 0.9 by Week 6, < 1.2 by Week 10 or < 1.8 by Week 12 had a < 5% chance of having LDA at both Years 1 and 2. For any given change in DAS28, failure to respond by Week 12 was more predictive of failure to achieve LDA at both Years 1 and 2 compared with failure to respond by earlier time points.

Conclusion: The majority of patients responded to treatment with CZP by Week 12. These data stress the importance of significant early response by Week 12, in order to achieve long term low disease activity and help the clinician in the treatment decision process.

58 Efficacy and Safety of Certolizumab Pegol Plus Methotrexate in Patients With Rheumatoid Arthritis: 3-Year Data From the RAPID 2 Study

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Objective: To evaluate the predictability of the time to and level of DAS28 response on the likelihood of achieving low disease activity (LDA) at both Years 1 and 2 in rheumatoid arthritis (RA) patients treated with certolizumab pegol (CZP) + methotrexate (MTX).

Methods: Patients treated with every other week CZP 200 or 400 mg + MTX in RAPID 1 were combined for analysis (N=783). The proportion of patients who achieved DAS28 LDA (DAS28 ≤ 3.2) at Years 1 and 2 (during the open-label extension [OLE]) were assessed according to the level of DAS28 response (i.e., DAS28 decrease from baseline [BL] ≤ 0.3, 0.6, 0.9, 1.2, 1.5 and 1.8 units) by various time points (Weeks 1, 2, 4, 6, 8, 10 or 12). Last observation carried forward (LOCF) imputation was used for patients who did not reconsent to enter the OLE, received rescue medication or who withdrew from the OLE.

Results: Of the 783 patients randomized to CZP + MTX, 670 patients entered the OLE; of these, 96 patients withdrew and 574 remained in the OLE at Year 2. 98% of randomized patients had DAS28 ≥5.1 at BL (mean BL DAS28 was 6.9). 86.0% of patients had a 1.2 DAS28 response by Week 12. LDA was achieved by 35.2% of the original CZP ITT population at Year 2. Failure to achieve LDA at both Years 1 and 2 was dependent on the level of DAS28 change up to Week 12. Patients with DAS28 changes < 0.3 by Week 4, < 0.9 by Week 6, < 1.2 by Week 10 or < 1.8 by Week 12 had a < 5% chance of having LDA at both Years 1 and 2. For any given change in DAS28, failure to respond by Week 12 was more predictive of failure to achieve LDA at both Years 1 and 2 compared with failure to respond by earlier time points.

Conclusion: The majority of patients responded to treatment with CZP by Week 12. These data stress the importance of significant early response by Week 12, in order to achieve long term low disease activity and help the clinician in the treatment decision process.
Efficacy Sustained After Dose De-escalation of Certolizumab Pegol in Rheumatoid Arthritis Patients: Post-hoc Analysis of the RAPID 2 Open-label Extension

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Objective: To investigate the impact of certolizumab pegol (CZP) dose decrease on efficacy in rheumatoid arthritis (RA) patients.

Methods: This analysis includes all RAPID 2 CZP 200 and 400 mg completers who received CZP 400 mg EOW + MTX in the OLE and who subsequently had the CZP dose decreased to 200 mg EOW by the 3-year data cut. CZP dose decrease was mandatory after ≥6 months in the OLE. As the dose decrease occurred at different times, data are shown up to 48 weeks of CZP exposure following dose decrease, with Week 0 (for this analysis) set as the last efficacy assessment visit prior to dose decrease; CZP dose decrease occurred between Weeks 0 and 10. Week 12 is therefore the first visit after dose decrease. Analyses include mean DAS28 (ESR) and HAQ-DI scores (last observation carried forward [LOCF]) and ACR responses (non-responder imputation). Data are shown by treatment originally received in RAPID 2 (200 or 400 mg EOW + MTX).

Results: Of 342 RAPID 2 completers who received OL CZP 400 mg + MTX, the CZP dose was decreased in 287 (139 CZP 200 mg and 148 CZP 400 mg completers) by the 3-year data cut. All 287 patients received OL CZP 400 mg for ≥1 year prior to dose decrease, with 126 and 132 CZP 200 and 400 mg completers, respectively, having reached up to 48 weeks exposure following dose decrease (Week 48 of this analysis). Mean DAS28 scores were 3.77 (SD: 1.22) and 3.54 (1.08) in CZP 200 and 400 mg completers at Week 0 and remained similar after dose decrease to Week 48. Mean HAQ-DI scores were 0.91 (0.61) and 0.90 (0.56) in CZP 200 mg and 400 mg completers, respectively, at Week 0 and were similar to Week 48 (0.87 [0.59] and 0.84 [0.56], respectively). The ACR50 response rates at Week 48 after dose decrease were 47% and 42% for CZP 200 mg and 400 mg completers, respectively; the ACR70 response rates were 24% and 22%, respectively.

Conclusion: In RA pts who had an initial response to CZP, efficacy was maintained in the OLE after CZP dose decrease from 400 mg to 200 mg EOW + MTX.

Number Needed to Treat to Achieve Broad Relief From the Burden of Rheumatoid Arthritis (RA) in Patients Treated With Certolizumab Pegol Plus Methotrexate

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Objective: To determine the number needed to treat (NNT) to achieve minimum clinically important differences (MCIDs) in multiple patient reported outcomes (PROs) following treatment with certolizumab pegol (CZP) 200 mg + MTX compared with placebo (PBO) + MTX in the RAPID 1 and RAPID 2 trials.

Methods: The proportion of patients reporting improvements ≥MCID in RAPID 1 (Weeks 24 and 52) and RAPID 2 (Week 24) was determined for the following PROs: arthritis pain (0–100-mm visual analogue scale [VAS], MCID ≥10 mm), fatigue (Fatigue Assessment Scale, 0–10 numeric rating scale, MCID ≥1 point), physical function (Health Assessment Questionnaire-Disability Index, MCID ≥0.22 points), patient’s global assessment of disease activity (PGA, 0–100-mm VAS, MCID ≥10 mm), and HRQoL (SF-36 Physical and Mental Component summaries [PCS, MCS], MCID ≥2.5 points). NNT and benefit ratios (BR, % responders in active treatment/% responders in PBO) to achieve improvements ≥MCID in at least 1, 2, 3, 4, 5 or 6 out of the 6 considered PROs were calculated.

Results: The NNT to achieve clinically meaningful improvements in up to 5 of 6 PROs following treatment with CZP 200 mg + MTX was 2–3 additional patients after 24 weeks (RAPID 1 and RAPID 2) and remained similar at 52 weeks (RAPID 1); the NNT for improvements in all 6 PROs was 5 patients. Patients having achieved MCIDs in at least 5 of 6 PROs by Week 52 were more likely to be reported in pain, fatigue, physical function and PGA than SF-36 PCS and MCS. Of the patients who reported improvements ≥MCID in 5 of 6 PROs, 29% and 46% of patients did not report changes ≥MCID in SF-36 PCS and MCS at Week 52, respectively. In contrast, 2–12% of patients did not report changes ≥MCID in the other PROs. Compared with PBO + MTX, CZP 200 mg + MTX patients were 4–6 times more likely to achieve improvements in 5 of 6 PROs, and 6–7 times more likely to report improvements in all 6 PROs.

Conclusion: Low NNTs indicate relatively few patients need to be treated with CZP + MTX to achieve RA relief.

A Comparison of Sleep Quality in Rheumatoid Arthritis and Osteoarthritis Patients

Regina Taylor-Gjevre (University of Saskatchewan, Saskatoon); John Gjevre (University of Saskatchewan, Saskatoon); Bindu Nair (University of Saskatchewan, Saskatoon); Robert Skomro (University of Saskatchewan, Saskatoon); Hyun Lim (University of Saskatchewan, Saskatoon)

Objective: To evaluate and compare aspects of sleep quality in Rheumatoid Arthritis (RA) and Osteoarthritis (OA) patient populations.

Methods: Consecutive RA and OA clinic patients were invited to participate in a self-administered questionnaire study which included the multi-domain Pittsburgh Sleep Quality Index (PSQI).

Results: The study population included 145 RA and 78 OA patients. No significant differences in PSQI global or domain scores were observed between diagnostic groups. PSQI global scores were abnormal in 62% of RA and 67% of OA patients. Increased abnormalities in subjective sleep assessment, sleep latency, sleep duration, sleep efficiency, daytime dysfunction and increased sleep aid medication use were observed in both populations. The most common abnormality reported by both RA and OA patients was increased sleep fragmentation with frequent disturbances.

Conclusion: A high prevalence of abnormal sleep quality in both RA and OA patient populations was observed. The most common abnormality was sleep fragmentation with an increased sleep disturbance score.

Development, Evaluation and Implementation of a Successful Interprofessional Education Program for Adults with Inflammatory Arthritis

Kelly Warmington (St. Michael’s Hospital, Toronto); Carol Kennedy (St. Michael’s Hospital, Toronto); Dorcas Beaton (St. Michael’s Hospital, Toronto); Rachel Shupak (St Michael’s Hospital, Toronto); Sheliah Hogg-Johnson (Institute for Work & Health, Toronto)

Objective: Arthritis is a chronic, debilitating disorder characterized by inflammation, pain and joint destruction. Effective patient education about arthritis and its treatment is an important component of patient care, complementing medical treatment by teaching people to self-manage their disease. This evaluation was designed to assess the feasibility of a one-day, interprofessional, inflammatory arthritis education program and to explore the effect of the program on arthritis self-efficacy, arthritis knowledge and other outcomes. This presentation examines the knowledge translation and adaptive strategies that made the evaluation, implementation and integration of the program possible at an urban teaching hospital.

Methods: A patient-based needs assessment and ongoing patient feedback
prior to and during recruitment guided program development. An interprofessional arthritis care team, adult educators, clinical researchers and an arthritis consumer were involved in determining and refining program format, duration and content. The interprofessional team was involved in developing and delivering program content and adapting the program to patient needs following the completion of the present study. Patients attended a single day (6 hours) education session which combined didactic, small group and large group modalities. This was a non-randomized, wait-listed control (with cross-over) trial of patients with inflammatory arthritis. Data was collected at baseline, following intervention (I), at 6 months [cross-over: control group (C) receives I, following cross-over and at 1 year. Self-report measures included: demographics, disorder-related, arthritis self-efficacy, arthritis knowledge, coping efficacy, illness intrusiveness. Outcomes assessed using reliable and valid measures. Analysis included: baseline comparison (I vs C), Standardized Effect Size (SES) at 6 months, Generalized Estimating Equations (GEE) analysis to evaluate repeated measures. Results: Patient interest was very high. The one-day program format combined with the non-randomized study design made participation and attendance feasible for patients. Program and study modifications based on patient input made recruitment possible. 42 persons participated (I n=23; C n=19) with 93% follow-up at 1 year. No significant baseline differences between groups. Comparison of change at 6 months (I vs C) showed moderate effect sizes (SES ranging from 0.5 to 0.7). GEE analysis showed significant main effect, pre to post RxEd, in both groups across outcomes. Conclusion: Program feasibility was dependent on patient feedback and program adaptations. This study provides evidence that the RxEd program is feasible, improves arthritis self-efficacy, arthritis knowledge and other outcomes. The program is now successfully being implemented as part of usual care, supported by ongoing program evaluation.

63 Low Rates of Infliximab Dose Titration and Discontinuation Are Observed in Rheumatoid Arthritis (RA) Patients in a Real-life Canadian Cohort

Bill Benson (McMaster University, Hamilton); Rafat Farawi (N/A, Kitchener); Hayssam Khalil (Merck Canada Inc, Montreal)

Objective: The recommended dose of infliximab (IFX) in RA is 3 mg/kg given as an IV infusion followed by additional 3 mg/kg doses at 2 and 6 weeks after the first infusion then every 8 weeks thereafter. For patients who have an incomplete response, consideration may be given to adjusting the dose up to 10 mg/kg and/or treating as often as every 4 weeks. The aim of this analysis is to evaluate the dose changing patterns and related therapeutic response observed in RA patients treated with IFX in Canada.

Methods: The data for this analysis were obtained from an observational study of adult RA patients initiated on treatment with IFX and followed prospectively as per routine care since 2002. Patients enrolled were biologic naive or had initiated treatment with a biologic less than six months prior to enrolment. All adverse events were reported using preferred term and high-level System Organ Class codes, using the most severe intensity for that event.

Results: 765 patients were recruited with a mean (SD) age of 55.9 (13.4) years and mean (SD) duration of disease at baseline of 10.3 (9.9) years. A mean follow-up of 17.8 (16.9) months, 76 out of 765 patients (9.9%) reported 121 serious adverse events (SAEs). Among these, serious infections were reported by 23 patients (3.0% or 2.2 serious infections / 100 pt-ys). Non serious AEs (NSAEs) were reported by 36.2% of patients, including 92 patients (12.0%) experiencing an infection. Malignancies were reported in 6 patients (0.8%) and 33 out of the 765 patients (4.3%) had infection-related reactions, 85% of which were mild to moderate in severity. There was one case of disseminated tuberculosis reported 25.4 months after baseline, which resulted in death. A newly acquired infection seems likely as the patient’s TB screening at baseline was negative and the patient had traveled to India four months prior to TB onset. One additional death was possibly related to the study treatment (atherosclerosis of coronary artery), while 3 deaths were judged unrelated.

Conclusion: In the Canadian routine care setting IFX was well tolerated for the management of RA.

64 Long-term Safety, Under Routine Care, of Infliximab in Patients With Rheumatoid Arthritis in a Large Canadian Cohort

Bill Benson (McMaster University, Hamilton); Denis Choquette (Hôpital Notre-Dame, Montreal); Niall Jones (University of Alberta, Edmonton); Dalton Sholter (124 Street Medical Group, Edmonton); Alex Yan (University of Alberta, Edmonton); Rafat Farawi (N/A, Kitchener); Heidi Imhoff (Merck Canada Inc, Kirkland)

Objective: The efficacy and safety of Infliximab (IFX) in Rheumatoid Arthritis (RA) has been demonstrated in several controlled clinical trials. Assessment of long-term safety under real-life conditions is necessary for the population based benefit-risk evaluation. This analysis describes for the first time the long-term safety profile of IFX in a routine care cohort of Canadian patients with RA.

Methods: The data for this analysis were obtained from an observational study of adult RA patients initiated on treatment with IFX and followed prospectively as per routine care since 2002. Patients enrolled were biologic naive or had initiated treatment with a biologic less than six months prior to enrolment. All adverse events were reported using preferred term and high-level System Organ Class codes, using the most severe intensity for that event.

Results: 765 patients were recruited with a mean (SD) age of 55.9 (13.4) years and mean (SD) duration of disease at baseline of 10.3 (9.9) years. A mean follow-up of 17.8 (16.9) months, 76 out of 765 patients (9.9%) reported 121 serious adverse events (SAEs). Among these, serious infections were reported by 23 patients (3.0% or 2.2 serious infections / 100 pt-ys). Non serious AEs (NSAEs) were reported by 36.2% of patients, including 92 patients (12.0%) experiencing an infection. Malignancies were reported in 6 patients (0.8%) and 33 out of the 765 patients (4.3%) had infection-related reactions, 85% of which were mild to moderate in severity. There was one case of disseminated tuberculosis reported 25.4 months after baseline, which resulted in death. A newly acquired infection seems likely as the patient’s TB screening at baseline was negative and the patient had traveled to India four months prior to TB onset. One additional death was possibly related to the study treatment (atherosclerosis of coronary artery), while 3 deaths were judged unrelated.

Conclusion: In the Canadian routine care setting IFX was well tolerated for the management of RA.

65 The Efficacy of Non-biologic Disease-modifying Antirheumatic Drugs (DMARDs) in the Treatment of Pain in Early Versus Late Inflammatory Joint Disease (IJD): a Systematic Literature Review

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Objective: Non-biologic DMARDs have been used in the management of IJD for decades. In recent years, the importance of prompt initiation of such treatment to prevent the development of joint erosions and resultant damage has become apparent, especially in the treatment of rheumatoid arthritis (RA). Another clinically important outcome is that of pain control. In this systematic literature review, we investigated the effect of commonly
prescribed non-biologic DMARDs on pain in early and late IJD. Biologic DMARDs were not studied.

**Methods:** A systematic literature search was performed with Medline, Embase, Cochrane Central and Cochrane Database of Systematic Reviews, and abstracts from the 2008/2009 annual congress of the American College of Rheumatology. A manual search of the citation lists of retrieved publications was performed. Only randomized controlled trials were included in the analysis. Their quality was assessed with the Risk of Bias tool; those fulfilling a minimum of 3/5 criteria were included. Descriptive statistics were used in the metaanalysis.

**Results:** Of 9,860 articles identified, 29 (8 for ankylosing spondylitis (AS), 6 for psoriatic arthritis (PsA), 8 for early rheumatoid arthritis (ERA) and 7 for RA) were included for analysis (some had ≥1 DMARD arm). For each of AS and PsA, only one study reported average disease duration <5 years; the remainder studied established disease. In AS, 4 studies revealed VAS-pain improvement with sulfasalazine, while 4 studies revealed no VAS-pain improvement with DMARDs (2 studied sulfasalazine, 1 leflunomide, 1 methotrexate). In PsA, 5 studies (3 sulfasalazine, 2 gold) reported VAS-pain improvement, whereas 3 studies (1 each of methotrexate, methotrexate + cyclosporine, and gold) did not. In ERA and RA, use of all DMARDs and combinations thereof resulted in significant VAS-pain improvement excepting two studies of gold salts. Although there was heterogeneity, for studies that could be analyzed, the DMARD-associated mean VAS-pain decrement in ERA, RA, PsA and AS (using a 100 mm scale) was 29.3, 20.6, 16.9, and 12.8 (median 28.4, 21.4, 13.5 and 11.5), respectively. There was no difference in mean disease duration between studies reporting efficacy and those that did not in any disease category.

**Conclusion:** Sulfasalazine may be beneficial in improving pain in AS and PsA. All DMARDs appear to improve pain in early and established RA. The greatest VAS-pain decrement was in ERA patients, and the least in AS patients. Related efficacy of DMARDs in pain control in early versus late IJD could not be addressed.

**66 Assessing the Efficacy of Early Optimal Parenteral Methotrexate in an ERA Cohort, Single-site Experience**

David Rowe (Saba University School of Medicine, Stouffville); Carter Thorne (Southlake Regional Health Care, The Arthritis Program, Newmarket); CATCH Scientific Advisory Committee (Canadian Arthritis Cohort, Toronto)

**Objective:** We have previously used the CATCH cohort to investigate the efficacy of treatment of rheumatoid arthritis with early optimal dosing of parenteral methotrexate (pMTX) (≥ 20 mg/week) — initial results suggested increased remission rates. As a follow-up study we examined a single site (with an established treatment strategy that uses early optimal pMTX) in an attempt to develop more robust data. Outcomes were: Proportion of single-site patients treated with early optimal pMTX achieving DAS28-defined remission (DAS28 < 2.6) and low disease activity (LDA; DAS28<3.2) by 3, 6 and 12 months.

**Methods:** A chart audit was conducted for a Newmarket, ON community Rheumatology practice. Patients previously eligible for the CATCH cohort were selected for review. Baseline clinical data was recorded from first visit so as to capture evidence of disease activity prior to treatment. Clinical indicators of disease activity were assessed at baseline, 3, 6 and 12 months — including swollen joint count, tender joint count, ESR/CRP, DAS28 and HAQ score. Rheumatoid factor (RF) and anti-CCP positivity as well as radiographic evidence of erosive change were also recorded if available.

**Results:** One hundred and nineteen (n=119) patient charts were eligible for review at time of submission. At this site 76% of patients with Early Rheumatoid Arthritis were started on early optimal doses of pMTX. Of these, 81% also received initial corticosteroid injections or short course oral prednisone. At 12 months 67% of patients started on early optimal pMTX had achieved DAS28-defined remission; 86% had achieved low disease activity (LDA). 52% of patients were RF positive.

**Conclusion:** Remission rates in patients treated with early optimal pMTX at this particular site appear to be higher than previously reported results within the cohort. Potential confounders include patient enrolment in a local arthritis program, concurrent treatment with corticosteroids and, in fewer cases, other DMARDs, and the possibility of more self-limiting disease in those patients who are RF negative. At time of conference, further review of updated clinical visits and data will be available to strengthen initial results.

**67 Correlation of CDAI and SDAI with DAS in a Large, Real-life Cohort of RA Patients Treated With Infliximab**

Denis Choquette (Hôpital Notre-Dame, Montreal); Bill Bensen (McMaster University, Hamilton); Milton Baker (University of Victoria, Victoria); Haysssam Khalil (Merck Canada Inc, Montreal)

**Objective:** In recent years, the efficacy of anti-TNF-alpha in the management of RA has been demonstrated in numerous controlled clinical trials. The Clinical Disease Activity Index (CDAI) and Simplified Disease Activity Index (SDAI) have been recently designed as simplified disease activity scores. The purpose of this analysis is to evaluate the correlation between these simplified disease activity scores and routine clinical practice scores.

**Methods:** The data for this analysis were obtained from an observational study of adult RA patients initiated on treatment with infliximab and followed prospectively as per routine care since 2002. Patients enrolled were biologic naive or had initiated treatment with a biologic less than six months prior to enrolment.

**Results:** A total of 440 patients, who were enrolled up to 31 May 2006 for RA and thus had the potential of treatment for 48 months, were included in this analysis. Mean (SD) age was 56.4 (13.6) years and mean (SD) disease duration at baseline was 11.0 (10.2) years. Mean (SD) SDAI at month 0, 6, 12, 24, 36 and 48 were 44.0 (16.5), 18.8 (13.9), 16.5 (13.1), 13.5 (12.0), 13.4 (11.9) and 10.6 (9.8), respectively. Mean (SD) CDAI at months 0, 6, 12, 24, 36 and 48 were 41.6 (15.9), 17.5 (13.4), 15.0 (11.9), 12.3 (11.7), 11.5 (11.6) and 8.7 (9.7), respectively. Mean (SD) DAS28-4 CRP at month 0, 6, 12, 24, 36 and 48 were 5.0 (1.1), 3.3 (1.2), 3.2 (1.2), 3.0 (1.1), 2.9 (1.2), and 2.6 (1.0), respectively. HAQ scores at month 0, 6, 12, 24, 36 and 48 were 1.8 (0.7), 1.3 (0.8), 1.2 (0.8), 1.2 (0.8), 1.1 (0.8) and 1.0 (0.8), respectively. These results show that by 6 months of treatment significant changes (P < 0.05) were observed using all scores. Further slight improvement in between months 6 and 48 months were observed with all analyzed scores.

**Conclusion:** The results of this real-life observational study demonstrate that over four years of treatment infliximab is effective in reducing symptom severity and improving outcomes in patients with Rheumatoid Arthritis using different scores. Also, the data from this registry confirmed the validity of the SDAI and CDAI as disease activity measures in a real-life RA cohort.

**68 Profile of Patients with Rheumatoid Arthritis Treated With Infliximab in Canada-Trends Toward Less DMARD Use Prior to a Biologic, Earlier Use of Infliximab and Differences in Baseline Disease**

Bill Bensen (McMaster University, Hamilton); Christopher Atkins (University of Victoria, Victoria); Maqbool Sheriff (Nanaimo Regional General Hospital, Nanaimo); John Kelsall (Mary Pack Arthritis Center and St Paul’s Hospital, Vancouver); Haysssam Khalil (Merck Canada Inc, Montreal)

**Objective:** The efficacy of Infliximab (IFX) in Rheumatoid Arthritis (RA) is well established. Patient profiles and use of biologics have reportedly changed since their introduction. The aim of this analysis is to describe Canadian patient profiles at the time of initiation of IFX and treatment outcomes in the years 2002 until 2009.

**Methods:** The data for this analysis were obtained from an observational study of adult RA patients initiated on treatment with IFX and followed prospectively as per routine care since 2002. Patients enrolled were biolog-
ic naïve or had initiated treatment with a biologic less than six months prior to enrolment. Patients were analyzed by the year of their enrolment.

Results: A total of 757 patients were enrolled between 2002 and December 2009. A tendency was observed across years towards earlier IFX initiation upon disease diagnosis as indicated by the decrease in disease duration (12.4 years in 2002 vs 7.8 years in 2009) and treatment of patients with fewer DMARDs prior to study enrollment, as indicated by the decrease in proportion of patients who had received >4 DMARDs prior to initiation of IFX (25% in 2002 vs 5% in 2009). Furthermore, patients’ profile at baseline (BL) changed significantly across years towards less severe disease: mean DAS28-CRP 5.9 in 2002 vs 4.6 in 2009; mean HAQ 1.8 in 2002 vs 1.4 in 2009; mean SJC 13.9 in 2002 vs 7.4 in 2009; mean TJC 16.1 in 2002 vs 10.1 in 2009; mean PGA 7.2 in 2002 vs 5.9 in 2009; mean SGA 63.4 in 2002 vs 54.9 in 2009; and mean pain (VAS) 60.1 in 2002 vs 50.6 in 2009. Interestingly, patients with provincial coverage (n=380) had higher DAS28 [5.5 (1.1) vs. 5.0 (1.3)], HAQ [1.9 (0.6) vs. 1.5 (0.7)], SJC [12.9 (7.0) vs. 10.8 (6.9)], TJC [15.0 (7.9) vs. 12.9 (7.7)], PGA [7.0 (1.8) vs. 6.1 (2.3)], SGA [64.8 (22.2) vs. 57.2 (26.0)], Patient Pain [62.4 (22.6) vs. 52.6 (25.4)] and AM stiffness [75.2 (43.4) vs. 67.2 (43.9)] compared to patients with private coverage (n=270).

Conclusion: The results of this study show a significant change in several clinical and patient outcomes towards lower disease activity at initiation of IFX treatment between 2002 and 2009. Patient management has also changed, with a trend to initiate IFX treatment after failure of fewer DMARDs. Finally, patients with public coverage appear to have a more severe disease profile at baseline compared to patients on private coverage.

69 Disconnect Between Disease Activity and Joint Space Narrowing for Patients with Early Ra Treated with Adalimumab plus Methotrexate but not Methotrexate Alone: Case for Anti-Tnf Cartilage Protection

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Objective: Joint space narrowing (JSN) is inhibited by treatment with the combination of adalimumab (ADA) and methotrexate (MTX). Importantly, it is not known whether ADA+MTX treatment exerts these protective effects solely by controlling inflammation or also by a specific effect on cartilage as has been shown for joint erosions. The objective of this analysis was to compare the relationship between disease activity (DAS28) and progression of JSN in patients with early rheumatoid arthritis (RA) treated with ADA+MTX vs. MTX.

Methods: Two-year data of the PREMIER study (a randomized controlled trial comparing MTX with ADA+MTX in patients with early RA) were used to perform this analysis. Data were from patients (n=525) randomized to MTX or ADA+MTX. DAS28 was time-averaged (TA–DAS28) over 3 intervals from baseline: 26, 52, and 104 weeks, and multivariate analyses were performed to assess the impact of treatment and TA–DAS28 on change in JSN after 26, 52, and 104 weeks of treatment. To control for continuous between-group variations in DAS28, we compared groups by TA–DAS28 quartile.

Results: All results are changes in JSN expressed by quartile (range) of TA–DAS28. In the MTX group, JSN increased as TA–DAS28 increased [Week 26 (observed): Q1 (< 3.6): 0.38; Q2 (3.6-4.4): 0.39; Q3 (4.4-5.1): 0.64; Q4 (≥5.1): 2.43. Week 52 (observed): Q1 (< 3.2): 0.60; Q2 (3.2-4.0): 1.05; Q3 (4.0-4.8): 1.38; Q4 (≥4.8): 3.97. Week 104 (linear imputation): Q1 (< 3.3): 0.82; Q2 (3.3-4.2): 2.11; Q3 (4.2-5.1): 2.98; Q4 (≥5.1): 8.14]. However, this relationship was not apparent in the ADA+MTX group [Week 26: Q1 (< 3.6): 0.15; Q2 (3.6-4.4): 0.17; Q3 (4.4-5.1): -0.06; Q4 (≥5.1): 0.63. Week 52: Q1 (< 3.2): 0.52; Q2 (3.2-4.0): 0.43; Q3 (4.0-4.8): 0.55; Q4 (≥4.8): 0.53. Week 104: Q1 (< 3.3): 0.56; Q2 (3.3-4.2): 0.90; Q3 (4.2-5.1): 1.02; Q4 (≥5.1): 1.60]. Week 104 results were similar using either observed data or linear imputation.

Conclusion: The typical relationship between TA–DAS28 and progression of JSN was observed in patients treated with MTX; however, this relationship was not apparent in patients treated with ADA+MTX. These results suggest that ADA+MTX may have direct protective effects on cartilage that are beyond its ability to control for disease activity, potentially through the inhibition of catabolic activities in chondrocytes.

70 Safety of Infliximab Treatment in a Real-World Clinical Setting: Description and Evaluation of Infusion Reactions

John Kelsall (University of British Columbia, Vancouver); Mary De Vera (Arthritis Research Centre of Canada, Vancouver); Pamela Rogers (Arthritis Research Centre, Vancouver); Griselda Galindo (Arthritis Research Centre, Vancouver); Alice Klinkhoff (Mary Pack Arthritis Program, Vancouver)

Objective: Our objective was to describe acute and delayed infusion reactions in a large cohort of patients treated with infliximab (IFX).

Methods: We conducted a retrospective chart review of patients treated with IFX at the Mary Pack Arthritis Centre between 2000 and 2008. Primary outcome was the occurrence of acute infusion reactions occurring during or up to 2 hours after each infusion and secondary outcome was the occurrence of delayed infusion reactions occurring between 1 to 14 days after an infusion. Descriptive statistics were used to characterize demographics, clinical histories, and acute and delayed infusion reactions. Rates of acute and delayed reactions were calculated as the number of reaction episodes divided by the number of INF infusions during the follow-up. Analyses were conducted for all patients and for patients with rheumatoid arthritis (RA) separately, who represented the largest proportion of patients in the cohort.

Results: Overall, we report on 200 patients: 135 (67%) patients had RA, 23 (12%) psoriatic arthritis, 22 (11%) ankylosing spondylitis, 6 (3%) ocular inflammatory disease, and 14 (7%) other inflammatory arthritis. Mean disease duration at first infusion for all patients and RA patients were 15.8 ± 10.9 and 16.7 ± 11.2 years, respectively. Altogether, patients received 4,399 IFX infusions over mean 140 ± 132 weeks of follow-up. Of these, 135 were patients with RA who received 2,977 IFX infusions over mean follow-up of 138 ± 132 weeks. 258 episodes of acute reactions were observed for an overall acute reaction rate of 5.9% (5.2% for RA patients). Acute reactions were mostly mild (42.6%) and moderate (43.8%) in presentation and the most commonly affected sites were head and neck (31.5%) and skin (21.1%). 37 delayed reaction episodes were observed (0.8% for all patients; 0.81% for RA patients) and were also mostly mild (16.2%) and moderate (64.9%) in presentation.

Conclusion: This study provides a description of acute and delayed infusion reactions in 200 patients treated for rheumatologic conditions in a real world clinical setting. Overall, data demonstrate that acute and delayed infusion reactions occur infrequently and when they do occur, are mostly mild to moderate in severity.

71 A Description of Surgical Procedures Among Patients with Rheumatoid Arthritis on Infliximab Treatment

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Objective: Despite the growing use of biologics in rheumatoid arthritis (RA), there is limited information on the characteristics of patients undergoing surgeries during treatment courses with these agents. Our objective was to characterize RA patients undergoing surgeries during treatment on infliximab (IFX) in a real world clinical setting.

Methods: We conducted a retrospective chart review of RA patients treated...
ed with IFX at the Mary Pack Arthritis Centre between 2000 and 2008. Extracted clinical data included demographic information, RA disease characteristics, comorbidities, medication history, and information over all infusions performed. A detailed history of all surgical procedures occurring after a first IFX infusion was collected. Surgeries were classified according to specialty (i.e., orthopedic, cardiothoracic) as well as type (i.e., arthroplasty, bypass procedure). For each surgery, we calculated the elapsed period from a prior and subsequent IFX infusion. Descriptive statistics were used to present the data. To compare characteristics of RA patients who received surgery with those who did not, we used independent samples t-tests for continuous variables and chi-square tests for categorical variables.

Results: A total of 135 RA patients (79% female) received 2,977 IFX infusions over mean follow-up of 138 ± 132 weeks. At baseline (1st IFX infusion), mean age was 54 years and RA duration was 16.7 ± 11.2 years. Overall, 39 RA patients (29%) underwent at least one surgical procedure during treatment with IFX. RA patients who underwent surgery did not differ from RA patients who did not undergo surgery across baseline disease characteristics. Among the 39 surgical patients, a total of 78 procedures were recorded during treatment with IFX (24 patients underwent 1 surgery, 6 patients underwent 2 surgeries, 4 patients underwent 3 surgeries, 1 patient underwent 4 surgeries, 2 patients underwent 5 surgeries, 1 patient underwent 7 surgeries, and 1 patient underwent 8 surgeries). The most frequent type of surgery was orthopedic 58% (n=45) of these 47% were joint protheses; 10% (n=8) were cardiothoracic surgeries; 9% (n=7) were nodule excisions and tendon repairs, 8% (n=6) involved abdominal procedures such as colostomies; 4 were dental procedures, 4 were genitourinary procedures and 4 miscellaneous, including ophthalmological procedures.

Conclusion: This study provides a description of surgical procedures in RA patients undergoing IFX treatment in a real world clinical setting. Overall, data demonstrate that surgical patients did not differ from nonsurgical patients at baseline disease and that orthopedic procedures represent the most common surgeries in these patients.

72 A Comparison of Methotrexate Use Amongst Dermatologists and Rheumatologists in Canada
Elaine Dupuis (University of British Columbia, Vancouver); Jan Dutz (Department of Dermatology and Skin Science, Vancouver)

Objective: Methotrexate (MTX) is commonly used by both dermatologists in the treatment of psoriasis and rheumatologists for psoriatic arthritis (PsA) and rheumatoid arthritis (RA). Treatment guidelines on use of MTX have recently been published in both specialties but current use patterns are largely unknown. This study set out to explore and compare the current preferences of MTX use amongst Canadian dermatologists and rheumatologists.

Methods: An online survey was made available to 414 Canadian dermatologists and 415 Canadian rheumatologists during a two-week period in September 2010. The 50 question survey explored MTX use in the treatment of psoriasis, PsA, and RA with topics ranging from administration route to biologics use. Influencing factors were also explored.

Results: 27.2% of rheumatologists and 16.4% of dermatologists responded to the survey. Psoriasis 80.0% of rheumatologists and 96.8% of dermatologists who treated psoriasis used oral tablets to initiate MTX therapy. When needed, 95.7% of rheumatologists and 49.2% of dermatologists would switch to parenteral MTX. When they switched, 98.0% of rheumatologists and 62.5% of dermatologists switched to subcutaneous (SC) injections. When using biologics with MTX, 75.6% of rheumatologists did not change the MTX dose, while 81.1% of dermatologists discontinued MTX. Psoriatic Arthritis 82.0% of rheumatologists and 100% of dermatologists who treated PsA initiated MTX therapy with oral tablets. When needed, 100% of rheumatologists versus 68.8% of dermatologists would switch to parenteral MTX, specifically to SC injections (98.0% of rheumatologists, 81.8% of dermatologists). When using biologics, 70.4% of dermatologists did not change MTX dose while 43.8% of dermatologists discontinued MTX.

Conclusion: The survey had an overall response rate of 21.8% (95% CI: 15.8% to 27.8%) so the results should be interpreted with this in mind. In treatment of psoriasis and PsA both specialties initiated MTX treatment with oral tablets. However, rheumatologists were more likely to switch to a parenteral route and use SC injections. While both specialties used biologics, they differed in how they bridged it from MTX. Rheumatologists would often not change the MTX dose after initiating a biologic whereas dermatologists would discontinue MTX, either immediately or through a taper. Rheumatologist’s use of MTX was largely similar for RA and PsA. Overall, this study showed that in the treatment of psoriasis and PsA, rheumatologists and dermatologists do not differ in their initial use of MTX. However, the specialties showed a notable difference in their preferences for how they proceed with MTX use.

73 Patient-physician discordance of global disease assessment in psoriatic arthritis patients
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Objective: The visual analog scale (VAS- using a standard 0–10 range) is a common measure for global disease severity used by both patients and physicians. We assessed the concordance of psoriatic arthritis (PsA) patient scores compared with physician scores.

Methods: In our longitudinal study, 10 patients with active PsA completed the VAS assessing their global disease activity approximately every 4 weeks for up to 4 years. A physician’s VAS was completed for every patient VAS completed. In addition, a count of both swollen and tender joints was included for each visit, representing a standard scale of severity.

Results: Overall 237 assessments were analyzed, which showed VAS scoring for global disease by patients differed from the physician significantly; patients gave a higher level of severity than the physician (mean for patients = 2.70, mean for physician =1.97, paired t-test = 3E-9). More specifically, 7 of the 10 patients gave values that were significantly higher than the physician’s values. The physician’s VAS values correlated more strongly with the swollen joint count than the patient’s VAS values (physician vs. swollen r = 0.74, patient vs. swollen r = 0.36).

Conclusion: This study demonstrates a significant discordance of the VAS scores for global assessment for patients with PsA between the patients and their physician. The physician’s VAS score values correlated more strongly with the swollen joint count than did the patients. For patients, it would appear there are other factors beyond their swollen joints contributing to their global disease measurement.

74 Clinical and Radiographic Implications of Time to Treatment Response in Patients With Early Rheumatoid Arthritis
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Objective: Recent publications advocate treatment adjustment at 12 weeks (wks) for patients with rheumatoid arthritis (RA); still, data support the possibility of later responses to therapy. Our objective was to evaluate the association of early (12 weeks) and delayed (24 weeks) clinical responses with rates of clinical remission, low-disease activity (LDA), and rapid radiographic progression (RRP) at 52 weeks in patients with early RA treated with MTX monotherapy or adalimumab (ADA) + MTX combination therapy in the PREMIER trial.

Methods: PREMIER was a 104-week, phase 3, randomized, placebo-controlled trial in a MTX-naïve population with early RA. In this post hoc analysis, observed data comparing MTX with ADA + MTX therapy are presented. Clinical outcome measures included the 28-joint Disease Activity Score (DAS28) and mean change from baseline in modified Total RA Activity Score (DAS28) and mean change from baseline.
Sharp Score (ΔmTSS) at 52 weeks. Patients were categorized on the basis of clinical response (DAS28 improvement >1.2 or ≥50/70% improvement in ACR score) at 12 and 24 weeks: “early responders” achieved the clinical target at week 12 and maintained the response at week 24; “delayed responders” did not meet the clinical target until week 24. The percentages of patients at 52 weeks with LDAS (DAS28 < 3.2), clinical remission (DAS28 < 2.6), and RRP (ΔmTSS > 3 units/year) in each group were determined.

**Results:** In both treatment groups, early clinical responses were associated with better long-term outcomes than delayed responses. Achieving early or delayed ACR70 responses did not result in treatment group differences in the proportion of patients achieving LDAS or clinical remission at week 52. However, delayed responses to MTX resulted in a high proportion of patients with RRP. Indeed, delayed ACR70 responses were associated with an RRP prevalence of 40%. In addition, an early improvement of DAS28 > 1.2 with MTX was insufficient to slow radiographic progression (41% RRP). In contrast, early or delayed clinical responses to ADA + MTX resulted in low proportions of RRP at 52 weeks, even for patients with a delayed ACR20 response (11% RRP). Of note, ADA + MTX delayed responders had less RRP than MTX-treated early responders.

**Conclusion:** MTX-treated patients with early RA who fail to achieve an ACR70 within 12 wks of treatment are at risk for RRP and should be considered for treatment adjustment. In contrast, ADA + MTX treatment is associated with better clinical outcomes and less severe radiographic progression at 52 wks, even among patients with a delayed clinical response.

### 75 The Relationship Between Oral Health and Psychosocial Outcomes in Systemic Sclerosis

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**Objective:** Orofacial manifestations of systemic sclerosis (SSc) are common and SSc is known to be strongly associated with worse psychosocial outcomes, including depression, health-related quality of life (HRQoL), function and fatigue. The purpose of our study was to evaluate the association between oral health and psychosocial outcomes in SSc patients.

**Methods:** In a cross-sectional study, SSc patients from the Canadian Scleroderma Research Group Registry, were randomly recruited from 7 centers. Oral health was assessed using the Oral Health Impact Profile (OHIP), a validated self-reported measure of dysfunction, discomfort and disability attributed to oral conditions. The OHIP is composed of 7 subscales (functional limitation, physical pain, psychological discomfort, physical disability, psychological disability, social disability and handicap). Each subscale is scored separately from 0 to 40 (with 0 representing better and 40 representing worse quality of life). An overall score, ranging from 0 to 40, can also be computed using a detailed algorithm. In this study, psychosocial outcomes of interest included: depression (measured using the Center for Epidemiologic Studies Depression questionnaire, range 0–60), HRQoL (measured using the Medical Outcome Trust Short Form 36 Physical and Mental summary scores, SF-36 PCS and MCS, range 0–100, mean = 50, standard deviation = 10), function (measured using the Health Assessment Questionnaire, HAQ, range 0–3) and fatigue (measured using the Vitality subscale of the SF-36). The associations of the OHIP and the outcomes of interest were estimated using hierarchical regression analyses, adjusting for age, gender, education, current smoking and disease duration.

**Results:** There were 151 patients in the study: mean age 56.5 years, 90.1% female, 52.1% with more than high school education, 9.7% current smokers and mean disease duration 13.8 years. Mean OHIP score was 8.67. Mean SF-36 PCS and MCS scores were 37 and 50, respectively, HAQ was 0.79, depression was 14 and fatigue was 45. In multivariate analyses controlling for sociodemographic variables and disease duration, the OHIP was an independent predictor of the SF-36 PCS (p<0.001), SF-36 MCS (p<0.001), HAQ (p<0.001), depression (p<0.001), and fatigue (p<0.001). The OHIP contributed 7 to 13% of the variance in the outcomes of interest.

**Conclusion:** This study demonstrates the significant impact of oral health on psychosocial outcomes in SSc. We recommend more attention and research on oral health in SSc patients.

### 76 Exploring the Needs of People with Rheumatoid Arthritis

Brigitta Choi (McGill, Montreal); Ines Colmegna (McGill, Montreal); Susan Bartlett (McGill, Montreal)

**Objective:** Comprehensive effective treatments for Rheumatoid Arthritis (RA) require patient-centered approaches that identify and address patients’ needs and encourage patients to work in partnership with their health care providers. The goal of this study was to evaluate the extent to which medical, psychological, and social needs of people with RA are being met. Findings will be used to tailor interventions to optimize treatment and self-management.

**Methods:** Participants were recruited from the general rheumatology clinics at a major urban university hospital. Two focus groups of RA patients were held in August 2010 to elicit discussion about patient experiences and preferences. Sessions were audio-taped, transcribed, and analyzed using grounded theory methodology.

**Results:** Nine women and 2 men participated with a mean (SD) age of 53.6 (18.3), disease duration of 17.8 (13.3) yrs, and HAQ of 1.6 (0.8). Patients reported an average of 23.6 (22.7) minutes of morning stiffness, pain of 33.6 (28.4) and patient global function score of 42.1 (35.0). Nearly half (46%) were on DMARDs and/or biologics. Almost all endorsed a need for more information about their disease, RA medications, ways to effectively maneuver the health care system for prompt care, self-management and complementary/alternative treatments (CAM), along with ways to identify and access credible resources. Uncertainty related to RA (disease course, medications, disability, prognosis) increased patients’ need for emotional support from family, friends, employers, health care providers, and the community at large. Current community-based services were seen as infrequent and inadequate to meet emotional and information needs, particularly with respect to self-management. Patients expressed a strong desire to partner with providers through ongoing communication and active participation in treatment decisions. Most described creating effective partnerships with providers by being assertive and taking initiative. Continued care with patient-centered multi-disciplinary providers was highly valued. Referral and access to specialists knowledgeable about the needs of RA patients and coordination of services is suboptimal.

**Conclusion:** While new therapies and treatment paradigms have changed RA outcomes, many daily challenges remain under-recognized and unaddressed. Timely, reliable information in an accessible format is needed about disease process, as well as conventional and CAM therapies. Support to remain active in family, work and community roles, creation of multi-disciplinary treatment teams and emphasis on creating and sustaining patient-centered partnerships offer important opportunities to improve quality of life. Evidenced-based methods to address unmet needs (e.g. information toolkits, support groups, patient-provider communication skills training) warrant investigation.

### 77 Demyelinating events in Seniors with Rheumatoid Arthritis (RA): A Population-based Study

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Newmarket); Janet Pope (University of Western Ontario, London); Alfred Cividino (McMaster University, Hamilton); Claire Bombardier (University of Toronto, Toronto)

Objective: Up until recently, demyelinating syndromes were reported only rarely in RA. However, since the introduction of RA therapies targeting tumour necrosis factor (TNF), numerous case reports have arisen in the literature. Currently there are very few cohort-based assessments of the incidence of demyelinating events in RA, and/or the possible influence of drug exposures. The Ontario Biologics Research Initiative (OBRI) is an innovative undertaking to promote real-world rheumatic drug surveillance. Using Ontario’s administrative healthcare databases we were able to assess the risk for developing demyelinating events in seniors with RA, and explore for potential drug effects in this sample.

Methods: We studied a population-based RA cohort using physician billing and hospitalization data (1992–2008) for patients aged >65. RA diagnosis was based on > 2 billings with a diagnosis code of RA >2 months apart but < 5 years and >1 prescription for an oral glucocorticoid, DMARD or biologic. Cohort entry was defined by the first RA billing code; we excluded any individuals with a diagnosis of a demyelinating event, prior to their entry into the RA cohort. Our primary outcome was assessed over 1998–2008. Our case definition of a demyelinating event was based on >1 hospitalization diagnoses, or >2 billing claims diagnoses (> 8 weeks apart, but < 2 years). Cases were matched (on age, sex, and date of cohort entry) to up to 5 controls from the same RA cohort. We calculated the incidence rate of demyelinating events in seniors, and described medication use in relationship to these events.

Results: In 85,458 seniors with RA (over 614,915.5 person-years), 51 demyelinating events occurred. This provides an event rate of 8.3 events/100,000 person-years. Biologic exposures were rare in our cohort, and none of the cases of demyelinating events in our RA cohort had been exposed to an anti-TNF agent at the time of the event, or within the 12 months preceding the event. In both cases and controls, the most common medication exposures were NSAIDs/COXIBs, glucocorticosteroids, hydroxychloroquine, and methotrexate.

Conclusion: We provide novel data on the incidence of demyelinating events in a cohort of seniors with RA. The incidence rate is comparable to recent rates for Canadian seniors in the general population. None of these events appeared to have been triggered by anti-TNF drug exposures. Estimating the risk for demyelinating events due to these agents was problematic in our sample, given relatively low drug exposure rates.

78 The Incidence of Herpes Zoster in Seniors with Rheumatoid Arthritis: A Population-Based Study
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Objective: Herpes zoster (HZ) is a painful cutaneous eruption caused by varicella-zoster reactivation. It results in substantial morbidity, particularly in elderly and/or immunocompromised patients. Recent literature suggests that patients with rheumatoid arthritis (RA) are at particular risk for HZ. The Ontario Biologics Research Initiative (OBRI) conducts real-world surveillance through administrative database linkage with primary data collection, based in Canada’s largest province (population > 13 million).

Methods: An RA cohort was assembled from Ontario billing, hospitalization and prescription data, 1992–2008. Analyses were limited to subjects aged >65 who filled >1 prescription for a disease-modifying agent (DMARD), oral corticosteroid, or biologic. We studied cases of HZ identified from physician billing and hospitalization diagnoses over 1998–2009. RA controls (age, sex and time matched) were randomly selected by risk-set sampling. Multivariate conditional logistic regression assessed the independent effects of concomitant drug treatments on HZ, adjusted for demographics, co-morbidity, and markers of RA severity (rheumatology visits, extra-articular RA features, joint replacement).

Results: A total of 3,999 cases of HZ were recorded among 85,458 seniors with RA during 614,915 person-years (6.5 events/1000 person-years). Comparing these HZ cases to 19,995 RA controls, 21.9% of cases versus 10.8% of controls were exposed to prednisone at the time of infection. Multivariate models demonstrated that risk of HZ was higher among current and previous users of current and past use of all DMARD groups. There was a notable increasing trend for higher risk of HZ with increasing steroid doses. Due to low rates of biologic drug exposures in our sample, the estimated effects of these agents were imprecise, but also consistent with a higher risk.

Conclusion: Our estimates emphasize an association of anti-rheumatic therapies with the occurrence of HZ. However, potential limitations of our study include the possibility of incomplete ascertainment of biologic exposures, disease activity and ‘channelling bias’ (where persons at highest risk for infections may not be prescribed biologics).

79 Treating Rheumatoid Arthritis to Target: A Canadian Physician Survey
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Objective: To assess agreement and application of T2T recommendations in Canadian practice.

Methods: A nationwide, web-based survey was conducted. Agreement with each recommendation was measured on a 10 point Likert scale (1= fully disagree, 10 = fully agree). A 4 point Likert scale (never, not very often, very often, always) assessed application of each recommendation in current practice. Responders who answered “never” or “not very often” were asked whether they were willing to change their practice according to the particular recommendation.

Results: 78 physicians (approximately 26% of the Canadian rheumatology community) responded. The mean number of participants’ years in practice was 18 and the average number of patients seen per month was 98. Average agreement scores ranged from 6.92 for recommendation #5 (Measures of disease activity must be obtained and documented regularly, as frequently as monthly for patients with high/moderate disease activity or less frequently [such as every 3 to 6 months] for patients in sustained low disease activity or remission) to 9.1 for recommendation #10 (The patient has to be appropriately informed about the treatment target and the strategy planned to reach this target under the supervision of the rheumatologist). A majority of participants indicated that they apply T2T recommendations in their practice. However, recommendations #4 (Until the desired treatment target is reached, drug therapy should be adjusted at least every 3 months), #5, and #6 (The use of validated composite measures of disease activity, which include joint assessments, is needed in routine clinical practice to guide treatment decisions) received the highest number of “never” or “not very often” responses (15.38%, 33.33%, and 32.05% for recommendations #4, #5, and #6, respectively). In addition 92%, 73%, and 17% of participants who were not applying recommendations #4, #5, and #6, respectively, in their practice indicated that they were not willing to change their practice according to these recommendations. Busy practice and disagreement with inclusion of composite outcome measures in treatment decisions were the main reasons for objections.

Conclusion: Although a majority of Canadian rheumatologists agreed with and supported T2T recommendations, there was also resistance toward specific aspects of these recommendations. Efforts are needed to better understand reasons behind identified disagreements, upon which action plans to reinforce application of T2T recommendations in Canada should be developed.
Objective: The goals of the Ontario Biologics Research Initiative (OBRI) are to determine the long term effectiveness and safety of Biologics in actual practice and to develop and evaluate a range of strategies to facilitate best practice implementation. To describe the disease characteristics of RA patients being prescribed a new biologic in Ontario.

Methods: Patients registered in the OBRI, and prescribed a new biologic at the time of their enrollment, where included in the analysis. Two groups were identified; patients receiving their first biologic prescription (i.e., biologic naïve, n = 73) versus patients who had previously used a biologic (i.e., not biologic naïve, n = 77). Rheumatologist reported data at the time of enrollment included patient demographics and measures of disease activity. t-tests of the means were used to compare the two groups.

Results: A total of 150 (25%) of the 579 patients registered in the OBRI study were prescribed a new biologic at the time of enrollment. Their mean age was 53.2 years (SD of 12.9), and 85% were females. The mean RA duration was 12.9 years (10.7), physician global 5.9 (2.1), patient global 5.8 (2.5), mean ESR 33.1 mm/hr (23.1), and CRP 14.5 mg/l (19.6). Erosions on X-rays were reported in 80% of patients and 77% of patients were positive for Rheumatoid Factor. Two or more co-morbidities were reported in 60% of patients. Mean tender joint count was 9.3 (6.7), swollen joint count 9.0 (5.8), mean DAS 28 was 5.5 (1.2), SDAI was 33.5 (14.2), and CDAI was 30.4 (14.1). The majority of these patients were on concurrent Methotrexate treatment at the time of the new biologic prescription (69%). Enbrel was the most commonly prescribed biologic (33% of patients), followed by Humira (28%), and Rituxan (9.3%). When the biologic naïve patients were compared to those patients who had previously used a biologic, there were no statistically significant differences in any of the above measures.

Conclusion: While the biologic naïve patients were found to have higher DAS 28, SDAI, CDAI and patient and physician global scores, when compared to patients who had previously used a biologic, these differences were not found to be statistically significant.

A Conceptual Framework for the Design of Real-Time Systems for Clinical Monitoring and Research in Rheumatology

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Objective: The use of computers in rheumatology clinical practice is increasing with many clinicians developing their own databases, the use of institutional e-charts and the NIH Patient-Reported Outcomes Measurement Information System. This topic is of particular importance in rheumatology as current guidelines recommend tight monitoring of patient outcomes as a component of optimal care. Our objective was to develop a conceptual framework for the design of real-time systems for clinical monitoring and research in rheumatology.

Methods: Phased feasibility pilot to develop and evaluate technical prototypes combined with a scooping study which included a review of the literature and key informant interviews with experts within the fields of rheumatology, health informatics, ethics, privacy and security, patients and rheumatologists.

Results: We found that few of the established initiatives address the complex dynamics of a clinical research environment and issues related to ethics, privacy and data security. The E-Rheum infrastructure was developed through a series of phased feasibility studies funded by the CIHR. Phase one included key informant interviews with a range of stakeholders; testing of various types of devices and technologies for data entry; and the development of a prototype patient data capture interface that allowed patients with rheumatoid arthritis to complete validated measures and to summarize these data in a cumulative report available at the point-of-care. Phase two explored the feasibility of having the electronic data-capture and reporting system available on-line and continued to evaluate ease of use and satisfaction. Phase three involved multi-site deployment and real-life implementation to determine the organizational and technical requirements to integrate the application into usual care. Challenges related to ethics, privacy and data security were identified during each phase. In 2009, investigators received funding to develop the system for full implementation and deployment. Data from the feasibility pilot and scoping study informed the development of a conceptual framework for system development.

Conclusion: While there is an increasing body of literature to address issues of standardization, parsing, classification, etc. within health informatics, we could not find a conceptual framework through which we could communicate with our information technology experts to build user and system requirements that can respond to evolving ethics and privacy legislation. By including ethics and privacy experts as a part of the investigative team we were able to create a conceptual framework that takes into account the dynamic nature of the electronic clinical research environment.
Conclusion: The EIA Detection Tool shows very good discriminate validity between the four study groups, and excellent Comprehensibility, Test-Retest reliability and Internal Consistency. Further analyses will be conducted to determine if weighting scales and/or decision rules may be imposed on the EIA Detection Tool to improve its discriminative properties.

83 Incidence of Post-operative Complications following Orthopaedic Procedures in Patients with Rheumatoid Arthritis treated with TNF-α Inhibitor Therapy

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Objective: TNF-α inhibitors therapies (TNFi) have improved the management of rheumatoid arthritis (RA). The therapies are however associated with an increased risk of infection and delayed wound healing. This observation raises concerns particularly in patients who are having surgical procedures. Although complications following orthopaedic procedures are commonly reported in RA patients there are limited data regarding RA patients being treated with TNFi. In this study, we examined the incidence of post-operative complications following orthopaedic surgery in such patients and sought to identify other potential risk factors for complications.

Methods: We identified all TNFi-treated RA patients who underwent an orthopaedic procedure between January 1st 2005 and December 31st 2009 in the Calgary Health Region. Data on these patients is included in our Pharmacovigilance database. Demographic and clinical data, which included the type of orthopaedic procedure, disease duration, co-morbidities and current therapies, were recorded for each patient. Patients were followed for a minimum of one year and post-operative complications were recorded. The complication rates were compared between surgery types, and with the rates recorded in the literature.

Results: Between January 1st 2005 and December 31st 2009, a total of 57 patients on TNFi therapy underwent 90 orthopaedic procedures. A total of 16 complications occurred (17.7%) which was higher than the 6% complication rate reported for orthopaedic procedures in RA patients. The complications were stratified into post-operative wound infections (11/90, 12.2%) and other types of complications (5/90, 5.5%). No independent predictors for post-operative complications were identified in this group.

Conclusion: TNFi therapy in RA patients appears to confer an increased risk of post-operative complications. Larger scale studies are required to elucidate how best to manage RA patients who are receiving TNFi therapies when they are to undergo orthopaedic surgical interventions.

84 Prevalence of Metabolic Syndrome in Psoriasis and Psoriatic Arthritis

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Objective: Psoriasis (Ps) is an immune-mediated skin disease affecting 2–3% of the population, of whom about 30% develop Psoriatic Arthritis (PsA), an inflammatory arthritis. The metabolic syndrome (MetS) is a cluster of cardiometabolic risk factors that includes abdominal obesity, dyslipidemia, hyperglycemia and hypertension. It is known that Ps and PsA patients have an increased prevalence of cardiovascular disease. However, the prevalence of MetS in PsA and the differential cardiometabolic risk between Ps and PsA are not established. The objective of this study was to determine if PsA patients have a higher prevalence of MetS compared to Ps patients because of higher inflammatory burden.

Methods: Patients with PsA are followed prospectively in the Toronto Western Hospital PsA clinic. Patients with Ps without arthritis have been included in an observational cohort since 2006. All patients undergo a clinical examination according to a standard protocol which includes assessment of the components of MetS. Descriptive statistics are used to describe the patients. Univariate analysis including t-tests for continuous variables and chi-squared tests for dichotomous variables was performed to compare MetS in Ps and PsA. Multivariate analysis using a stepwise logistic regression model was used to identify associations between potentially related variables and MetS.

Results: 167 patients with PsA (42.5% F/ 57.5% M, mean age 51.1 yrs, mean Ps duration 25.3 yrs, mean PsA duration 15.6 yrs, mean number of actively inflamed joints 8.6, mean PASI (psoriasis skin severity score) 4.1) and 98 Ps patients (43.9% F/56.1% M, mean age 50.3 yrs, mean Ps duration 18.4 yrs, mean PASI 5.8) were included. Prevalence of MetS was 36.5% in PsA, and 25.5% in Ps (p=0.0773). Multivariate analysis revealed that age, use of anti-TNF agents, and psoriasis skin severity scores (PASI) are associated with MetS, with odds ratios of 1.063 (p<0.0001), 2.455 (p=0.055), and 1.049 (p=0.033) respectively.

Conclusion: Our interim results provide the first report of the prevalence of MetS in PsA. Our results further show that MetS is not more prevalent among patients with PsA compared to Ps. However, a larger sample size may be necessary to detect a significant difference. It is notable that markers of severe disease activity, such as use of anti-TNF agents and high PASI scores, are associated with increased the development of MetS in patients with Ps with or without arthritis.

85 Predictors of Radiographic Progression in Adalimumab-Treated Patients with Ankylosing Spondylitis

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Objective: To identify factors contributing to radiographic progression in Ankylosing Spondylitis (AS) patients treated with adalimumab (ADA).

Methods: The ATLAS trial randomized AS patients to treatment with ADA or placebo for a 24-week double-blind period, followed by an open-label extension with ADA. Two independent blinded readers scored X-rays obtained at baseline and year 2 using the mSASSS method. Dependent variables were: 1) change in mSASSS ≥2 and ≥4, and 2) development of new syndesmophytes. Independent variables were age, disease duration, baseline spinal mobility, baseline ASDAS, baseline mSASSS, and 2-year area under the curve (AUC) for CRP and ASDAS. Categorical variables included: HLA-B27, sex, peripheral synovitis at baseline (SJC>0), peripheral enthesitis at baseline (MASES>0), presence of baseline syndesmophytes, and history of uveitis. Associations were tested univariately; significantly associated variables were entered as explanatory variables in a multivariate analysis.

Results: This analysis includes 275 subjects with 2 years of exposure to ADA; at baseline, subjects had mean disease duration of 10.8 years, mean ASDAS of 3.7, and mean mSASSS of 20.3; syndesmophytes were present in 85% of patients at baseline. Radiographic progression (ΔmSASSS ≥2) was found in 61 subjects (22%), and severe radiographic progression (ΔmSASSS ≥4) was observed in 22 subjects (8%). New syndesmophytes were found by either reader in 106 subjects (39%). Univariate analysis identified significant associations of age, mobility, and baseline bone damage with radiographic progression. For example, odds ratios (95% confidence intervals) for ΔmSASSS ≥2 were: age, 1.04 (1.009, 1.062); baseline syndesmophytes, 3.87 (1.126, 13.301); baseline mSASSS, 1.03 (1.011, 1.039); and baseline cervical rotation, 0.98 (0.968, 0.995). Linear regression revealed similar findings. Sex, HLA-B27, uveitis, peripheral synovitis or enthesitis, disease duration, baseline ASDAS, and CRP levels were not predictive in any analysis. In multivariate analysis, only baseline mSASSS was consistently identified as a significant contributor to radiographic progression (ΔmSASSS ≥2 and ≥4, OR [95% CI]: 1.02 [1.005, 1.036] and 1.02 [1.001, 1.046]) and only baseline syndesmophytes were predictive of the development of new syndesmophytes (OR [95% CI]: 7.63 [2.381, 24.476]).
Conclusion: Clinical measures of disease activity were not related to radiographic progression. Only the presence of radiographic damage at initiation of therapy was consistently associated with the formation of new syndesmophytes in adalimumab-treated AS patients. These results support previous studies demonstrating a disconnect between disease activity and bone formation in patients with long-standing AS, and suggest treatment initiation prior to syndesmophyte formation might be advantageous for decreasing structural damage.

Psoriatic arthritis (PsA) in Canadian Clinical Practice: the PsA Assessment in Rheumatology (PAIR)

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Objective: We aimed to determine disease severity and treatment of patients with PsA followed in rheumatology practice in Canada.

Methods: Rheumatologists were invited to participate in the Assessment in Rheumatology (AIR) PsA program through the Canadian Rheumatology Association. Rheumatologists were asked to complete a form for each patient addressing demographic questions, CASPAr criteria, medication use, current status including joint counts, presence of dactylitis, enthesitis, back involvement, patient (PGA) and physician (MDGA) global assessment, acute phase reactant, assessment of prognosis and plans for change of medication. Descriptive statistics are provided.

Results: From across Canada 22 rheumatologists, from 5 provinces submitted 233 consecutive PsA patients 145 males (62.2%), 88 females (37.8%), mean age of 53.2 (12.7) years, 88.4% having disease for >2 years. 80.7% fulfilled CASPAr criteria (95% entered on peripheral arthritis, 15.9% on spondyloarthritis and 34% on enthesis). The majority fulfilled current psoriasis, 50 (21.7%) did not have current psoriasis but had previous psoriasis or a family history of psoriasis. 38% had nail lesions, 80% were rheumatoid factor negative, 48% had dactylitis, and 16% had flabby periostitis. 30% had taken no DMARDs. Current (past) medications included 6.9% (22.9%) oral steroids, 7.3% intra-articular injections, 58% (25%) methotrexate, 12.0% (25.8%) sulfasalazine, 3.9% (10.3%) leflunomide, 6% (17.5%) anti-tumor necrosis factor, and 2.6% (6.9%) on gold/auranofin. 67 patients were taking biologics, the majority receiving etanercept. At the time of the visit, patients averaged 3 swollen joints, 4 tender joints, PGA 2.3, MDGA 1.9. 16% had dactylitis at the time of the visit with equal distribution in hands and feet. 11% of the patients had enthesitis, mainly at the Achilles tendon or both Achilles and plantar fascia. Spinal involvement was documented in 13% of the patients. Most rheumatologists did not measure spinal metrics. Clinical joint damage was documented in 60% of the patients, active skin disease in 70% and nail lesions in 32%. Only 22% were rated as moderate to high disease activity while 52% were rated as low disease activity and 26% were deemed in remission. The decision was based on joint counts, PGA, MDGA and acute phase reactants. 27% of the patients were to have their medications changed based on the current visit, the majority for inadequate response to medications.

Conclusion: PsA patients seen in regular rheumatology practice fulfill CASPAr criteria, have active disease, and more than half have clinical damage. The majority have low activity or remission.

Clinical Trials in Canada — A Review of Study Design and Selection Criteria in Rheumatoid Arthritis (RA) Trials

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Objective: Current clinical trial design for pharmacologic interventions in rheumatoid arthritis (RA) do not reflect the innovations in RA diagnosis, treatment and care in Western countries over the past decade. The objective of this project was to develop evidence-informed entry criteria and to make recommendations about additional study design requirements that best meet the Canadian RA population characteristics and current best practices for usual care in Canada.

Methods: Initial recommendations were developed by an expert panel of rheumatology trialists and other experts affiliated with the Canadian Rheumatology Research Consortium. A scoping review methodology was then used to examine the evidence available to support or refute each initial recommendation. Scoping reviews can include a literature review and a key informant consultation phase. Research considered in this project included very recent diagnosis and treatment guidelines, systematic reviews and meta-analyses, and primary research data. Recent critical reviews and narrative reviews by experts in the field were also considered. Recommendations were finalized using a consensus process.

Results: Recommendations for clinical trial inclusion and exclusion criteria addressed measures of disease activity [use of the Disease Activity Score (DAS) with 28 joint count, tender and swollen joint count, acute phase reactants, functional classification criteria] and disease duration; concurrent conditions [prior infection, laboratory abnormalities and tuberculosis screening prior to starting biologics]; and previous and concomitant RA treatments [stability and duration of Methotrexate and other DMARDs at optimal dosing for add-on trials, stability, dosing and duration of oral corticosteroids, minimum washout requirements, and use of prior biologics and DMARDs]. Additional recommendations regarding study design addressed rescue strategies, the use of intra-articular corticosteroid injections for rescue, long-term extension and timing of visits.

Conclusion: Over the past two decades, clinical trials in rheumatology have become increasingly complicated. Early aggressive treatment and tight monitoring means that rescue is an important component of trial design. Most pharmacologic treatment evidence collected to date has been in moderate to severe RA populations. There has been a recent movement to the globalization of trials which impacts the generalizability of research results. Less severe disease in high income countries impacts rescue strategies and rules for concomitant medications in trials. There is an urgent need to modify trial inclusion and exclusion criteria to better reflect the current characteristics of people living with RA in the countries where the new agents will be used.

Primary anti-TNF Failures Experience Better Clinical Responses but Similar Health Care Utilization to a Second anti-TNF Agent than Secondary Failures: Analysis of the Alberta Rheumatoid Arthritis Biologies Registry

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Objective: Meta-analysis of anti-TNF switching data from observational cohorts has concluded that responses are inferior in those switching due to primary as compared to secondary anti-TNF failures but limitations include small sample size of individual studies, failure to define response, and selection bias. We assessed the impact of switching anti-TNF agents at different time points in the Alberta Biologics Registry, an observational cohort of RA patients starting anti-TNF therapy in 2004, where collection of outcome data on all patients is requested by the Provincial pharmaceutical formulary.

Methods: The Alberta Biologics Registry collects clinical, employment, and health economic data at baseline, 3 months, and every 6 months thereafter. Health-related quality of life is measured with the EQ-5D and self reported health care utilization is measured for the six months prior to each visit. We analyzed responses according to time of switch (3 month versus subsequent time points) and according to specific anti-TNF agent switches.

Results: From 1,222 patients in the registry, 649 patients had 27 month follow-up data. The switch to a second anti-TNF agent was associated with improved clinical responses; patients switching to etanercept had better responses than patients who continued on adalimumab. The switch to a second anti-TNF agent was also associated with similar health care utilization to a second anti-TNF agent than secondary failures; in both cases, health care utilization was similar to that of patients who continued on original treatment. These findings are consistent with previous meta-analysis of anti-TNF switching data from observational cohorts.
low up assessment and 498 (76.7%) of these remained on the first anti-TNF during the study period. There were 28 (4.3%) primary failures and 123 (19%) secondary failures who switched a median of 15 months from baseline. The response rate to the second anti-TNF was somewhat better in the primary versus the secondary failures (p=NS) at 3 months after initiation of the second anti-TNF for HAQ, DAS, EQ-5D. By 27 months, switchers due to primary failures had attained comparable reductions in outcomes to non-switchers while changes in secondary failures were from 50% (HAQ) to 68% (EQ-5D) lower compared to non-switchers (p< 0.05). Health care utilization was significantly reduced in four measured parameters over 27 months: number of rheumatologist visits (−0.31 visits, p< 0.001), family physician visits (−0.95, p< 0.001), % having ≥ 1 outpatient visit (−0.22, p< 0.001), and % having day surgery (−0.026, p< 0.001). This reduction was comparable between switching groups and non-switchers.

Conclusion: The results from this mandatory registry show that primary failures to anti-TNF show similar responses to patients responding to their first anti-TNF agent. Clinical responses in secondary failures are less optimal. Despite this, there is no significant difference between primary and secondary failures in the significant reduction in the health care utilization while receiving their second anti-TNF agent over the course of the 27 month follow up period.

89 Oral Health Related Quality of Life and Clinical Features in Systemic Sclerosis
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Objective: Orofacial manifestations of systemic sclerosis (SSc), as well as xerostomia and caries, are thought to occur commonly. Nevertheless, few studies have systematically assessed their prevalence and impact on oral health related quality of life (OHRQoL). The purpose of this study was to describe the orofacial abnormalities, caries and the impairment of OHRQoL in SSc compared to controls.

Methods: All SSc patients were randomly recruited from 7 sites of the Canadian Scleroderma Research Group (CSRG) registry. Controls were non-SSc rheumatology patients from the same clinics. Patients and controls underwent a standardized dental examination that included a Diseased/Missing/Filled Teeth (DMFT) scoring, interincisal and oral aperture measurements and the Saxon test for saliva production. The OHRQoL was measured using the Oral Health Impact Profile-49 (OHIP-49) questionnaire, which consists of 7 domains. Orofacial abnormalities and OHRQoL were compared in a multivariate regression analysis between SSc patients and controls, adjusting for demographic characteristics, partial and full dentures, and study center.

Results: There were 151 SSc patients and 150 controls included in the study. SSc patients and controls were similar: mean age 56.5 and 57.9 years, 90.1% and 91.2% female, 52.1% and 61.7% with more than high school education and 9.7% and 13.4% current smokers, respectively. On average, oral aperture and interincisal distance in SSc patients were 18.7 mm (95%CI = 14.2–23.9) and 7.0 mm (95%CI = 5.2–8.8) smaller than controls, respectively. They had an average of 0.19 g (95%CI = −0.01–0.39) less saliva production per minute. SSc patients had more missing and filled teeth than controls, mainly in the maxillary and mandibular posterior quadrants (P< 0.05). The OHIP-49 total score was significantly higher in SSc patients than controls (mean increase: 1.88, P<0.001), indicating worse OHRQoL. OHIP-49 domains showing the greatest Impairment were functional limitation, psychological discomfort and physical disability (P<0.002).

Conclusion: This study demonstrated that SSc patients have a significantly smaller oral opening and interincisal distance than controls, and there was a strong trend towards greater xerostomia. The OHIP-49 indicates that SSc patients have significantly worse OHRQoL than controls. The results of this research will facilitate the development of future projects related to the prevention and treatment of orofacial manifestations of SSc, with the aim of reducing its impact on quality of life.
TION study pts). Data from the ongoing long-term extension (LTE) study were used.

Methods: Pts included in the analysis received ≥1 dose of TCZ (8 mg/kg every 4 wks) in the AMBITION or LTE studies. Pts who showed a reduction of < 50% from baseline in tender joint count (TJC) and swollen joint count (SJC) during the AMBITION study were eligible to receive MTX or other permitted DMARDs during LTE. A separately evaluated subgroup of pts received TCZ 8mg/kg as monotherapy for the duration of their treatment. Assessment of efficacy parameters was performed every 12 weeks (wks) from initial TCZ exposure. Efficacy data were analyzed from the time of initial TCZ exposure through February 6, 2009. Results included pts who had assessments at each visit and no imputation was performed for missing data.

Results: 618 pts received TCZ 8 mg/kg either as monotherapy or in combination with MTX/DMARDs, 2.4% of whom withdrew due to insufficient therapeutic response. There was a continuous increase in ACR 20, 50 and 70 response rates over time. The proportions and absolute numbers of pts who achieved low disease activity (LDAS; DAS28 ≤3.2) and/or DAS28 remission (DAS28 ≤2.6) were sustained through wk 60 of TCZ treatment; proportions of pts were maintained through wk 156. By wk 96, 25%, 40%, and 23% of pts had zero TJC, zero SJIC, and achieved HAQ-DI scores of zero, respectively. The TCZ monotherapy subgroup amounted to 234 pts. Efficacy in this subgroup was demonstrated by sustained improvements in ACR 20, 50 and 70 and DAS remission rates.

Conclusion: Response rates to TCZ, as monotherapy or in combination with DMARDs, were maintained with up to 3 years of treatment. As the results of this analysis indicate, the benefits of TCZ treatment for RA pts who had never been exposed to or had never failed MTX continued beyond 24 wks.

92 Tocilizumab (TCZ) Long-Term Efficacy in Rheumatoid Arthritis (RA) Patients (pts) Treated up to 3.7 Years
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Objective: To assess TCZ long-term efficacy in RA pts treated with TCZ and DMARDs/ methotrexate (MTX).

Methods: Two populations from ongoing long-term extensions (GROWTH95, GROWTH96, open-label phase of LITHE) of phase 3 trials were analyzed: 1) pts who previously had inadequate response to DMARDs (DMARD-IR: OPTION, TOWARD, LITHE) and 2) pts with no previous failure or exposure to MTX (AMBITION). Besides pts from the AMBITION study who received TCZ monotherapy, pts received ≥1 dose of TCZ + DMARDs/MTX in the phase 3 or extension trials. Pts from AMBITION with < 50% reduction from baseline in tender and swollen joint counts (TJC, SJIC) were eligible for DMARDs/MTX in the extension. In the original studies and in the extensions, outcomes were assessed every 4 wks and every 8 (LITHE) or 12 (GROWTH95/96) wks from initial TCZ exposure to Aug 28, 2009, respectively. For pooling, data were assigned to the nearest 12 wk point. Due to withdrawal or failure to reach later assessments, the number of pts with assessments decreased over time. Results included pts who had assessments at each visit, with no imputation for missing data. Data were included until < 10% of the baseline pts was reached.

Results: 2904 DMARD-IR pts and 618 never exposed/failed MTX pts were analyzed. 27.7% of DMARD-IR and 24.6% of never exposed/failed MTX pts withdrew by the cutoff date. The absolute numbers of DMARD-IR pts reaching ACR50, LDA (DAS28 3.2), and DAS28 remission (DAS28 2.6) through wk 96 and ACR70 through wk 120 continuously increased. The absolute numbers of never exposed/failed MTX pts achieving ACR50/70, LDA, and DAS28 remission to wk 96 were sustained. The proportion of pts achieving ACR50/70, LDA, and DAS28 remission was maintained to wks 168 and 192, with lower absolute numbers reaching these visits. By wk 24, 20% and 27% of assessed DMARD-IR and never exposed/failed MTX pts, respectively, had achieved the major clinical response of ACR70 maintained for 24 consecutive wks. At wk 120, 52.3% and 38.4% of assessed DMARD-IR pts and 59.5% and 38.3% of assessed never exposed/failed MTX pts, respectively had 1 SJIC and 1 TJC. 38.4% and 48.4% of DMARD-IR and never exposed/failed MTX pts had HAQ-DA scores of 0.5.

Conclusion: Increasing and sustained numbers and/or proportions of pts achieving ACR50/70, LDA, and DAS28 remission support TCZ as an effective, long-term treatment for RA pts.

93 Safety Analysis of Tocilizumab (TCZ) in Rheumatoid Arthritis (RA) Patients (pts): Long-Term Extension Studies (Median of 3.1 Years of Treatment)
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Objective: To assess the longer-term safety of TCZ in RA pts using pooled data from long-term extension studies.

Methods: The analysis included pts who received ≥1 dose of TCZ in the 24-week (wk) phase III clinical trials (OPTION, AMBITION, RADIATE, TOWARD), in the 2-year phase III clinical trial (LITHE), in a phase I study, or in the ongoing, open-label extension studies (GROWTH95, GROWTH96). Safety data from the all-exposed population were pooled and analyzed from the time of initial exposure to TCZ to the cutoff date of August 28, 2009.

Results: A total of 4,009 pts received TCZ, with a total TCZ exposure of 10,011 pt-yrs (PY) and a total duration of observation of 10,994 PY. The median treatment duration was 3.1 years (mean of 2.7 years). Withdrawal rate due to adverse events (AEs) was 5.4/100 PY. The overall serious AEs (SAEs) rate was 14.6/100 PY and the overall rate of serious infections was 4.5/100 PY. The overall rate of malignancies, including non-melanoma skin cancers, was 1.1/100 PY. Myocardial infarction and stroke occurred at an overall rate of 0.27 and 0.16/100 PY, respectively. Both rates remained stable with continued exposure to TCZ. There was an increase from baseline to wk 6 in mean total cholesterol, low-density lipoprotein, high-density lipoprotein, and triglyceride levels, which then stabilized. 313 pts (7.8%) initiated lipid-lowering therapy during TCZ treatment and generally responded to treatment without complications. ALT/AST elevation >3x upper limit of normal occurred in 7.8% of pts during the first 12 months of treatment, with no rate increase over time. Dose reductions and/or interruptions were used to manage transaminase elevations, which were not associated with clinically apparent hepatitis or hepatic dysfunction.

Conclusion: Results from this analysis indicate that no new safety signals have emerged with prolonged exposure to TCZ, which supports a favourable benefit/risk ratio for the use of TCZ in pts with moderate-to-severe RA. During longer-term TCZ treatment, AE and SAE rates were stable over time, and transaminase elevations could be effectively managed with no clinically significant sequelae detected.

94 Treatment to Target: Retreatment with Rituximab (RTX) Provides Better Disease Control than Treatment as Needed in Patients with Rheumatoid Arthritis (RA)
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Objective: Assessing differences in efficacy and safety profiles of the two treatment approaches employed in RTX RA clinical trials may help in determining an optimal treatment regimen.

Methods: RA patients (pts) who were inadequate responders to methotrexate (MTX) were recruited into Phase II or III studies (MIRROR, SERENE, Phase IIa and DANCER). Pts received open-label RTX 2 x 1000mg, IV 2 weeks apart + MTX based on two retreatment strategies: a) Treatment to target (TT), with pts assessed and retreated 24 weeks (wks) after each course, if and when not in remission (DAS ≥2.6); b) Treatment as needed (PRN), with pts retreated at the physician’s discretion after ≥16 wks if both swollen and tender joints were ≥8. In both approaches, study visits were performed at least every 8 wks. Pooled data were analyzed according to treatment group. Clinical outcomes, including ACRn, DAS28-ESR and HAQ-DI, and safety data were assessed over time.

Results: Compared to baseline, responses were maintained or improved over multiple courses of RTX in both treatment strategies. Compared with PRN, TT resulted in greater improvements in DAS28-ESR, lower HAQ-DI and higher ACRn, reflecting tighter control of disease activity. PRN resulted in recurrence of disease symptoms as indicated by DAS28-ESR scores returning close to pre-RTX treatment levels and higher rates of withdrawals from the trial due to RA flare. Compared with PRN, TT resulted in more pts achieving major clinical response (ACR70 at 6 months; 12.3% vs 5.1%). TT led to more frequent retreatment with a median time between courses of approximately 25 wks compared with approximately 62 wks for PRN. Comparable safety profiles were obtained for the two regimens. However, compared with PRN, TT had a numerically reduced rate of serious infections (2.2 vs 3.5 per 100 pt-yrs) and serious adverse events (12.0 vs 16.2 per 100 pt-yrs). There were no clinically relevant differences in the proportion of pts with Ig levels below the lower limit of normal across the two treatment groups.

Conclusion: Repeat treatment to a target of DAS28 remission with RTX led to tighter control of disease activity compared with PRN treatment.

95 The Role of the Patient Ambassador in Support of the Identified Theme of Hope in the Needs of Patients Attending an Inflammatory Arthritis Education Program at The Arthritis Program (TAP).

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Objective: Patient Ambassador Pilot Project — to determine the response and success of the pilot patient ambassador role within the inflammatory arthritis education program. QA Project — to trend the monthly identified individual goals of patients attending the inflammatory arthritis education program to determine if these goals were being met by attendance and completion of the program.

Methods: Patient Ambassador Pilot: Patients who had attained self-management and empowerment over their disease process and who were seen an dynamic and good orators were identified by TAP. They were asked to consider participating in group speaking engagements within the inflammatory arthritis education program. Some predetermined guidelines were given for use in the talks to groups. QA Project: patients participating in the QA project were asked questions by the TAP team social worker about their educational needs and the goals they hoped to achieve as a result of attending the two-week inflammatory arthritis education program.

Results: Sample patients that attended the inflammatory arthritis education program identified the need to hear hopeful information on treatment options and disease prognosis. The majority of patients in the sample described a “hopeful” outlook as a result of attending TAP’s inflammatory arthritis education program. This finding was in support of our pilot initiative of developing the role of the patient ambassador within the inflammatory arthritis program. Identifying patient ambassadors to express their own experiences may be a way to improve the outlook of other patients.

Conclusion: Based on the results gathered, the patient ambassador role is now being considered for pilot in other education programs within TAP and the Chronic Disease Management Portfolio.

96 Assessing the Rate of Serious Infections in Rheumatoid Arthritis (RA) Patients who Receive Other Biologic Therapies after Discontinuing Rituximab (RTX)

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Objective: To describe the rate of serious infection events (SIEs) in RA patients (pts) treated with RTX and who subsequently received another biologic disease-modifying anti-rheumatic drug (BDMARD) while being potentially peripherally B-cell depleted as a result of RTX selectively targeting CD20+ B-cells.

Methods: Pts included in the study had moderately-to-severely active RA and received RTX + methotrexate (MTX) within an international trial program. After completion or withdrawal from their studies, pts entered a safety follow-up (SFU) during which peripheral B-cell counts were monitored at regular intervals for 48 weeks (wks) and BDMARDs could be received. All SIEs, defined as adverse events and/or infections that required IV antibiotics, were collected.

Results: As of September 2009, 3,189 RA pts had received at least 1 course of RTX, yielding a total follow-up number of 9,365.03 pt-yrs, 283 pts who entered SFU subsequently received another biologic (median time of 8.5 months (mo) after last RTX infusion. Of these 283 pts, 30.7% received their biologic within 6 mo of their last RTX infusion. The largest group (n=230 pts) received a TNF-inhibitor (TNFi) after RTX. The median follow-up time post-reception of the subsequent biologic was 11 mo. 83% of patients had peripheral B-cell counts below the lower limit of normal (< 80 cells/µL) at the time of receiving further BDMARD treatment. For this group of 283 pts, 6.01 SIEs per 100 pt-yrs were reported during treatment with RTX and prior to receiving the biologic. Following BDMARD treatment initiation, the rate fell to 4.97 SIEs per 100 pt-yrs. The median time to SIE after initiation of BDMARD treatment was 11 mo. In 43 pts who received abatacept (ABA) as their initial BDMARD, 1 SIE before and 1 SIE after receiving ABA were reported (97.7 total pt-yrs). Overall, the infections were variable and typical for RA pts. No opportunistic or fatal infections were reported.

Conclusion: As indicated by this updated analysis, subsequent biologic therapies after RTX discontinuation were not associated with an increased rate of serious infections in pts who received biologics or in the subgroup who received TNFi. The SIE rate was consistent with rates observed in long-term safety data.

97 Results from the RESET Study: Rituximab Response Based on Reasons for TNFi-Discontinuation and Rheumatoid Factor Status

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Objective: To analyze the response to rituximab (RTX) based on the reasons for discontinuing a TNF-inhibitor (TNFi) as well as baseline characteristics that can be used as predictor of response.

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Management including recommendations on care. We also recom-

In conclusion, just over half of patient's management of SSA therapy, 9 (60%) were treated appropriately, 6 (40%) inappropriately. Of 9 SSA patients on leflunomide, none were managed appropriately. 21 (51%) patients had appropriate anti-rheumatoid management. 2 were excluded for unclear anti-rheumatoid medications, surgical risk factor and complication data.

Conclusion: Treatment with RTX resulted in clinically significant improvements in disease activity. Compared with the overall population, RF positive pts appear to have an enhanced response. RTX efficacy was not affected based on the TNFi-discontinuation reasons.

89 Management of Rheumatoid Arthritis in the Peri-operative Period: A Look at the Literature and Local Practices

Methods: A literature review was conducted to ascertain current guidelines and recommendations of pharmacotherapy perioperatively in the RA population. Studies on the safety of methotrexate periarthroplasty suggest that it can be continued, except in patients with specific comorbidity profiles. Other sources make suggestions for DMARD management perioperatively on the basis of pharmacokinetics. We reviewed 49 charts of RA patients who had TKR or THR between January 2006 and March 2010. We collected demographic, anti-rheumatoid medications, surgical risk factor and complication data. We deemed anti-rheumatoid management appropriate if it did not conflict with current guidelines or with what current literature suggested was appropriate management. 41 were deemed eligible for the study, 6 were excluded for lack of anti-rheumatoid treatment, and 2 were excluded for unclear management. 21 (51%) patients had appropriate anti-rheumatoid management, while 20 (49%) had inappropriate. Of the 15 patients on biologic therapy, 9 (60%) were treated appropriately, 6 (40%) inappropriately. Of 9 patients on leflunomide, none were managed appropriately.

Conclusion: In conclusion, just over half of patient's management of rheumatoid arthritis received "appropriate" care. We recommend that further studies be done to evaluate the appropriate care for RA patients around the time of arthroplasty to strengthen current guidelines. We also recommend introducing a standard pre-arthroplasty form for perioperative management including recommendations on care.

99 Baseline Characteristics and Effectiveness of Treatment With Infliximab in Canadian Patients With Rheumatoid Arthritis: Comparison of an Individual Practice With the BioTRAC Registry

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Objective: The efficacy of Infliximab (IFX) in Rheumatoid Arthritis (RA) has been well established in controlled clinical trials. Small area variations with respect to patient profile and outcomes may affect global assessment of real-life effectiveness. The aim of the current analysis is to compare the patient profile and outcomes of an Individual Rheumatology Practice cohort in Ontario to that of the entire Ontario and Canadian RA cohorts.

Methods: The data for this analysis were obtained from BioTRAC, an observational prospective registry of adult RA patients initiated on IFX since 2002 and managed as per routine care.

Results: A total of 70 RA patients were enrolled in the Individual Rheumatology Practice (IRP) between 2002 and 2010 while 695 patients comprised the total registry (Canadian) and 291 patients the Ontario cohort (ON). Patient baseline characteristics differed between the 3 cohorts with patients in the IRP cohort having significantly lower mean age (50.1 vs. 56.4 and 57 years in the IRP, Canadian and ON cohorts, respectively), disease duration (5.7 vs. 11.1 and 9.4 years, respectively), ESR (25.5 vs. 33.8 and 37.1 mm/hr, respectively) HAQ (1.5 vs. 1.7 and 1.7, respectively), pain (50.9 vs. 58.8 and 59.1, respectively), Physician’s Global Assessment of Disease Activity (PGA) (4.5 vs. 6.8 and 7.0, respectively), swollen joint count (SJC) (7.9 vs. 12.2 and 12.4, respectively) and DAS28 (4.8 vs. 5.3 and 5.4, respectively) compared to the Canadian and ON cohorts. Regression analysis over time showed that morning (AM) stiffness, Patient’s Global Assessment of Disease Activity (SGA), HAQ, tender joint count (TJC), SJC, and DAS28-CRP improved significantly in all cohorts without significant between-group differences. However, median time to discontinuation due to treatment failure (adverse event, disease progression, lack or loss of response) was significantly longer in this IRP cohort vs. Canadian (P=0.004) or ON (P=0.011) cohorts. After mean follow-up of 12.8, 13.0 and 13.3 months for the IRP, Canadian and Ontario cohorts ACR20/50/70 response rates were 54%/52%/52%, 49%/46%/43% and 40%/38%/33%, respectively.

Conclusion: The results of this real-life observational study demonstrate that significant variation in patient baseline characteristics in individual rheumatology practices may exist within the BioTRAC registry. This may impact individual physician experience with respect to median time to discontinuation due to treatment failure. Nevertheless, treatment with IFX for up to 4 years is effective in reducing symptom severity and improving outcomes in patients with RA in this Individual Rheumatology Practice, Canadian and ON cohorts within the BioTRAC registry.
Ontario (ON). Patient baseline (BL) characteristics differed between the two provinces with patients from ON having a significantly higher ESR (34.9 mm/hr vs. 28.2 mm/hr) (P=0.004) and a significantly higher number of prior disease-modifying antirheumatic drugs (DMARDs) (58% of QC patients treated with 1 DMARD vs. 39.6% of ON; P=0.007) despite the comparable disease duration (8.6 years in ON vs. 9.5 years in QC; P=0.413). The vast majority of patients starting IFX in both provinces had a high disease activity (DAS28≥5.1). Treatment with IFX resulted in statistically (P<0.001) and clinically significant reductions in the DAS28 (DAS28ON: -1.4 and -1.7, DAS28QC: -1.9 and -2.2 at 6 and 12 months, respectively) and HAQ (HAQON: -0.3 and -0.4, HAQQC: -0.5 and -0.6 at 6 and 12 months, respectively). However, significantly lower DAS28 and HAQ values were achieved by 6 and 12 months in patients from QC compared to ON (P<0.001). Similarly, lower disease activity was achieved in patients from QC compared to ON as indicated by the EULAR definition of response (P6mo=0.006 and P12moo=0.003) and DAS28 categories (P6moo=0.008 and P12moo=0.019). Regression analysis over time showed that all parameters observed (CRP, ESR, AM stiffness, HAQ, pain, patient and physician global assessment, tender and swollen joint count and DAS28-CRP) improved significantly. The only difference between provinces was a stronger decrease in CRP in ON.

Conclusion: The results of this study have shown a significant regional variation in Canadian RA patients with patients from ON having higher ESR and having been treated with more DMARDs before initiation of IFX. All patients showed a significant response to IFX treatment with patients from QC reaching lower disease activity.

101 Age Differences in the Prescription of Biologies versus DMARDs
Charmaine Navis (University of Alberta, Edmonton); Paul Davis (University of Alberta, Edmonton); Walter Maksymowycz (University of Alberta, Edmonton); Elaine Yacyshyn (University of Alberta, Edmonton)
Objective: The treatment of patients with Rheumatoid Arthritis (RA) has reported to have age bias in elderly patients. We investigated whether a similar bias occurred in our database of patients on biologics versus leflunomide.
Methods: We performed an analysis of our RA Clinical Registry patients to determine whether an age difference existed between initiation with a biologic versus leflunomide. Data was collected from the RAPPORt database (Rheumatoid Arthritis Pharmacovigilance Program and Outcomes Research in Therapeutics). Information collected included date of birth, dates of visit, HAQ (Health Assessment Questionnaire) and DAS (Disease Activity Score).
Results: Data of 1271 patients with RA were analyzed. A modest age difference of patients initiated on biologics were younger by 3.83 years. Disease severity was higher in elderly patients initiating biologics in analysis of both the HAQ and DAS.
Conclusion: In this cohort of patients with RA, we detected a modest age bias in the use of biologics compared to leflunomide. Several confounding factors may include: incomplete data on all patients treated with leflunomide; and younger patients with better insurance coverage. Clinical measures identified that the elderly patients had more severe disease compared to the younger patients, identifying a need for treatment. Treatment disparities are a serious concern, and elderly patients must have access to medications when appropriate.

102 The Relationship between Function and Disease Activity as Measured by HAQ DI and DAS Varies by Rheumatoid Factor Status in ERA. Results from the CATCH cohort.
Tristan Boyd (University of Western Ontario, SJHC, London); Vivian Bykerk (Mount Sinai Hospital, Toronto); Boulos Harauzi (University of Montreal, Montreal); Carter Thorne (Southlake Regional Health Centre, Newmarket); Carol Hitchon (University of Manitoba, Winnipeg); Gilles Boire (Université de Sherbrooke, Sherbrooke); Janet Pope (University of Western Ontario, London)
Objective: Older publications have compared the relationship between function and disease activity over the course of RA. Some have found HAQ correlated significantly with DAS scores in the earlier phases of RA while others have found a strong correlation throughout the disease course. Our goal was to investigate the relationship between disease activity and functional capacity in the early stages of inflammatory arthritis using data collected in the CATCH cohort and to determine if the correlations changed; and whether they were similar when studying the effects of age and RF status.
Methods: Data from patients(n=1145) enrolled were collected from the Canadian Early Arthritis Cohort (CATCH); a multi-site observational cohort of early inflammatory arthritis. The HAQ and DAS28 were assessed at each visit. Correlations were done between HAQ and DAS every 3 months for the first year and then at 18 and 24 months. Data were then stratified by age (< 65 vs. ≥65), and RF status (positive versus negative).
Results: Mean HAQ and DAS scores were highest at first visit. All correlations between HAQ and DAS were significant at all time points (p<0.01). At baseline, there was a good correlation between HAQ and DAS (r = 0.49) whereas at 6, 9, and 12 months the correlation was weaker (r = 0.39, r = 0.29, and r = 0.38, respectively). However, correlations between HAQ and DAS were strongest at 18 months (r = 0.52) and 24 months (r = 0.53). Age did not change the association between HAQ and DAS (< 65 years old (r = 0.50, N=868) vs. ≥65 (r = 0.48, N=254)). The correlation between HAQ and DAS was stronger with RF+ patients (r = 0.63, N=636) than RF negative (r = 0.47, N=477).
Conclusion: Through comparison of correlations of HAQ and DAS at different time points in early RA, we were able to determine how strongly these measures were associated in a population with a relatively short duration of symptoms; most of whom had not yet experienced significant joint damage which would lead to irreversible functional impairment. Functional capacity was strongly influenced by disease activity in early RA. Although associated, the scores are measuring different aspects of RA and both are necessary to determine activity and function in ERA.

103 Treatment of Vascular Involvement in Systemic Sclerosis (SSc): What to Use When First-line Treatment Fails - a Consensus of SSc Experts. Kyle Walker (Trinity College, Dublin, Ireland, London); The CSRG and SCTC (University of Western Ontario, London); Janet Pope (University of Western Ontario, London)
Objective: Most published treatment in SSc is in first-line therapy such as ACE inhibitors (ACEi) for scleroderma renal crisis (SRC). There is a need for standardization in SSc management, particularly for treatment after failure of first-line therapy. We attempted to gain consensus among SSc experts for treatment and management of specific organ systems.
Methods: Members of the Scleroderma Clinical Trials Consortium (SCTC) and Canadian Scleroderma Research Group (CSRG) (n=117) were sent electronic surveys. The surveys asked both open ended and multiple choice type questions pertaining to various treatments, management and testing for the manifestations of SSc including vascular complications such SRC, Raynaud’s phenomenon (RP) and digital ulcers (DU). Each survey was sent 3 times. Those who responded to the first survey were invited to continue in the study for a total of 3 surveys. Results are in % who responded with each treatment option and only common choices are reported.
Results: SRC — Forty-seven would routinely hospitalize a patient with mild SRC and 93% in more severe SRC. Regardless of severity, first-line therapy for SRC is an ACEi (97%). For mild SRC, second-line is either adding a calcium channel blocker (CCB) (37%) or angiotensin receptor blocker (ARB) (35%), third-line is a CCB (35%) and fourth-line an alpha-blocker (27%). For more severe SRC, second-line is adding a CCB (27%), third-line is either a CCB (28%) or ARB (27%) and fourth-line an alpha-blocker (20%). RP — For mild RP, first-line treatment is a CCB (92%), second-line a phosphodiesterase inhibitor (PDEi) (35%), third-line an ARB (32%) and fourth-line iloprost (23%). For more severe RP, second-line is either a PDEi (45%) or iloprost (32%), third-line is either a
104 Prevalence of and Predictive Factors for Sustained Remission in Early RA: Results from SONORA Study

Pooneh Akhavan (University of Toronto, Toronto); Maggie Chen (Clinical Decision Making & Health Care, TORONTO); Xiuying Li (University Health Network, Toronto); Claire Bombardier (University of Toronto, Toronto)

Objective: Remission constitutes the best achievable state in patients with rheumatoid arthritis (RA). Current measures of Disease Activity - such as the DAS28 - define the patient’s remission status at a given point in time. While, for the patient, sustained remission over time is the ultimate goal. The purpose of this study is to assess the frequency and predictors of sustained remission in a large cohort of early RA patients in regular clinical practice.

Methods: A total of 994 patients diagnosed as early RA (symptoms ≥3 and ≤12 months) by a board-certified rheumatologist across North America were recruited in this study. We analyzed remission and sustained remission in 851 patients who had two-year complete follow-up information. Remission was defined as less than 2.6 for DAS28 and sustained remission was defined as consecutive remission at year 1 and year 2. Univariate logistic regressions were used to explore the predictors for sustained remission and multivariate logistic regression were used to estimate the remission probabilities controlling for significant factors.

Results: The mean age of patients was 53 years (SD, 14.8), with 72% female and 90% Caucasian. The mean RA symptom duration was 170 days (180), 61% were seropositive for rheumatoid factor and 43% anti-CCP positive (>20 unit/ml) at baseline. Seventy-four percent of patients had received DMARDs at baseline compared to 90% at year 1 and, 87% at 2. Two percent of the subjects were on Biologics at baseline compared to 90% at year 1 and, 87% at 2. Remissions at any one of the two visits were seen in 238 (28%) patients. Among them, 68 (8%) patients achieved sustained remission. The univariate logistic regression showed that low base-line DAS28 score, HAQ score, disease duration and CRP are significant predictors for sustained remission. The multivariate logistic regression showed that HAQ was no longer significant when other factors (low base-line DAS28, low CRP and short disease duration) were included in the model. Therefore it was excluded. In this final multivariate analysis the low baseline DAS28 (OR 0.66, 95% CI 0.54–0.81; p< 0.0001), disease duration (months) (0.88, 0.8–0.97; p=0.0091) and baseline CRP (0.83, 0.72–0.96; p=0.013) remained significant.

Conclusion: Low sustained remission rates were observed in this early RA cohort recruited before the wide use of biologics. The multivariate model predicts the probability of sustained remission using easily accessible clinical and laboratory variables. These identified factors can help guide rheumatologists in making treatment decisions for early RA patients.

105 Demographics of Seniors Attending a Rheumatology Clinic

Paul Davis (University of Alberta, Edmonton); Angela Juby (University of Alberta, Edmonton)

Objective: An increasingly aging population is impacting healthcare delivery in subspecialty areas of medicine outside of geriatrics including rheumatology. Geriatric patients can be challenging due to comorbidities and polypharmacy. This study was undertaken to assess the impact and demographics of seniors attending a rheumatology clinic and data compared to a younger cohort.

Methods: A retrospective chart review was undertaken on all patients attending a subspecialty rheumatology clinic in 2008. All patients were pre-screened and triaged for inflammatory arthritis or multisystem connective tissue diseases before attending the clinic. Patients with degenerative peripheral or axial disease and those with chronic pain syndromes were excluded where possible. Charts were reviewed for demographics including age, sex, diagnosis and comorbidities the data obtained from those >65 were compared to the younger cohort.

Results: 295 patients were seen in a 1 year period. 78 patients (26%) were >65. Their mean age was 73 (range 65–90) compared to the mean age of the < 65 group which was 53 (range 16–65). The gender ratio in the >65 group was 1.25:1 compared to the < 65 group of 2.06:1. Rheumatoid arthritis and other inflammatory arthropathies was the predominant diagnosis in both groups of patients(48% v 53%). Other connective tissue diseases were equally represented (12% v 14%). Osteoarthritis (usually inflammatory) was twice as common in the >65 group (17% v 8%). Polymyalgia rheumatica was diagnosed in 12% of seniors. Fibromyalgia was observed in 6% of the < 65 group. Co-morbidities were a prominent feature of the >65 group. Hypertension (31%), osteoporosis (27%), diabetes (15%), hypothyroidism (11%) and coronary artery disease (9%) were the most prevalent. Only 1 patient had cognitive impairment. Given the high number of comorbidities, polypharmacy and potential drug/drug interaction with anti-rheumatic therapy was often encountered.

Conclusion: Seniors compromise a significant proportion of patients attending a specialty rheumatology clinic. Inflammatory arthritis, polymyalgia rheumatica, osteoarthritis were the commonest diagnoses. Osteoporosis was commonly observed as a comorbidity. Other comorbidities and polypharmacy posed a significant challenge in many. This study highlights the need for reciprocal knowledge by both rheumatologists and geriatricians alike to optimize care for seniors with rheumatic diseases.
107 GAVE Unmasked by Alprostadil for Digital Ulceration in a Scleroderma Patient
Mohammed Omair (Mount Sinai Hospital, Toronto); Sindhu Johnson (University of Toronto, Toronto)
Objective. Prostaglandins are commonly used in the treatment of systemic sclerosis (SSc)-associated digital ulceration. Similarly, gastro-intestinal (GI) bleeding secondary to vasculopathic lesions in the GI tract is a recognized complication in SSc. We highlight an infrequent but clinically important occurrence in a common practice — gastric antral vascular ectasia (GAVE) unmasked by alprostadil therapy for severe digital ulceration.
Case Report: A 54 year old female with limited SSc based on sclerodactyly, calcinosis, telangiectasia, esophageal dysmotility, Raynaud’s phenomenon and anti-centromere antibody presented with a refractory ulcer in the right 3rd digit. She was treated with nifedipine, losartan, topical norglycerin, aspirin and pentoxifylline with inadequate response. She was admitted to hospital for intravenous (IV) alprostadil. The ulcer size and pain improved. On day 3 of the infusion, she developed hematemesis and a significant decline in hemoglobin. Endoscopy revealed severe esophagitis, esophageal ulceration and appearance of the stomach consistent with GAVE. A previous endoscopy in February 2008 did not show any of these findings. She was treated with blood transfusion, pantoprazole and discontinuation of alprostadil. The bleeding stopped and her hemoglobin stabilized.
Discussion: Prostaglandins produce inhibition of platelet aggregation, vasodilatation and smooth muscle proliferation through a G-protein coupled receptor linked to adenylate cyclase; and promote fibrinolysis by reducing plasma concentrations of tissue-type plasminogen activator and plasminogen activator inhibitor–1. Long-term therapy reduces the level of factor VIII and Von Willebrand factor causing further inhibition of the coagulation cascade. GAVE is a rare but important cause of anemia in SSc patients with a prevalence of 2%-5.7%. The endoscopic pattern of GAVE is classically described as erythematous streaks on the longitudinal rugal folds traversing the antrum and converging on the pylorus. As these streaks resemble the stripes on the outside rind of a watermelon, this condition is also known as “watermelon stomach.” Biopsy specimens demonstrate mucosal dilated capillaries containing fibrin thrombi, reactive epithelial changes, and fibromuscular hyperplasia of the lamina propria. The time of presentation is usually variable, presenting early in the diffuse and late in the limited subtypes; and may be affected by other factors like use of non-steroidal anti-inflammatories, steroids and proton pump inhibitors.
Conclusion: Alprostadil may precipitate bleeding from high-risk vascular lesions in the GI tract of SSc patients through its vasodilatory effects, inhibition of platelet aggregation, and promotion of fibrinolysis. Identification of high risk patients, close monitoring for occult blood loss and early intervention is recommended.

108 Arthritis In Celiac Disease Patients Does Not Respond Significantly To Gluten Free Diet
Celiac Disease Arthropathy Study — A Single Centre Canadian Perspective
Tarig Iqbal (The Queensway Carleton Hospital, Nepean); Mukarram Zaidi (The Northern Ontario School of Medicine, Laurentia, Sudbury); George Wells (University of Ottawa Heart Institute, Ottawa); Jacob Karsh (The Ottawa Hospital - Riverside Campus, Ottawa)
Objective: The purpose of our study was to determine the prevalence of arthritis in a Canadian population of Celiac disease patients and to ascertain whether a gluten free diet improves the symptoms of arthritis associated with Celiac disease.
Methods: This prospective, questionnaire based, cross-sectional cohort study was designed to evaluate the presence or absence of arthritis (primary outcome) simultaneously in both Celiac and non-Celiac disease cohorts. 1770 questionnaires in a ratio of 1:2 were sent to patients with Celiac disease and healthy age and sex matched volunteer non-Celiac disease controls respectively.
Results: 356/590 (60.33%) patients with celiac disease responded to the invitation to participate in this study. 443 (75%) responders (median age 58 years) were female; 60.5% with Celiac disease and 39.5% with non-Celiac disease. Celiac disease diagnosis (median duration 7 years) was endoscopically confirmed in 78.6% patients Overall, a doctor diagnosed arthritis in 223 (37.8%) patients; (65.5% GP & 22.9% rheumatologists). 131 cases of arthritis were reported in Celiac disease patients and 92 in non-Celiac disease patients. Osteoarthritis (89 vs. 59, p=0.93) was the most common diagnosis reported by Celiac disease patients, while rheumatoid arthritis (23 vs. 16, p=0.017) and psoriatic arthritis (5 vs. 1, p=0.60) were more commonly reported in non-Celiac disease patients. 4 patients with Celiac disease had Sacroilitis and 2 patients had Ankylosing Spondylitis. Celiac disease group patients with diarrhea (66%) and anemia (53%) improved on gluten free diet. Only 51 (14.5%) patients with Celiac disease reported improvement in arthritis symptoms with gluten free diet compared to 121 (34%) patients reported no improvement. Univariate logistic regression analysis showed ≤ high school education (OR 4.13, p=0.003), age ≥ 60 yrs (OR 4.6, p=0.001), and osteoporosis (OR 2.78, p= < 0.001) to be significantly associated with report of arthritis in celiac disease patients, the latter two being still significant on multivariate logistic regression analysis. Being on gluten free diet and smoking did not significantly reduce or increase the incidence of arthritis in Celiac disease patients respectively. Autoimmune thyroiditis (10.6% vs. 0.4%), insulin dependent diabetes mellitus (2.2% vs. 1.7%), SLE (1.1% vs. 0), and psoriasis (12.9% vs. 5.5%) occurred more frequently in celiac disease patients.
Conclusion: There was no increase in inflammatory arthritis (Rheumatoid arthritis and Psoriatic arthritis) in Celiac disease patients. Being on gluten free diet did not result in significant improvement in arthritis symptoms, compared to improvement in anemia and diarrhea in celiac disease patients.

109 Telemedicine as a Tool Assisting Therapists to Deliver Arthritis Care in Remote/Rural Communities
Sydney Lineker (The Arthritis Society, Toronto); Mary Ellen Marcon (The Arthritis Society, Sault Ste. Marie); Jocelyne Murdock (The Arthritis Society, Sudbury); Sue MacQueen (The Arthritis Society, Kitchener); Diane McGall (The Arthritis Society, Owen Sound); Barbara Brown (The Arthritis Society, Kenora); Julie Herrington (The Arthritis Society, Burlington)
Objective: Telemedicine technology is in widespread use and therapists working in rural and remote communities are in a position to improve access to arthritis care through the use of this technology. This presentation will describe how therapists use telemedicine to enhance the integration of arthritis care in remote/rural communities.
Methods: Physical and occupational therapists working for a community rehabilitation program 1) developed a training protocol and trained telemedicine coordinators and nurse practitioners to be the ‘hands’ of the therapists and assess patients with arthritis remotely.
Results: Therapists reported that they have been able to expand the number of communities and patients they served, at a reduced cost in terms of travel time and mileage expense. They reported other benefits including less stress with winter driving, less wear on their vehicles, more efficient use of time, and fewer patient ‘no shows’. They also identified potential benefits for patients including more timely access to care, less client travel and reduced costs of receiving care. Challenges were also identified including difficulties with scheduling and the need for extra people to assist with the technology.
Conclusion: Telemedicine technology was free, efficient and easy to use, offering benefits to therapists delivering arthritis care in remote and rural locations. The potential benefits to patients, other health professionals, rheumatologists and the health care system need to be assessed further.

110 Systemic Lupus Erythematosus Disease Activity Index (SLEDAI-2K) Responder Index (SRI)-50: A Valid Index for Measuring Improvement in Disease Activity
www.jrheum.orgDownloaded on October 19, 2023 from www.jrheum.org
SRI-50 describes partial improvement, ≥50%, in disease activity between visits in lupus patients. We aim to determine whether SRI-50 would capture patients who have improved by ≥50% as determined by physician global assessment (PGA), construct validity of SRI-50 for assessing improvement in disease activity in SLE.

Methods: All patients attending the Lupus Clinic from September 2009 to December 2009 were enrolled in a prospective longitudinal study. Of the 298 patients enrolled 141 had a follow-up visit and were studied further. SLEDAI-2K and SRI-50 scores were determined initially and on a follow-up visit at 1–3 months. During the first visit a PGA was determined on a visual analog scale (VAS) line of 100 mm, with anchors of 0 “no disease activity” and 10 for very active disease”. During the follow-up visit a PGA was determined on a 7-point Likert VAS; 7 much, 6 moderately, and 5 slightly improved, 4 unchanged, 3 slightly, 2 moderately, and 1 much worse. We defined a 50% improvement as PGA ≥6. An external clinician evaluated patients’ records and grouped them on follow-up visit into: improved, same and worse using standardized predefined definitions. The external construct was the Likert VAS. We hypothesized that patients who had ≥50% improvement (PGA≥6) would be captured by SRI-50 and the change in their SRI-50 scores would meet the definition of improvement by SLEDAI-2K (decrease ≥4).

Results: 126 females and 15 males were enrolled. 58% were Caucasian, 16% Black, 10% Asian and 16% others. Age at diagnosis 29.1 ± 11.4, age at the visit 29.1 ± 11.4, disease duration 15.3 ± 11.2 years and time between baseline and follow-up visits 3.2 ± 1.4 months. Patients were assessed as: worse 14, same 65 and improved 62. SRI-50 scores did not decrease below their presenting SLEDAI-2K score in patients who remained stable or worsened. In patients who improved, the SRI-50 score decreased by a mean of -2.40±3.11 while SLEDAI-2K scores did not decrease. SRI-50 scores decreased more in patients with PGA≥6 compared to PGA 4-5 with a decrease of ≥4 (r=0.52; p=0.0001). The decrease in SRI-50 scores compared to the decrease in SLEDAI-2K scores were statistically and clinically more significant in patients with PGA≥6 (p < 0.0001) compared to those with PGA 4-5 (p=0.003).

Conclusion: These results show that the SRI-50 has construct validity. SRI-50 is able to demonstrate incomplete improvement which would not have been discerned using SLEDAI-2K.

III Smoking Significantly Increases Disease Activity in Systemic Lupus Erythematosus (SLE): Results from the 1000 Faces of Lupus Cohort

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Objective: Smoking has been shown to increase SLE disease activity. However, smoking is also strongly associated with sociodemographic variables such as ethnicity, education and income, all of which also impact on SLE disease activity. We examined the relationship between smoking, sociodemographic variables, and disease activity in SLE patients.

Methods: Adult SLE prevalent and incident cases were enrolled in a prospective, multi-centre cohort. Sociodemographic variables, and data on health-related habits, diagnostic criteria, disease activity, autoantibodies, treatment, and damage were collected annually using standardized tools, and results were compared between smokers and non-smokers. Disease activity was evaluated using the Systemic Lupus Erythematosus Disease Activity Index (SLEDAI). We analyzed annual follow-up data over a 3 year period, testing for differences in disease activity between smokers and non-smokers in univariate analyses; significant variables from univariate analyses were included in multivariate regression models examining predictors of disease activity.

Results: A total of 1380 adult participants were enrolled from July 2005-May 2009. Two hundred forty-one (17%) were current smokers and 1139 were non-smokers (83%). There were no significant differences between smokers and non-smokers with respect to age (44 ± 0.9 years vs. 45 ± 0.9 years), gender (88% vs 91% female), disease duration (11 ± 0.6 years vs. 12 ± 0.3 years), age at diagnosis (31 ± 0.9 years vs. 31 ± 0.4 years) and ACR classification criteria met (5.9 ± 0.1 vs. 6.0 ± 0.1), and SLICC/ACR damage index (SDI) (1.5 ± 0.1 vs. 1.6 ± 0.1). A higher proportion of Caucasians (19%) and Aboriginals (44%) were smokers compared to Asians (6%), and Afro-Caribbeans (9%), (p < 0.001). Thirty-seven percent of smokers had annual incomes >$50000 compared to 47% of non-smokers, and 25% of smokers had annual incomes <$15000 compared to 12% of non-smokers; p=0.002. Smokers (76%) were less likely to have completed high school compared to non-smokers(87%), p< 0.001. SLEDAI scores did not differ between smokers and non-smokers in univariate analysis over the 3 years (5.53 in smokers compared to 4.95 in non-smokers at first visit) but in multivariate analysis smoking status was the only significant predictor of SLEDAI,( parameter estimate=1.2, 95% CI 1.7–2.3, model R2=55%) other than current treatment with prednisone, when income, education, ethnicity, ACR criteria, and age were included.

Conclusion: Smoking contributes to higher disease activity in SLE, and accounts for some of the differences in disease activity seen between ethnic and socioeconomic groups.

112 Quality Assurance: Pharmacist Feedback on a Cost Effective Solution for Rheumatology Electronic Prescription Software

Steven Katz (University of Alberta, Edmonton); Elaine Yacyshyn (University of Alberta, Edmonton)

Objective: Hand written physician prescriptions are fraught with potential medical errors. With improving patient safety in mind, electronic health records and electronic prescription programs are becoming more common, but they remain cost-prohibitive and can be technically difficult to implement. We previously presented a cost effective (free) design and implementation of an e-prescription program specifically for the rheumatologist. Pharmacist feedback was now sought to determine if this new program is perceived to be an improvement on handwritten prescriptions and equal to or potentially more costly e-prescription programs.

Methods: Between May and August 2010, consecutive rheumatology patients receiving a printed copy of their prescription from the electronic prescription software were asked to submit a 1 page survey to their pharmacist when filling the prescription. 100 surveys were to be distributed. A pre-stamped envelope was provided for return of the survey. The survey asked pharmacists to rank the legibility, clarity and overall effectiveness of the printed prescription on a scale of 1(worse) to 6(better) as compared to a handwritten prescription in terms of legibility, clarity, and overall effectiveness. The surveys were anonymous. Pharmacists were asked to rank the legibility, clarity and overall effectiveness of the printed prescription on a scale of 1(worse) to 6(better) compared to a handwritten prescription as well as other electronic prescriptions. Space was provided for comments. The survey was anonymous. Ethics approval was received from the University of Alberta Health Ethics Research Board.

Results: 100 surveys were distributed, with 61 returned. Compared to hand written prescriptions, the electronic prescription software was highly rated, with an average of 5.84 for legibility, 5.64 for clarity and 5.69 overall. Interestingly, the electronic prescription program was also rated higher than other electronic software available, rated 5.03 for legibility, 4.95 for clarity and 5.02 overall. 36 comments were received, the majority considered positive. Recurring comments included appreciation for developing the software, soliciting pharmacist feedback, and the simplicity of the prescription print out itself compared to other prescriptions.

Conclusion: This cost-effective rheumatology specific prescription pro-
gram was well received by pharmacists and was identified as a superior tool for health education. A better collaboration between specialists and FPs should improve the evaluation and treatment of affected patients. Since January 2007, the OPTIMUS initiative is an attempt to reach that objective in the Estrie area of the Province of Québec. With OPTIMUS, rates of appropriate treatment of osteoporosis at one year in previously untreated patients more than double (53% vs 20%). In OPTIMUS, FPs remain responsible for investigation and treatment of their patients after identification of a bone fragility fracture. A coordinator based in orthopaedists’ outpatient clinics identifies fragility fractures in patients older than 50 y.o., informs them about bone fragility and its link to osteoporosis, and spurs them to contact their FPs to get treated; the importance of persistence on treatment is reinforced during phone follow ups. Initially and when patients remain untreated upon follow up, the coordinator sends a letter to the patient’s FP about the occurrence of the fracture, its predictive value for future fractures, and the need for investigation and treatment. This represents a personalized form of continuous medical education for FPs, in the hope that FPs become leaders in the prevention of fragility fractures. To evaluate the perception of FPs about OPTIMUS, we performed a mail survey targeting FPs reached at least once by OPTIMUS.

**Results:** The survey was sent to a total of 212 FPs. One hundred and nine (51.4%) answered. Of these, 97 (89%) agreed that a fragility fracture is an indication for treatment of osteoporosis; 56 (51%) agreed that OPTIMUS had helped them take charge of osteoporosis; and 105 (96.3%) were Satisfied or Very Satisfied of the OPTIMUS initiative.

**Conclusion:** Because of this high level of acceptance, we propose to put into place a more elaborate intervention including a fall prevention program that will be managed by nurse coordinators in 16 FP Groups (GMF); these 16 Groups include 178 of the 360 FPs of the area. The FPs practicing in GMF are also involved in teaching to colleagues, residents and medical students; we expect an exponential effect on the practice of FPs over the years. We believe this enhanced intervention will improve the quality of life and autonomy of the patients while decreasing their rate of fractures.

**114 Efficacy and Safety of Cannabinoids for Pain in Musculoskeletal Diseases: a Systematic Review and Meta-analysis.**

Tabitha Kung (University of Toronto, Toronto); Jacqueline Hochman (University of Toronto, Toronto); Ye Sun (University Health Network, Toronto); Louis Bessette (Antrim Area Hospital, Northern Ireland); Boulos Harouei (University of Montreal, Montreal); Janet Pope (University of Western Ontario, London); Vivian Bykerk (Mount Sinai Hospital, Toronto)

**Objective:** To evaluate the efficacy and safety of Cannabinoids compared to placebo in adults with musculoskeletal disease.

**Methods:** We performed a systematic review comparing cannabinoids to placebo for the treatment of pain in patients with musculoskeletal (MSK) diseases. Trials were identified in MEDLINE, EMBASE, the Cochrane Library and ACR/EULAR meeting abstracts for 2008–2009. The primary outcome for efficacy was the mean difference in comparable numerical pain outcomes: pain Visual Analogue Scales (VAS) and Numerical Rating Scales (NRS). Primary outcomes for toxicity were serious adverse events (SAEs) and withdrawals due to adverse events. Secondary outcomes for toxicity were 3 specified adverse events (AEs): drowsiness, confusion or euphoria.

**Results:** A total of 4 randomized trials (218 patients) from 2450 citations investigated use of cannabinoids vs. placebo in MSK diseases. Although a much broader definition of MSK disease was entertained, only trials in rheumatoid arthritis (RA), back pain and fibromyalgia (FM) were retrieved. Where comparable data were not available, authors were contacted to obtain original data. For efficacy, the mean difference (10-pt scale) favored cannabinoid treatment for pain over placebo (mean difference –1.47, 95% CI –2.01,0.94) which is above the minimal important difference. There was no statistically significant difference in the risk of SAEs (Odds Ratio: OR 0.61, 95% CI 0.10, 3.68, Power=0.08) withdrawals due to adverse events (OR 1.32, 95% CI 0.43, 4.01, Power=0.08) or risk of euphoria (OR 4.05, 95% CI 0.24, 67.39, Power=0.16). Side effects were rare with no between group differences but analyses were underpowered. With respect to the secondary outcomes, AEs were statistically significantly different and more common in cannabinoids as compared to placebo for drowsiness (OR 4.05, 95% CI 1.82, 9.00) and confusion (OR 5.48, 95% CI 1.91, 15.73), translating to numbers needed to harm (NNH) of 4 and 9 respectively.

**Conclusion:** Cannabinoids appear to be efficacious for treatment of pain in the musculoskeletal diseases RA, FM and back pain. The statistically significant improvement in pain scores corresponded to a modest clinical difference in these few studies (only one in RA) against placebo. Information is still lacking with respect to the most important toxicity outcomes designated as SAEs and those leading to withdrawal of medication. However, substantial numbers of patients may experience bothersome adverse events such as confusion and drowsiness. Given preliminary efficacy data but incomplete data on toxicity, further studies with cannabinoids in MSK disease are warranted, particularly against active comparators.

**115 SLEDAI-2K Responder Index (SRI)-50: A Reliable Index for Measuring Improvement in Disease Activity**

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**Objective:** To test the inter-rater and intra-rater reliability of the SRI-50, an index designed to measure ≥50% improvement in disease activity between visits in lupus patients.

**Methods:** This is a multicenter, cross-sectional study with raters from Canada, United Kingdom and Argentina. Patient profile scenarios were derived from “real” adult patients. Ten rheumatologists, from university and community hospitals, and postdoctoral rheumatology fellows participated. An SRI-50 data retrieval form was used. Rheumatologist scored SLEDAI-2K at the baseline visit and SRI-50 on follow-up visit, for the same patients on two occasions 2 weeks apart. Physician Global Assessment (PGA) was determined on a numerical scale at baseline visit and Likert Scale (LS) on follow-up visit. Inter-rater and intra-rater reliability was assessed using intraclass correlation coefficient (ICC) and kappa statistics whenever applicable.

**Results:** Forty patient profiles were created. 55% were Caucasian, 22% black, 5% Asian and 18% others. Age at diagnosis 30.4 ± 12.7, age at the visit 38.0 ± 13.5 years, disease duration 7.6 ± 8.1 years and SDI 1.05 ± 1.45. All 24 descriptors of SLEDAI-2K were represented. The ICC performed on 80 patient profiles for inter-rater ranged from 1.00 for
SLEDAI-2K and SRI-50 to 0.96 for PGA. The ICC for SLEDAI-2K, SRI-50 and PGA ranged from 1.00 to 0.86. Substantial agreement was determined for inter-rater LS with a kappa statistics of 0.57.

**Conclusion:** The SRI-50 is reliable to assess ≥50% improvement in lupus disease activity. The use of the SRI-50 data retrieval form is essential to ensure the optimal performance of SRI-50. SRI-50 can be used by both rheumatologists and trainees and performs equally well in trained as well as untrained rheumatologists.

**116 SLEDAI-2K Responder Index-50 Enhances the Ability to Identify Responders in Clinical Trials**

Zahi Touma (University of Toronto, Toronto); Dafna Gladman (University of Toronto, Toronto); Dominique Ibanez (University of Toronto, Toronto); Shahzad Taghavi-zadeh (University of Toronto, Toronto); Murray Urowitz (University of Toronto, Toronto)

**Objective:** The 3 component SLE Responder Index (SRI) was able to demonstrate clinically significant improvement in recent trials of a new therapeutic agent in SLE. The purpose of our study was to evaluate the performance of SRI when SLEDAI-2K is substituted by SRI-50. To determine if SRI-50 will enhance the ability of SRI in detecting improvement in disease activity.

**Methods:** This is a cross-sectional study conducted on patients who attended the Lupus Clinic from September 2009 to July 2010, who had active lupus on baseline visit (SLEDAI-2K ≥4) and had one follow up visit. SRI incorporates SLEDAI-2K, BILAG and Physician Global Assessment (PGA). SLEDAI-2K, SRI-50, BILAG and PGA were determined initially and at follow-up. Patients who showed worsening in disease activity on follow-up visit (increase in SLEDAI-2K score) were excluded from the analysis. SRI response is defined as 1) a ≥4 point reduction in SLEDAI-2K score; 2) no new BILAG A or no more than 1 new BILAG B domain score, and 3) no deterioration from baseline in the PGA by ≥0.3 points. SRI was determined at follow-up visit according to the original definition using SLEDAI-2K score. SRI was further evaluated in the same group of patients but this time substituting SLEDAI-2K with SRI-50.

**Results:** 107 patients, 97 females and 10 males with SLEDAI-2K score ≥4 at baseline were further studied. The length of time between both visits was 2.9 ± 1.0 months. The mean change of SLEDAI-2K (SLEDAI-2K Follow-up - SLEDAI-2K Baseline) was −1.85 ± 3.27 and the mean change in SRI-50 (SRI-50 Follow-up - SLEDAI-2K Baseline) was −2.59 ± 3.41. Although patients had only one follow-up visit over a 3 months period, 30 patients (31%) met the original definition of SRI and 37 patients (35%) met the definition of SRI when SLEDAI-2K was substituted with SRI-50 score. The use of SRI-50 definitions allowed us to determine a clinically significant improvement in 7 additional patients. This improvement could not be discerned with the use of SLEDAI-2K as a component of SRI.

**Conclusion:** These results show that SRI-50 enhances the ability of SRI to capture patients with clinically significant improvement in disease activity. Although the period of follow-up was very short, SRI-50 was superior to SLEDAI-2K in detecting partial clinical improvement, ≥50%, between visits. SRI-50 should be used as the response measure of disease activity improvement in current trials of new treatments for lupus.

**117 Comparison of Lupus Quality of Life and SF-36 Questionnaires in Lupus Patients with Moderate Disease Activity: A Cross-sectional Study**

Zahi Touma (University of Toronto, Toronto); Murray Urowitz (University of Toronto, Toronto); Dominique Ibanez (University of Toronto, Toronto); Shahzad Taghavi-zadeh (University of Toronto, Toronto); Dafna Gladman (University of Toronto, Toronto)

**Objective:** We aimed to evaluate whether the LupusQoL contributed additional information not obtained using the SF-36 in Lupus patients and moderate disease activity.

**Methods:** 35 patients with moderate disease activity (SLEDAI-2K 30 days ≥4) seen at a single centre over 3 months were enrolled. Both questionnaires were co-administered at the same visit. Cumulative damage was determined by Systemic Lupus International Collaborating Clinics/ACR Damage Index (SDI). We performed a descriptive analysis of the mean scores for all domains and compared comparable domains in both questionnaires. For the 4 non-comparable domains of the LupusQoL, we determined the correlation between each domain with the Physical Component Score (PCS) and the Mental Component Score (MCS) of the SF-36. We determined the correlations between LupusQoL and SF-36 with SLEDAI-2K and SRI-50 scores. We compared LupusQoL and SF-36 scores in patients with and without damage.

**Results:** Among the 35 patients (female 29 /male 6), 40% were Caucasian, 31% Black, 1% Asian, and 17% other. The mean age at SLE diagnosis was 25 ± 10.9 years. At study visit the mean age was 35 ± 10.7 and disease duration 10.1 ± 6.4 years. SLEDAI-2K 10.3 ± 5.36 and SRI 1.06 ± 2.0. Both questionnaires assessed quality of life as low among patients. There was no statistically significant difference between comparable domains of both questionnaires. For the 4 non-comparable domains of the LupusQoL, there was a correlation between Body Image and MCS-SF-36 r=0.73, Planning and MCS-SF-36 r=0.63, Intimate Relationships and PCS-SF-36 r=0.59, and Burden to Others and MCS-SF-36 r=0.34 (all p were significant). Neither questionnaire correlated with disease activity nor with cumulative damage. When comparing the domains in patients with damage to patients without damage, there was a statistically significant difference with some of the SF-36 scores (Physical Functioning p=0.03 and PCS p=0.046) but not LupusQoL scores. In both cases, the scores were lower in patients with damage. No relationship could be identified between LupusQoL and fibromyalgia since there were only 2 patients with fibromyalgia.

**Conclusion:** Quality of life as determined by LupusQoL, and SF-36 questionnaires is significantly compromised in lupus patients with moderate disease activity, but does not correlate with disease activity or damage. These findings confirm that the quality of life is an independent outcome measure in the assessment of lupus. There is no superiority of LupusQoL over SF-36 in assessing lupus patients’ quality of life. The responsiveness of LupusQoL needs to be evaluated in patients with moderate to severe disease activity.

**118 Prolonged Serologically Active Clinically Quiescent (SACQ) Systemic Lupus Erythematosus (SLE): Novel Predictors of Flare?**

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**Objective:** Anti-double stranded DNA antibodies (anti-dsDNA) and complement levels can predict SLE flare. Some patients, however, are clinically quiescent despite persistent serologic activity (i.e., elevated anti-dsDNA and/or hypocomplementemia). Past studies reveal that 60% of such SACQ patients flare, but do so only after average 182 weeks. In these patients changes in anti-dsDNA and/or C3/C4 levels measured at routine clinic visits did not predict disease flare. Some studies suggest that anti-chromatin (-nucleosome) antibodies are more sensitive than anti-dsDNA to detect active SLE, and that time to first flare after a SACQ period significantly correlates with their presence. We investigated whether levels of anti-dsDNA and -chromatin isotypes, measured during a prolonged SACQ period, differed in patients who remained SACQ versus those who flared.

**Methods:** Archived serum samples of patients with a prolonged SACQ period, stored at −80 °C, were retrieved and divided by disease activity (during SACQ period vs during flare). Serum levels of IgM, IgA, total IgG, and IgG1-4 anti-dsDNA and anti-chromatin antibodies were measured by ELISA. H1-stripped chromatin was prepared from the human cell line, MOLT4. ELISA plates were coated overnight with dsDNA (40 μg/ml) and chromatin (8 μg/ml) diluted in PBS at 4°C. Serum was diluted 1/100 for IgM, IgA, and IgG, or 1/50 for IgG4-1. SACQ was defined as at least a two
The Prevalence of Systemic Lupus in Alberta: A Population-based Assessment
Cheryl Barnabe (University of Calgary, Calgary); Lawrence Joseph (Research Institute of the McGill University Health Center, Montreal); Steven Edworthy (University of Calgary, Calgary); Patrick Belisle (Research Institute of the McGill University Health, Montreal); Larry Svenson (Alberta Health and Wellness, Edmonton); Jeremy Labrecque (McGill University Health Centre (MUHC), Montreal); Brenda Hemmelgarn (University of Calgary, Calgary); Susan Barr (University of Calgary, Calgary); Sasha Bernatsky (McGill University Health Centre, Montreal)

Objective: To estimate the prevalence of SLE using population-based administrative data, and to compare prevalence rates between First Nation (FN) and non-FN persons.

Methods: Three case definitions were used to ascertain SLE cases from Alberta physician billing claims and hospitalization databases (covering over 3.7 million individuals): >1 billing codes by a rheumatologist; or >2 billing codes by any physician, >8 weeks apart but within 2 years; or a hospitalization diagnosis. The Alberta Health and Wellness registry file was used to determine FN status, and rural or urban residence by postal code. To account for imperfect case ascertainment, we employed a hierarchical Bayesian latent class regression model that accounted for possible between-test dependence conditional on disease status and potential differences in case ascertainment sensitivity and specificity based on patient characteristics (age, sex, and rural-versus-urban residence). Cases were ascertained from 1994–2007, and prevalence estimates based on those alive as of 2007.

Results: Accounting for error inherent in both data sources, the estimated overall SLE prevalence in Alberta is 27.3 cases per 10,000 females (95% credible interval, CrI 25.9–28.8) and 3.2 cases per 10,000 males (95%CrI 2.6–3.8). Prevalence was higher for individuals aged ≥45, particularly in urban women (51.2 per 10,000; 95% CrI 47.5–53.3). Although the overall prevalence in FN was similar to that of non-FN, interesting trends were seen with higher rates in FN women (30.2 per 10,000; 95% CrI 24.5–37.4) compared to non-FN women (27.1 per 10,000; 95% CrI 25.7–28.6). This was particularly marked for females aged≥45, with an urban FN prevalence of 100.8 per 10,000 (95%CrI 66.5–147.4) versus non-FN 50.6 per 10,000 (95%CrI 46.9–54.7); and rural FN prevalence of 86.7 per 10,000 (95%CrI 61.2–127.3) versus non-FN 44.3 per 10,000 (95%CrI 40.0–49.2). Prevalence rates tended to be higher in FN females aged≥45 compared to non-FN of that age group, but with overlapping 95%CrI. Point estimates in FN men were lower than in non-FN men, but the 95%CrI were wide and overlapping.

Conclusion: We demonstrated differences in SLE prevalence according to age, sex, and region. The administrative data suggest a 2-fold increase in SLE cases among FN females aged ≥45, compared to non-FN females of this age group. This may reflect a true predominance of SLE among FN women, but alternate explanations may be that patterns of health care use and/or billing codes may differ across demographic groups, creating biased estimates. An additional limitation is imprecision in some sub-group estimates.

120 Treatment of Hypertension and Hypercholesterolemia is not Successful in the Majority of Patients with Systemic Lupus Erythematosus
Elizabeth Pek (Toronto Western Hospital, Toronto); Dafna Gladman (University of Toronto, Toronto); Dominique Ibanez (University of Toronto, Toronto); Murray Urowitz (University of Toronto, Toronto)

Objective: Patients with SLE demonstrate accelerated atherosclerosis and are at an increased risk of coronary artery disease. Previous quality improvement studies have demonstrated that increasing numbers of patients are being treated for hypertension and hypercholesterolemia. The objective of this study was to determine whether the initiation of treatment with antihypertensive or lipid lowering medications led to successful control of these risk factors.

Methods: Patients from a large lupus cohort presenting within 1 year of SLE diagnosis and who received treatment with anti-hypertensive medications since 1985 and/or lipid lowering medications since 1995 were included. Success was defined as having met target blood pressure (BP), systolic BP ≥ 140 and diastolic BP ≥ 90 mmHg, serum total cholesterol (TC), TC ≥ 5.2 mmol/L or serum LDL, LDL ≥ 3.2 mmol/L during at least 90% of follow-up.

Results: 70% and 29% of patients with documented hypertension or hypercholesterolemia respectively were initiated on appropriate therapy. 107 patients were treated for hypertension (86% female, mean±SD age at treatment was 43.3±15.4, mean±SD disease duration at treatment was 2.6±4.2 years) and 49 were treated for hypercholesterolemia (82% female, mean±SD age at treatment was 42.9±13.3, mean±SD disease duration at treatment was 3.2±3.6 years). Overall the adjusted mean systolic pressure decreased from 147.00±18.71 mmHg to 131.49±14.32 mmHg following treatment and the adjusted mean diastolic pressure decreased from 90.37±12.05 mmHg to 80.39±14.32 mmHg. However, only 36 of 104 patients (35%) met our criteria for successful treatment of hypertension. The adjusted mean total serum cholesterol and LDL decreased from 6.29±1.48 mmol/L to 4.76±1.01 mmol/L and 3.65 ± 1.29 to 2.56 ± 0.81 respectively. However, only 19 of 48 patients (40%) attained target total cholesterol levels while 25/40 (63%) attained target LDL levels during over 90% of follow-up.

Conclusion: Treatment of hypertension and hypercholesterolemia does not necessarily result in successful control of these risk factors in the majority of SLE patients. Further analysis will be important to discern the reasons for unsuccessful treatment and to compare CAD outcomes in patients who were successfully treated and those who were not.
damage, as measured by the SDI, was categorized as definitely related, possibly related, or independent of CS. Steroid courses over this period were captured and used to calculate accumulated dose and average daily dose. Multivariable stepwise logistic regression and Mantel-Haenszel chi-square tests were performed to identify significant associations between dose dependent variables and steroid-related permanent damage.

**Results:** Of the 342 patients in our analysis (295 female, mean(±std) age of 35±13 years at enrolment), the median cumulative steroid dose increased from 0.49g to 13.2g from enrolment to 5 years follow-up. During the same period, the mean damage (SDI) increased from 0.15±0.50 to 0.97±1.33, of which 0.24±0.60 (25%) was definitely related to steroids. Damage associated with cumulative dosages are as follows: at 0 g total SDI was 0.50±0.84 of which 0.11±0.34 (19.4%) was definitely related to CS, and at ≥ 40 g the total SDI was 1.77 ± 1.74 of which 1.00±1.15 (50%) was definitely related to CS. Damage associated with average daily dosages are as follows: total SDI at 0 mg/day was 0.50±0.84 of which 0.11±0.34 (19.4%) was definitely related to CS, and at a 20 mg/day the total SDI was 1.64±1.75 of which 0.54±0.96 (28.9%) was definitely related to CS.

**Conclusion:** SLE patients receiving CS therapy accrue damage due to disease and other therapy factors, as well as due to CS over time; however the relative contribution of damage due to CS remains the same over a five year period. Additional research is required to better determine the susceptibility of SLE patients to steroid damage due to dose over an increased duration of corticosteroid use.

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### 122 Adverse Obstetrical and Neonatal Outcomes in RA and SLE

Cheryl Barnabe (University of Calgary, Calgary); Peter Faris (Alberta Bone and Joint Institute, Calgary); Huda Quan (University of Calgary, Calgary)

**Objective:** Adverse obstetrical and neonatal outcomes have historically been documented in women with rheumatic disease. These outcomes may be improved in recent times where better rheumatic disease and prenatal management is available.

**Methods:** An administrative database (years 1998/9 to 2008/9) provided obstetrical hospitalization details for women with RA and SLE, and each identified case was matched with 4 controls based on maternal age and year of delivery. Conditional logistic regression was used to calculate the odds ratio (OR), with adjustments made for known confounders, for the following outcomes in patients compared to controls: pregnancy-related hypertension, cesarean section, premature births and neonates meeting criteria for small for gestational age (SGA). We also compared the hospital length of stay and proportion of neonates requiring special care unit admission.

**Results:** There were 38 singleton pregnancies in women with RA and 95 in women with SLE during the study period. The adjusted OR (aOR) for pregnancy-related hypertension in RA was 2.9 (95% CI 1.0–8.3; p=0.051) and in SLE 2.2 (95% CI 1.2–4.3; p=0.017). The aOR for cesarean section in RA was 2.9 (95% CI 0.9–6.3; p=0.097) and in SLE 2.8 (95% CI 1.5–5.1; p=0.01). The aOR for premature is RWA in 2.7 (95% CI 1.0–7.0; p=0.043) and in SLE 6.6 (95% CI 3.5–12.3; p<0.001). The aOR for SGA in RA was 3.0 (95% CI 1.2–7.2; p=0.017) and in SLE 2.8 (95% CI 1.5–4.9; p=0.001). Additionally, more women with SLE experienced postpartum infections compared to their controls (6.3% vs 1.3%; p=0.004). The maternal length of stay was longer for women with rheumatic disease (mean difference for RA 0.9 days (95% CI 0.4–1.3; p=0.003), for SLE 1.8 days (95% CI 1.1–2.6; p<0.001). More neonates born to mothers with RA or SLE required admission to the special care unit (RA 29% vs 11%; p=0.006; SLE 36% vs 13%; p<0.001).

**Conclusion:** Women with RA and SLE have increased odds of developing pregnancy-related hypertension, and a large proportion deliver by cesarean section. Neotones of women with rheumatic disease are more likely to be premature, and small for gestational age. These findings are in keeping with the historical literature, and do not appear to have improved over time. Additionally, women with SLE demonstrate a trend to an increased risk of postpartum infections, which has not been previously identified. Increased collaboration between rheumatologists and obstetrical care providers is suggested to identify modifiable risk factors for these adverse outcomes.

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### 123 A 50 Year Old Woman with Fever, Hemoptysis and Rash

Zorheh Sabbagh (University of Saskatchewan, Saskatoon); Regina Taylor-Gjevre (University of Saskatchewan, Saskatoon)

**Case Report:**

BACKGROUND: Churg Strauss Syndrome (CSS) is an eosinophil-associated small vessel vasculitis. Its incidence is 2.4–4 per million which makes it one of the rarest of the systemic vasculitides. ANCA, both PR3 and MPO, have been detected with variable frequencies in patients with CSS and is more associated with cutaneous, neurological, and pulmonary involvement. CASE: We present a 50 year-old woman with a history of asthma and rhinitis who was admitted because of fever, hemoptysis, recurrent ear infections, sinusitis, weight loss, and purpuric rash. She reported swelling in her elbows and knees as well as tingling and numbness in her feet. In addition, leukocytosis, eosinophilia, elevation of CRP and ESR were observed. She developed rapid renal failure with serum creatinine of 189, proteinuria of 0.7 g/day and RBC casts. Moreover, ANCA/PR3 was positive. Chest radiograph and computed tomography showed patchy air-space consolidation in both lung fields. Echocardiogram was normal. Skin biopsy depicted lymphocytic vasculitis with eosinophils. Given the clinical picture, laboratory data and pathologic findings, our patient fulfilled the ACR criteria for diagnosis of CSS. Following the skin biopsies, therapy with methylprednisolone and cyclophosphamide was initiated. Eosinophilia, fever, hemoptysis, and weakness improved dramatically in the first 24 hr.

CONCLUSION: Our patient is a rare ANCA/ PR3 positive CSS with involvement of the lung, skin, kidney, and nervous system. The presence of ANCA/PR3 may contribute in severity of her renal impairment. These manifestations in a patient with asthma and eosinophilia should alert the clinician to the possibility of CSS. Immunosuppressive therapy with steroids and cyclophosphamide is beneficial.

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### 124 Relapsing Polychondritis Associated with Hepatitis C Virus Infection

Iman Hemmati (Department of Medicine, UBC, Vancouver); Eric Yoshida (Division of Gastroenterology, UBC, Vancouver); Kam Shoania (University of British Columbia, Vancouver)

**Case Report:**

Objective: Review of relapsing polychondritis (RP) and its association to hepatitis C virus (HCV) infection. Method Used: A case of RP associated with HCV infection in a 59-year-old male is reported. The English medical literature was reviewed for RP and its association with HCV infection. Results Obtained: RP is a rare autoimmune and multisystem disorder of unknown etiology in which the cartilaginous and related tissues are the primary targets of inflammation. HCV infection is a more common systemic illness with known hepatic and extra-hepatic manifestations. Although RP is associated with other diseases in about 35% of cases, only one case of RP, HCV and mixed cryoglobulinemia has been reported. We report a case of RP associated with HCV infection. Treatment with pegylated interferon and ribavirin resulted in sustained virologic response and remission of treatment resistant RP with azathioprine. Brief Conclusion: We report a case of RP and associated HCV infection. Although treatment of HCV infection resulted in remission of RP, It is unknown if there is a causal relationship between HCV infection and RP.

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### 125 Perceptions of Advanced Clinician Practitioner in Arthritis Care (ACPC) Program-trained Practitioners: Roles and Role Utilization within the Ontario Healthcare System

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(St Michael’s Hospital, Toronto); Rayfel Schneider (The Hospital for Sick Children, University of Toronto, Toronto)

Objective: To capture practitioner and stakeholder satisfaction with the roles of Advanced Clinician Practitioner in Arthritis Care (ACPAC) program-trained physical therapists (PTs) and occupational therapists (OTs). Methods: ACPAC program graduates and their colleagues were recruited from 15 institutions across the province of Ontario. Participants included program graduates, nurse practitioners, physicians, unit managers and program directors. Patients’ perspectives have been captured in a separate study. Program graduates participated in focus groups and their clinical colleagues and administrators participated in individual interviews. Interviews and focus groups were digitally audio-recorded for verbatim transcription. Transcripts were verified and entered into HyperResearch software for textual data analysis. Transcripts were coded for anticipated and emergent themes using the method of constant comparison including searches for disconfirming evidence. Focus groups, interviews and analyses were conducted by a qualitative researcher.

Results: Graduates (n=20) valued their ACPAC training and the advent of their extended practice roles (where achieved), seeing them as positive opportunities for career advancement. Those enjoying extended practice roles felt they were improving communication and continuity of care, improving access to care in under-served communities, providing timely and appropriate referrals and earlier recognition of potentially serious problems. Barriers to role utilization included lack of dedicated funding and administrative recognition through title, remuneration and medical directives and the unwillingness of others to understand or accommodate extended practice roles within their practice structure. Colleagues of ACPAC graduates (n=18) generally highly valued graduates’ roles. They felt that graduates were innovative, communicative, provided enhanced provision of care in under-served areas, allowed physicians to see more patients and greatly enhanced education for patients regarding their disease process, treatment and recovery. Administrators expressed concern about the cost-effectiveness and sustainability of extended practice roles for graduates within the current system. A lack of hands-on therapists if graduates move into extended practice roles was also a concern. At the system-level, it was felt that ACPAC graduates could reduce patient wait times, improve access to rheumatologists, reduce long-term disability, and provide a better approach to chronic disease management for an aging population.

Conclusion: Administrators, clinical colleagues and program graduates themselves value their capabilities and perceive that they improve patient care on many levels; however, barriers to role utilization at the team, institution and system levels pose challenges for the sustainability of extended practice roles. Future work needs to focus on ways to break down these barriers and maximize role utilization for the benefit of patients with arthritis.

126 Advanced Clinician Practitioner in Arthritis Care (ACPAC) Program-Trained Therapists in Ontario: Impact on System Integration and Change
Carol Kennedy (St. Michael’s Hospital, Toronto); Kelly Warmington (St. Michael’s Hospital, Toronto); Leslie Soever (Mount Sinai Hospital, Toronto); Laura Passalent (St Michael’s Hospital, Toronto); Sydney Lineker (The Arthritis Society, Toronto); Ryan Thomas (St Michael’s Hospital, Toronto); Katie Lundon (St Michael’s Hospital, Toronto); Rachel Shupak (St Michael’s Hospital, Toronto); Rayfel Schneider (The Hospital for Sick Children, University of Toronto, Toronto)

Objective: The Advanced Clinician Practitioner in Arthritis Care (ACPAC) program is an innovative, clinical and academic, interprofessional education program for licensed physical and occupational therapists. The program focuses on assessment, diagnosis, triage and independent management of selected musculoskeletal and arthritis-related disorders. This study aimed to evaluate the performance of ACPAC program-trained extended role practitioners with respect to health care delivery using System Integration and Change (SIC) indicators. The research objectives were to measure: 1) the role utilization of the ACPAC program-trained practitioner, 2) access to ACPAC program-trained practitioners in Ontario, and 3) integration with internal/external services and other services/ resources.

Methods: ACPAC program-trained practitioners (n=30) were recruited from 15 healthcare institutions across the province of Ontario. These included urban, rural, academic, non-academic, adult and paediatric settings. ACPAC program-trained practitioners completed a longitudinal survey at the end of each fiscal quarter in 2009. Data were collected using SurveyMonkey©. SIC indicators and related questionnaire items were developed by: teleconference brainstorming, ranking and pilot testing with ACPAC program graduates; input from stakeholders (healthcare administrators and patients of these extended role practitioners). Descriptive statistics were used to summarize the data.

Results: The response rate varied from 83–93% over the fiscal quarters. Most respondents were working in an extended practice role (range 84–93%). The mean wait time to see an ACPAC program-trained practitioner varied from 14 to 22 days. These practitioners provided a wide range of services to patients in the 2009 fiscal year: referring 3946 patients to internal or external services, 1867 patients to medical doctors (general practitioners or specialists), and 3262 patients to educational resources. Most ACPAC graduates (75%) reported acting under the auspices of medical directives to support their extended practice role. Most respondents ordered X-rays (82%), lab tests (64%) and diagnostic ultrasounds (54%). 70% reported recommending medication/dosage changes and 4% made these changes independently. 89% reported recommending joint injections and 8% were performing them.

Conclusion: ACPAC program-trained practitioners were working in extended practice roles performing tasks that have the potential to improve access to care for patients with arthritis. Future evaluations will monitor the evolution of these new roles and assess their impact on patient outcomes. This new human health resource may be an effective strategy to address the declining number of arthritis care specialists which has resulted in inappropriate wait times for care and the need for an interprofessional approach to managing patients with musculoskeletal disorders more efficiently.

127 A Simulation Model of Medication Use and Impact among Persons with Osteoarthritis in Canada
Jacek Kopec (University of British Columbia, Vancouver); Eric Sayre (Arthritis Research Centre of Canada, Vancouver); M Mushfigur Rahman (Arthritis Research Centre of Canada, Vancouver); Weiqun Kang (Arthritis Research Centre of Canada, Vancouver); Philippe Finés (Statistics Canada, Montreal); William Flanagan (Statistics Canada, Ottawa); Jolanda Cibere (University of British Columbia, Vancouver); Nicholas Bansback (Centre of Clinical Epidemiology and Evaluation, Vancouver); A slam Anis (University of British Columbia, Vancouver); Elizabeth Badley (University of Toronto, Toronto)

Objective: The objective of this research was to build a drug treatment module for POHEM-OA, a population-based computer model of osteoarthritis (OA). POHEM-OA is a microsimulation model in which aggregate results for the adult population of Canada are obtained by simulating “life histories” of about 25 millions individuals, one at a time.

Methods: Model parameters have been derived from analyses of administrative data in BC (prescription drug use), national population surveys (over-the-counter use), and a comprehensive review of the literature (benefits and adverse effects of medication). POHEM-OA simulates the use of 4 types of medication (acetaminophen, NSAIDs, COX-2 inhibitors and opioids) as a function of age, sex, OA, and health level, measured by the Health Utilities Index 3 (HUI3). HUI3 is an 8-domain health index that includes pain. The model also simulates the benefits of medication in terms of its positive impact on HUI3 (estimated from data on pain reduction), as well as adverse effects of drugs and their negative impact on HUI3 and survival.

Results: Probabilities of use for each type of medication have been estimated for 390 subgroups defined by age, sex, OA diagnosis, OA duration, surgical treatment, and HUI3 category. These probabilities ranged from...
0.01 to 0.77 for acetaminophen, 0.03–0.93 for NSAIDs, 0.001–0.28 for Coxibs, and 0.0002–0.67 for opioids. For example, the highest users of coxibs were men, < 50 years of age, < 2 years after joint replacement surgery. HUI3 levels had a strong effect on the use of opioids and coxibs and moderate-to-weak effect on the use of acetaminophen and NSAIDs. Average relative pain reductions (0–100 scale) ranged from 28% for acetaminophen to 38% for NSAIDs and coxibs and 40% for opioids. Excess risks of adverse effects in NSAIDs/coxibs users were 7.4/1.1 per 1000 person-years for serious gastrointestinal complications, 3.7/4.5 for cardiovascular disease and 1.4/2.4 for stroke. Dyspepsia was most common with opioids (118 per 1000 p-y) followed by NSAIDs (57 per 1000 p-y). We also estimated the average impact of the side effects on HUI3 and the risk of death. These parameters have been implemented in POHEM- OA.

Conclusion: POHEM-OA synthesizes quantitative knowledge about the use and effects of medication in OA. Applications of the model include projections of the future use of drugs by persons with OA in Canada and evaluations of the health impact of changes in the pattern of drug utilization in the population.

128 MU2SCLES online: MUSculoskeletal MUlti-professional Simulated Collaborative Learning E-nitiativeS online

Jodie Jeffery (University of Saskatchewan, Saskatoon); Regina Taylor-Gjerve (University of Saskatchewan, Saskatoon); Liz Harrison (University of Saskatchewan, Saskatoon); Anne Dzus (University of Saskatchewan, Saskatoon); Rob Woods (University of Saskatchewan, Saskatoon); Jordan Buchko (University of Saskatchewan, Saskatoon); Katie Rooks (University of Saskatchewan, Saskatoon); Michael Katz (University of Saskatchewan, Saskatoon); Sathish Rajasekaran (University of Saskatchewan, Saskatoon)

Objective: Musculoskeletal (MSK) medicine exemplifies the benefits of collaborative interprofessional care. By incorporating an interprofessional approach into the foundation years of medical education, one can predict that it will not only encourage more collaborative patient care but that it will be established as ‘standard of care’. Currently, the allocation of teaching time in medical school devoted to MSK-related conditions is disproportionate to the burden of disease in society. As such, there is a need for creative, persistent and standardized MSK educational resources in the undergraduate curriculum.

Methods: A dynamic, self-study MSK learning resource was developed with the aid of various medical disciplines and allied health care professionals in Saskatoon. Actual patient cases are selected in accordance to both commonality of the problem in Saskatchewan and urgency of management to identify a minimum level of competency for managing patients with musculoskeletal problems. With the aid of the Bone Joint Decade Undergraduate Curriculum Group (BJDUCG) recommendations and Medical Council of Canada (MCC) objectives, all possible knowledge, skills, and attitudes that may be relevant to MSK conditions are prioritized. Integration of a Saskatchewan-developed pharmaceutical resource, RxFiles, and online discussion boards are additional features. Pre and post-case quizzes are integrated to reinforce key learning issues.

Results: “MU2SCLES online” complements the lecture component of the University of Saskatchewan undergraduate MSK curriculum. By providing evidence-based teaching, optimal learning can occur while developing an opportunity for equal exposure to all students. As a relatively low-cost educational tool, e-learning fits in with the distributed nature of today’s learning society. By using an intra and interprofessional, case-based approach, “MU2SCLES online” enhances the learning of musculoskeletal medicine and promotes professional collaboration. Future partnerships through the Canadian Healthcare Education Commons (CHEC) enable sharing of this unique Saskatchewan resource.

129 Amyloidosis and GCA/PMR: Case Report of a Rare Association

Kimberly Legault (McMaster University, Hamilton); Anjali Shroff (McMaster University, Hamilton); Mark Crowther (St. Joseph’s Healthcare Hamilton, Hamilton); Nader Khalidi (McMaster University, Hamilton)

Case Report:

Objective: AA amyloidosis is caused by extracellular deposition of fibrils that are composed of fragments of the acute-phase reactant serum amyloid A (SAA) protein. It is associated with several rheumatological conditions, most notably rheumatoid arthritis, juvenile idiopathic arthritis, ankylosing spondylitis, and systemic lupus erythematosus. GCA and/or PMR have not been commonly associated, with only nine cases previously reported in the literature. We present a case of secondary amyloidosis presenting as a nephrotic syndrome that developed in a patient who was previously diagnosed with GCA/PMR. In contrast to the majority of the cases previously reported, our patient did not have clinical evidence of uncontrolled rheumatologic disease activity at the time of presentation with amyloidosis, with the exception of persistently elevated ESR. To further clarify this complex clinical area we elected to survey the published literature with respect to the association between amyloidosis and GCA/PMR.

Methods: We systematically reviewed the published literature and summarized previous cases of AA amyloidosis in GCA/PMR, including treatment options.

Results: We identified a total of 9 cases in 7 reports. All except one of the patients reported presented with the nephrotic syndrome and renal dysfunction leading to a diagnosis of amyloidosis. Most of the patients died as a result of progressive renal insufficiency. However, two patients were treated with colchicine with subsequent stabilization of creatinine and proteinuria. In our patient, treatment with colchicine was initiated with subsequent evidence of stabilization of renal disease.

Conclusion: Our case highlights the need for consideration for the development of amyloidosis in patients with GCA/PMR presenting with renal insufficiency even if their rheumatological disease is quiescent. Although evidence is limited our results suggest a course of colchicine may be beneficial in ameliorating renal insufficiency.

130 Optimal Therapy for Osteoporosis in Respiratory Patients: A Systematic Review

Ganesh Subramanian (University of Alberta, Edmonton); Tripti Papneja (University of Alberta, Edmonton); Elaine Yacyshyn (University of Alberta, Edmonton)

Objective: Osteoporosis is a common problem in patients with chronic respiratory failure of various origins. The purpose of this review is to assemble the currently available high-quality treatment data for treatment of osteoporosis in patients with respiratory illnesses such as cystic fibrosis (CF), chronic obstructive pulmonary disease (COPD) on chronic steroid therapy, and post-lung transplant.

Methods: MEDLINE, EMBASE, and Cochrane trials registers were systematically searched to identify randomized controlled trials comparing drug therapy for osteoporosis in patients with CF, COPD on chronic steroid therapy, and post-lung transplant. In addition, reference lists were searched by hand. The articles were screened on title, abstract and full-text. Selected studies were scored using the Jadad score. The primary outcome was bone mineral density (BMD) changes. Data extraction was carried out by first reviewer and verified by a second reviewer.

Results: Four studies in patients with CF, eleven studies in patients on
chronic steroid therapy and three studies in patients with lung transplant were included. There are no clinical trials evaluating effects of treatment of osteoporosis in samples consisting of COPD patients exclusively. Efficacy of oral and intravenous bisphosphonates in increasing BMD has been demonstrated in patients with CF, chronic steroid therapy, and post-organ transplant. Risedronate was shown to decrease vertebral fracture risk in patients on chronic steroid therapy in one study. Teriparatide has been shown to improve BMD and decrease vertebral fracture incidence in patients with osteoporosis on chronic steroid therapy compared to alendronate.

**Conclusion:** Current evidence supports the use of oral and intravenous bisphosphonates in patients with CF, chronic steroid therapy and post-lung transplant. Teriparatide can be used for patients with osteoporosis on chronic steroid therapy who have failed bisphosphonates. These studies have not been powered to look at fractures as an end-point, so treatment recommendations are based on the effects on the surrogate end-points. Multicenter RCTs with long follow-up periods and larger sample sizes are needed in these patient populations to guide osteoporosis clinical care for them.

### 131 Community-based Rheumatologists Practice Audit during Electronic Medical Record Implementation

Manoji Pereira (Sherbrooke University, Mississauga); Matthew Got (Credit Valley Rheumatology, Mississauga); Andrew Chow (Credit Valley Rheumatology, Mississauga); Elaine Soucy (Credit Valley Rheumatology, Mississauga)

**Objective:** The purpose of this study is to illustrate that practice audit can be easily preformed during implementation of an electronic medical record.

**Methods:** Patient’s profile including demographics and current medications were inputted and updated during each patient’s visit. PS Suite by PS Solutions Software Inc. was used to create the EMRs, with the following fields entered manually: patient problem list, current medications, personal traits, risk factors, allergies, past health history problems, known allergies, and DMARD history. Patients with a diagnosis of RA were identified by either the presence of ICD-9 code 714.0 or the text “rheumatoid arthritis” contained in the patient’s problem list. The list of patients with RA was further refined to include only those over the age of eighteen. The data in these selected records was then examined and the practise profile was obtained.

As patients with inflammatory arthritis were reassessed every three to four months, a practise audit was performed four months after implementations of the EMR, most of the regular patients have been updated.

**Results:** From a total of 2987 EMRs, 896 was diagnosed with RA according to the search parameters specified above. 642 currently on Methotrexate, 344 (38.3%) on biologics agent, and the break downs are: 125 on Etanercept, 41 on Infliximab, 39 on Adalimumab, 14 on Abatacept, 10 on Tocilizumab, 8 on Golimumab, 6 on Rituximab, and 1 on Certolizumab.

**Conclusion:** In a community based rheumatology practice with two rheumatologists, once EMRs are implemented, many tasks that would have been very time consuming using traditional paper based charts can be accomplished quickly. This is an example of practise audit for biologics use in RA patients in the practice. If the database is set up properly, further analysis can be done on drug survival and identification of active patient that needs to have their medications adjusted.

### 132 Characteristics of Hospitalizations of Patients with Systemic Lupus Erythematosus: A retrospective study from London, Ontario

June Lee (University of Western Ontario, London); Janet Pope (St Joseph Health Care, London)

**Objective:** Hospitalization is an important cause of patient morbidity and health care burden in systemic lupus erythematosus (SLE). The aim of our study was to explore the causes of hospitalization and predictors of poor outcomes of patients with SLE admitted to hospitals in London, Ontario.

**Methods:** A retrospective chart review of all patients admitted to University Hospital, Victoria Hospital, and St. Joseph’s Hospital in London, Ontario with SLE between January 2006–June 2009. These patients were identified by a discharge diagnosis M32, which refers to SLE as per the ICD Version 10 (International Statistical Classification of Diseases and Related Health Problems).

**Results:** There were 160 hospitalizations for 102 individuals with SLE over the three and a half year period. The most common reasons for hospitalization were disease flare (20.0%), infection (15.6%), adverse drug reaction (8.1%) and labour and delivery (6.9%). Acute coronary syndrome accounted for 2.5% of hospitalizations, while venous thromboembolic event and ischemic stroke comprised 1.9% and 0.6%, respectively. The most frequent manifestations of disease flare were renal and hematologic flares. There were 22 hospitalizations (13.8%) resulting in an ICU admission and the mean length of hospital stay was 8.5 days. The in-hospital mortality rate was 5.6%. There was no significant difference in ICU requirement, length of hospitalization, or incidence of death between those who were hospitalized primarily for an SLE flare and those who were not. Patients who died in-hospital were older than those who did not (p=0.03).

There was no association of in-hospital mortality with disease duration, Charlson co-morbidity score, presence of anti-dsDNA or antiphospholipid antibody, or specific SLE medications.

**Conclusion:** Disease flare remains a major cause of hospitalization of SLE patients, specifically renal and hematologic flare. The morbidity of patients hospitalized secondary to SLE flare was not significantly different than those hospitalized for other reasons. Major predictor for in-hospital mortality in our cohort includes age.
Conclusion: Considering the diversity of administrative databases world-wide, the number of published validation studies is small. The quality of the studies and completeness of the reporting of study details varied considerably. Studies to evaluate the validity of administrative database ascertainment of RD in Canada are needed.

134 Which Coping Strategies do Women Living with Systemic Lupus Erythematosus Utilize?
Ellie Aghdassi (The University Health Network, Toronto); Paul R. Fortin (Toronto Western Hospital, Toronto); Stacey Morrison (The University Health Network, Toronto); Jiandong Su (Toronto Western Hospital, Toronto); Carolyn Neville (McGill University Health Center, Montreal); Sara Hewitt (St Joseph’s Health Care, London, London); Janette Pope (University of Western Ontario, London); Deborah Da Costa (McGill University Health Center, Montreal)

Objective: The Coping with Health, Injuries, and Problems (CHIP) Scale is a multidimensional self-report measure designed to assess four basic coping styles characteristically utilized by persons living with health problems. The coping dimensions measured include: distraction (a form of avoidance with actions and cognitions aimed at avoiding preoccupation with the health problem), palliative (self-help strategies to reduce the unpleasantness of the situation - making oneself comfortable, getting rest etc.), instrumental (active task-oriented strategies, such as seeking help and trying to learn more about the illness), and emotional preoccupation (focusing on the emotional impact of the health problem). The objective of this study was to assess the coping strategies used by women living with Systemic Lupus Erythematosus (SLE).

Methods: Demographics and SLE-Disease Activity Index (SLEDAI) were obtained from SLE females with no history of osteoporosis and cardiovascular disease enrolled in the Health Improvement and Prevention Program (HIPP) study. Coping strategies were assessed using the CHIP scale consisting of 32-items (8 items per subscale; range 8–40 for each subscale). Distraction, palliative and instrumental coping are considered “task-oriented” and emotional preoccupation is considered an emotional strategy. Participants used a 5-point Likert scale (1=not at all to 5=very much) to indicate how much they engaged in a specific activity when encountering their particular health problem.

Results: The sample was composed of 269 female, 54.3% were Caucasians, 53.9% were married and 90.2% graduated from high school among which 60% had some post-secondary education. The average (SD) age of the sample was 44.4 (13.1) years and the SLE duration was 11.5 (10.2) years. Patients had low SLEDAI score of 4.4 (4.5) at enrollment. The mean (SD) for each coping strategy were as follows: Distraction: 25.0(6.4); Palliative coping 23.0(4.8); Instrumental coping 29.1(5.7) and Emotional preoccupation: 19.7 (7.5). Emotional preoccupation and the use of distraction focused coping strategies were higher than the reported means for the general population (distraction: 19.2±6.1; emotional preoccupation: 16.3±6.2). There were weak correlations between emotional preoccupation coping and: age (r=–0.140; p=0.02), SLE duration (r=–0.173; P<0.004) and SLEDAI (r=0.193, p=0.003).

Conclusion: Women with SLE in this study used various forms of coping strategies despite a relatively low disease activity and a number of co-morbid conditions. This instrument would be useful for Rheumatologists and allied health professional (i.e. nurses, psychologists) involved in lupus care to better understand the specific ways by which patients cope with their disease.

135 Multiple Pulmonary Nodules Suspicious for Pulmonary Metastases: a Diagnosis Unmasked by Diffuse Alveolar Hemorrhage
Jodie Jeffery (University of Saskatchewan, Saskatoon); Chris Hergott (University of Saskatchewan, Saskatoon); John Gjevre (University of Saskatchewan, Saskatoon)

Case Report:
While Wegener’s granulomatosis is a rare cause of thoracic pathology, it is important to be aware of the various clinical and radiographic manifestations. We describe a case of Wegener’s granulomatosis initially manifesting as multiple pulmonary nodules presumed to be metastases. A 58-year-old female was seen in the outpatient respiratory clinic at the University of Saskatchewan for the workup of multiple pulmonary nodules recently found on a chest CT performed to evaluate dyspnea. Prior to visiting the clinic she was notified of the CT findings and their potential for pulmonary metastases. A chest x-ray (CXR) and pulmonary function tests (PFTs) were completed the morning of her appointment and available to the physician at the time of initial consultation. A striking result found among normal pulmonary flows and volumes was a DLCO (diffusing capacity of the lung for carbon monoxide) of 136%, suspicious for alveolar blood. The CXR revealed a large area of airspace consolidation within the right mid lung field; a striking change from a CXR done a month prior. Consultation revealed a four-day history of moderate hemoptysis, fatigue, generalized joint discomfort and a ten-pound weight loss with a low-grade fever over the preceding month. Blood work showed a twelve-point reduction in hemoglobin and urinalysis was positive for blood with few dysmorphic red cells and moderate protein. The patient was admitted to the pulmonary service for the work-up of a pulmonary-renal syndrome. Bronchoscopy with bronchoalveolar lavage was consistent with diffuse alveolar hemorrhage (DAH) and was negative for organisms and malignant cells. Investigations revealed a positive p-ANCA with a high titre MPO-ANCA. Toxicity and medication-induced etiology was ruled out and she was started on methyl-prednisolone. Limited findings on renal biopsy and a consistently normal creatinine ruled out significant renal involvement. The patient was diagnosed with Wegener’s granulomatosis and treated with daily, oral cyclophosphamide and prednisone. Her DAH drastically improved over a week and her hemoglobin stabilized and gradually improved. Six months following the diagnosis, the patient is clinically in remission on oral cyclophosphamide and prednisone. Physicians are taught to consider uncommon manifestations of common diseases over common manifestations of uncommon diseases. Wegener’s granulomatosis presents a diagnostic challenge to the physician due to its rarity and diverse clinical manifestations. Pulmonary nodules are common CT findings, thus physicians should have a broad differential while interpreting clinical data.

136 Case Based Learning in Pediatric Rheumatology - An Effective Method for Teaching the Medical Expert Role
Roman Jurencak (Children’s Hospital of Eastern Ontario, Ottawa); Johannes Roth (Children’s Hospital of Eastern Ontario, Ottawa)

Objective: To design, implement and evaluate a Case-based Learning (CBL) module focused on rheumatic disorders.

Methods: Course structure: 4 weekly sessions, each of 30 minutes duration, were implemented into each 4-week rheumatology rotation of pediatric residents. Course participants: pediatric residents. Case database: A case-scenario database was established from which cases were chosen to reflect the spectrum of clinical problems encountered by the resident in the past seven days. All cases are open-ended and allow for discussion, modification and adjustment of the clinical scenario as necessary. Each case was emailed to the residents several days in advance to allow for adequate preparation. Evaluation: Each resident completed an anonymous detailed evaluation questionnaire of the teaching module at the end of their rotation. The questionnaire consisted of 5-point Likert scale questions (1=strongly disagree, 5=strongly agree) as well as open ended questions.

Results: 24 CBL sessions were evaluated by 6 residents (each attended 4 sessions). The course was highly valued among the residents and consistently rated as very beneficial for thought organization, application of knowledge and learning organization (mean Likert scale score=5). The residents felt the course improved their clinical reasoning skills as well as problem solving skills (mean Likert scale score 5 for each domain). The trainees appreciated the extra time and space specifically dedicated to this teaching unit as well as the opportunity to study each case in advance.

Conclusion: Our study illustrates the usefulness of CBL in teaching of
pediatric rheumatology. In our experience, CBL greatly contributes to resi-
dent’s understanding of complex rheumatic disorders in pediatric popula-
tion such as systemic lupus erythematosus, inflammatory myopathies and
vasculitides which ultimately leads to improvement of residents’ analytic
skills in a clinical setting and their role as Medical Expert.

137 Moving From Patient-Centred To Family-Centred Care? A Systematic Review Of Psycho-Educational Programs For People And Partners Affected By Arthritis

Allen Lehman (Arthritis Research Centre of Canada, Vancouver); Sennait Yohannes (Arthritis Research Centre, Vancouver); Cynthia MacDonald (Arthritis Research Centre, Vancouver)

Objective: Coping with arthritis takes place in a social context among family and friends. A small but increasing number of interventions involve both people living with arthritis and family/friends to promote coping and overall health. Our objective was to review the effectiveness of psycho-
educational interventions targeted at people living with arthritis and a fam-
ily member in order to improve health outcomes and/or arthritis management.

Methods: We conducted a systematic review of controlled studies evaluat-
ing the effectiveness of psycho-educational interventions targeted at both people living with arthritis and a partner (i.e., spouse, other family member, friend) aimed at improving health outcomes and/or arthritis management. We conducted an extensive electronic literature search using Medline, PsycInfo, EMBASE, and CINAHL for English language publications from time of database inception through September 2010. Two independent reviewers screened the titles and abstracts and did secondary in-depth reviews of the included articles. Eligible articles were categorized by 1) type of intervention, 2) inclusion of partner-specific skills-training, and, 3) effectiveness at improving health outcomes.

Results: The search yielded 10 articles that met the inclusion criteria (including one that was a long-term follow-up of an included study). The intervention studies focused on OA of the knee/lower extremity (n=6), rheumatoid arthritis (n=3), and systemic lupus erythematosus (n=1). Interventions used a variety of techniques including cognitive behavioural therapy; disease self-management or skills training in social support, commu-

nication, problem solving, and/or pain coping; and educational informa-
tion. The duration of interventions varied from one session with monthly
telephone counselling for 6 months (n=1) to weekly meetings for six to 12
weeks (n=9). Overall, there is mixed evidence for the short- and long-term
effectiveness for interventions incorporating psycho-educational tech-
niques on variables such as self-efficacy, arthritis self-management, psy-
chological well-being, social support, couples’ communication, and physi-
cal function. All six interventions with positive health outcomes for the
person with arthritis included skills-training specifically targeted to a partner,
together with the other two of the four interventions with no positive effects did not offer skills-training to partners. A number of limitations were identified, such as small sample sizes, limited long-term follow-up, and self-selection bias (e.g., satisfied couples in long-term relationships).

Conclusion: This systematic review has highlighted the potential role for
family or partner-based psycho-educational interventions to promote health
outcomes and/or the management of arthritis. More research is required to
determine if specific couples might benefit more from inclusion in psycho-
educational programs and if, and under what conditions, long-term
positive effects are maintained

138 Identifying Patients who are Arthroplasty Candidates within a Medically based Osteoarthritis Education and Treatment Program

Lorna Bain (Southlake Regional Health Centre, Newmarket); Lisa Denning (Southlake Regional Health Centre, Newmarket); Sandra Mierdel (Southlake Regional Health Centre, Newmarket); Carter Thorne (Southlake Regional Health Care, The Arthritis Program, Newmarket)

Objective: To identify patients who are enrolled in an osteoarthritis edu-
cation and treatment program for medical management who currently meet
criteria and are good candidates for arthroplasty surgery

Methods: To determine the current tools through literature review and
expert consultation to assist with paper triage process To develop a pilot
paper and clinical algorithm for triage and identification To support addi-
tional options for those patients who are triaged as arthroplasty candidates
but don’t meet surgical criteria To evaluate the pilot project (clinical out-
comes, metrics and patient education) in order to determine next steps for
future recommendations

Results: Environmental scan showed that currently there was no clear cut
paper algorithm readily available in the arthritis literature to identify
patients who were candidates for an arthroplasty procedure. New tools
were in the works but not ready for threshold to be identified. A TAP paper
algorithm was developed for testing that included the WOMAC, PASS©, HOOS/HOOS-PS ©, KOOS/KOOS-PS ©, VAS, ICOAP©. An individual
TAP physical assessment process was developed to triage patients to deter-
mine if criteria were met for a surgical consult. Pilot process was successful
in identifying patients enrolled in a medical education and treatment
program who were arthroplasty candidates. Those triaged, who did not
meet inclusion criteria for surgery had other musculo skeletal issues that
were brought to the forefront due to the triage process

Conclusion: Patients referred to OA program are for the most part appro-
priate for these classes. A proportion of patients improved by the end of the
classes, others on their way to improvement. Some patients had barriers to
improvement in OA program because of other musculo skeletal issues that
needed to be addressed on an individual basis. Many patients had appoint-
ments for consultation with orthopods and were being followed even though
they did not have dates for arthroplasty. Further piloting is needed on
a larger scale to confirm and consolidate the algorithm developed.

139 Effect of Odanacatib on Bone Density and Bone Turnover Markers in Postmenopausal Women with Low Bone Mineral Density: Year 4 Results

Albert Leung (Merck & Co., Inc., Rahway); Romana Petrovic (Merck & Co., Inc., Rahway); Carolyn DiSilva (Merck & Co., Inc., Rahway); Elizabeth Rosenberg (Merck & Co., Inc., Rahway); Arthur Santora (Merck & Co., Inc., Rahway); Antonio Lombardi (Merck & Co., Inc., Rahway)

Objective: The selective cathepsin K inhibitor odanacatib (ODN) reduced
bone resorption markers and progressively increased bone mineral density
(BMD) during 3 years of treatment in a Phase 2b study. This study was
extended for 2 additional years to further assess ODN efficacy and
long-term safety.

Methods: In the 2-year base study, postmenopausal women with BMD T-scores between −2.0 and −3.5 at the lumbar spine, femoral neck, trochanter or total hip received placebo or ODN at 3, 10, 25 or 50 mg week-
ly. In Year 3, participants were re-randomized to ODN 50 mg weekly or
placebo. In Years 4/5, women who received placebo or ODN in Years
1/2 and placebo in Year 3 were switched to 50 mg ODN for Years 4/5; all
others continued with their Year 3 regimen. 141 women entered the exten-
sion, and 133 completed 4 years. Endpoints were BMD at the lumbar spine
(primary), total hip and hip subregions, and 1/3 radius; levels of biochemi-
cal bone turnover markers; and assessments of safety.

Results: Overall, 100 women received 50 mg ODN during Year 4 and 41
received placebo. Continuous treatment with 50 mg ODN for 4 years
induced significant BMD increases from baseline at the spine (10.7%),
total hip (8.3%), femoral neck (8.9%), and trochanter (10.3%) and mainta-
ined BMD (~0.1%) at the 1/3 radius; BMD changes from Year 3 were
2.8% (spine), 2.5% (total hip), 3.9% (femoral neck), and 2.9% (trochanter).
Serum CTx remained low at Year 4 (~41%), whereas BSAP was relatively
unchanged (~2%) from baseline. Women who received active treatment for
2 years and switched to placebo for 2 years experienced bone loss, with
BMD near baseline for most sites and decreased by 4.5% at the 1/3 radius
at the end of Year 4. Levels of bone turnover markers in women who dis-
continued active treatment after 2 years rose in the first month off-treat-
ment, but all levels returned to baseline by the end of Year 4. ODN was generally well tolerated.

**Conclusion:** 4 years of ODN treatment increased lumbar spine and hip BMD and was generally well-tolerated in postmenopausal women with low bone mass. Bone formation markers remained relatively unaffected. Discontinuation of ODN after 2 years of treatment was promptly followed by resolution of effects on bone turnover and density such that BMD and bone biomarker levels at Year 4 were at or near baseline.

### 140 Rheumatology Learning Needs Among Physicians in Kenya

Ines Colmegna (McGill University, Montreal); Susan Bartlett (McGill, Montreal); Omondi Oyoo (University of Nairobi, Nairobi)

**Objective:** The goal of this project was to identify the rheumatological learning needs of primary care physicians and internists in East Africa. Data will be used to inform the development of educational programs to enhance skills to recognize, diagnose and treat patients with musculoskeletal conditions in this region.

**Methods:** A survey was conducted among physicians attending the Kenya Association of Physicians 2010 Annual Scientific Conference. Areas queried included age, gender, specialty, number of years of practice, weekly patient load, former rheumatology education and duration, most common rheumatic conditions encountered, confidence performing a MSK exam and arthrocentesis, relevance of improving MSK skills and ways to do so.

**Results:** Participants included 36 (52%) community practicing physicians (CPP) and 33 (48%) residents from 6 cities in Kenya. Most (97%) were GPs or internists. CPPs were mostly male (71%) with a mean age of 45.1 ± 9.2 years; 52% of residents were male, with a mean age of 30.9 ± 2.5 years. CPP and residents reported seeing a median of 80 patients per week. Among CPP, 64% reported that one every ten patients they see has a MSK complaint, compared with 24% of residents (p=0.07). Back pain was ranked as the most common condition encountered (64%), followed by OA (47%), RA (19%), gout (11%) and septic arthritis (8%). Almost all physicians (97%) reported receiving some training in rheumatology; however, most (67%) received a total of < 2 weeks of instruction. Almost all (91%) reported greater confidence conducting a cardiovascular vs. MSK exam. 34% of CPP vs. 6% of residents reported injecting joints at least 1/month; 11% of CPP and 30% of residents reported not doing injections (p = .001). Only 20% of CPP (but 0% of residents) “always felt confident” injecting joints (p=0.01), though notably only in knees. Nearly all (88%) agreed it is “very relevant” to improve their skills in the evaluation and treatment of rheumatic conditions. To improve skills, 82% indicated a preference for face-to-face courses, followed by online tutorials (9%) and printed materials (6%).

**Conclusion:** Access to rheumatologists is severely limited in Eastern Africa. While internists see many patients with MSK complaints, their training in rheumatological evaluation, diagnosis and treatment remains minimal. Training CPP specific skills to identify and treat patients with musculoskeletal disorders can help improve health and reduce disparities in East African Countries.

### 141 Does Age Influence Choice of Pharmacotherapy for Rheumatoid Arthritis?

Paul Davis (University of Alberta, Edmonton); Angela Juby (University of Alberta, Edmonton)

**Objective:** Seniors (>65 age) constitute 26% of patients seen in our practice with rheumatoid arthritis being the most prevalent diagnosis. Ageism in medicine is of increasing interest with evidence to suggest that aging may be not only a barrier to access of care but also to choice of therapeutic options. Recent studies have suggested that this may also be the case in rheumatology. The objective of this study was to review therapeutic choices in the management of rheumatoid arthritis and compare them in a cohort of seniors with a younger group.

**Methods:** An audit of the charts of 295 patients referred to a specialty rheumatology clinic were reviewed. 78 (26%) were seniors, mean age 73 (range 65–90), M:F ratio 1.25:1. 37 were diagnosed with RA. Of the 217 younger patients 69 had RA. Current therapy for RA was extracted from the charts. Previous therapies were not recorded. The usage of anti-rheumatic drugs between the 2 groups was compared.

**Results:** Drug utilisation was documented under the following categories — NSAIDs/COXIBs, hydroxychloroquine, methotrexate, other DMARDs, leflunamide, prednisone, and biologics. Most patients were receiving >1 drug in a variety of combinations. All but 2 patients were receiving a DMARD. The usage of NSAIDs were similar in both groups (31% v 37%). Hydroxychloroquine therapy was greater in the < 65 group (22% v 37%). The use of all DMARDs was somewhat higher in the < 65 group (61% v 82%) with methotrexate being the most widely prescribed in both groups. Leflunamide usage was similar in both groups. Prednisone usage (< 15mg po daily) was slightly higher in the seniors group (19% v 11%). The only major difference between the 2 groups was the use of biologic agents which was twice as high in the younger cohort than the seniors (11% v 23%). An incidental, disturbing observation was that only 40% of patients on predosine were receiving anti resorptive therapy for osteoporosis.

**Conclusion:** This study demonstrates that in this small cohort of patients the pharmacotherapy for RA was not significantly different based on age. This limited experience suggests that seniors with RA can be just as effectively treated with the full spectrum of anti-rheumatic drugs as younger patients. We encountered no obvious issues relating to added toxicity in our senior patients. Minor differences in some drug utilisation might be explicable on the basis of disease presentation in the different groups (eg palindromic onset in the younger group v polymyalic onset in the elder group).

### 142 Outcomes of SLE Patients Cared for by Rheumatology or Nephrology

Serena Cheung (University of Alberta, Edmonton); Erik Beuker (University of Alberta, Edmonton); Steven Katz (University of Alberta, Edmonton); Neehs Panna (University of Alberta, Edmonton); Dwight Harley (University of Alberta, Edmonton); Elaine Yacyshyn (University of Alberta, Edmonton)

**Objective:** To assess the outcome and management of lupus nephritis (LN) patients under the care of both rheumatologists and nephrologists (R+N), rheumatologists only (R), and nephrologists only (N).

**Methods:** LN patients (n=66), who met the ACR criteria or had a positive kidney biopsy for systemic lupus erythematosus (SLE), were studied. Clinical and laboratory data, as well as past and current medications and/or other treatments were assessed. Disease damage and disease activity were scored using the Systemic Lupus International Collaborating Clinics Damage Index (SLICC)/American College of Rheumatology (ACR) Damage Index (SDI) and SLE Disease Activity Index (SLEDAI), respectively. Focus was placed on the comparison between the R+N and the N group, as the assumption was made that these patients had similar renal manifestations.

**Results:** Of the 66 patients studied, 48 were R+N patients, 8 were R patients, and 10 were N patients. The mean SDI score of the R+N, R, and N groups were 1.96(±1.81), 2.25(±3.14), and 1.89(±2.93), respectively. The mean SLEDAI of all 3 groups in the same order were 4.55(±4.06), 2.75(±1.58), and 5.44(±5.08). The differences in the SDI and SLEDAI between all 3 groups were not found to be significant. Forty-two out of forty-eight R+N patients (87.5%) compared to 50% of N patients were on hydroxychloroquine (HCQ). Using the Fisher’s Exact test, the differences in these two groups is significant (p value = 0.0153). All patients seen only by rheumatologists were on HCQ. Thirty-seven out of forty-eight R+N patients (77.1%) compared to 90% of N patients were on ACE inhibitors and/or angiotensin receptor blockers (ARB) (p value = 0.6700). The difference was not significant according to the Fisher’s-Exact test.

**Conclusion:** There is no difference in disease damage and disease activity among patients seen by both rheumatologists and nephrologists versus those seen by only one or the other subspecialist. However, the use of HCQ...
143 Evaluation of Patient Satisfaction at the Sunnybrook Health Sciences Centre Rheumatology Outpatient Clinic
Jenny Shu (University of Western Ontario, Toronto); Paula Veinot (Sunnybrook Health Sciences Centre, Toronto); Ruben Tavares (McMaster University, Hamilton); Jennifer Boyle (The Arthritis Society, Toronto); Mary Bell (Sunnybrook Health Sciences Centre, Toronto)
Objective: The purpose of this study was to evaluate and quantify overall patient satisfaction at the Sunnybrook Health Sciences Centre (SHSC) rheumatology outpatient clinic using the Leeds Satisfaction Questionnaire (LSQ), a validated and reliable tool designed specifically for a study of the follow-up of rheumatology patients. Differences in satisfaction scores between various aspects of care and amongst the four rheumatologists participating in this study were also assessed.
Methods: 329 LSQ questionnaires were collected July 2007 to June 2008. All patients attending a follow-up rheumatology appointment who were capable, over 18 years, and able to comprehend English were given the voluntary option of completing a LSQ anonymously. A total of 321 questionnaires were included in the study. Data was exported from a Microsoft Access 7 database to SAS for statistical analysis. Descriptive statistics (i.e. mean, median, standard deviation) were used to analyze the scores of the patient satisfaction questionnaires while the Kruskal-Wallis and one-way ANOVA tests were used to compare scores between rheumatologists.
Results: The satisfaction of patients at the SHSC with the care they received was generally positive and comparable with previous studies using the LSQ. The mean score across all providers was 4.08 on a Likert scale of 1 to 5 (SD = 0.49). There were statistically significant differences between the overall satisfaction of the 4 rheumatologists participating in this study (p < 0.05). Patients identified technical quality and competence as the area they were most satisfied with (4.44, SD = 0.47), whereas access to service and continuity of care received the lowest satisfaction score (3.77, SD = 0.68).
Conclusion: Patient satisfaction has been previously found to influence whether one seeks medical advice, treatment compliance, and the longitudinal relationship with a practitioner. Hence, in order to improve future delivery of care to patients with rheumatic disease, patient satisfaction with current care should be assessed to identify specific aspects of care that could potentially serve as target areas for reflection and improvement. This study is a pioneer example of evaluating patient satisfaction in a Canadian rheumatology outpatient setting and presents other rheumatologists with a potential tool to assess patient satisfaction in their practices. Furthermore, patient satisfaction with access to and continuity of care were found to be weaknesses in this study, which may suggest a future area of quality improvement.

144 Clinical Significance Of Renal Vascular Lesions (RVL) On Renal Biopsy In Lupus Nephritis.
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Objective: To determine the clinical significance of Renal Vascular Lesions (RVL) detected in renal biopsies of patients with systemic lupus erythematosus (SLE).
Methods: Renal biopsies were scored according to the ISN/RPS revised 2004 criteria for Lupus Nephritis (LN). RVL were defined as: 1) thrombotic microangiopathy (TMA), 2) arterial fibrinoid necrosis (AFN), 3) lupus vasculopathy (LV), and 4) arterial sclerosis (AS). Demographic, renal, vascular outcomes, overall mortality, disease activity measured by SLE-disease activity index-2000 (SLEDAI-2K) and organ damage assessed by SLICC damage index (SDI) were evaluated.
Results: 207 biopsies from 164 patients were examined. TMA was seen in 13 patients (7.9%), 15 had LV (9.1%), 3 patients had TMA and LV, 93 (56.7%) had only AS, 0 patients had AFN and 40 patients with LN and no RVL (24.4%) were used as controls. Baseline demographics including age at SLE diagnosis, gender and ethnicity were similar between groups. At time of renal biopsy the mean arterial pressure and the percentage of patients with an SDI score ≥ 1 was higher in the TMA (MAP 110.6 ± 20.7mHg, P < 0.001; SDI: 55.6%, P = 0.018), LV (MAP 108.3 ± 14.3mHg, P < 0.001; SDI: 43.8%, P = 0.033), and AS patients (MAP 101.9 ± 13.9mHg, P < 0.001; SDI: 45.4%, P=0.001) compared to controls (MAP 91.6 ± 10.9mHg, SDI: 14.3%). Only patients with LV had higher SLEDAI at the time of biopsy compared to controls (16.9±8.5 vs 10.5±6.2, P=0.003). Grade of LN, activity indices and proteinuria were similar between groups; however, chronicity indices on biopsy were significantly higher in all RVL subgroups compared to controls. GFR by MDRD was lower in LV (60.7 ± 33.0 mL/min/1.73m2, P< 0.001), and AS patients (70.5 ± 33.3 mL/min/1.73m2, P=0.03) compared to controls (84.5 ± 26.6 mL/min/1.73m2). A subset of 133 patients with similar duration of follow-up was then evaluated for associations between RVL and outcomes such as thrombotic events (TE), end-stage renal disease (ESRD), chronic kidney disease (CKD) and death. On univariate analysis, presence of RVL was significantly associated with TE (P=0.009). However, RVL was not independently predictive of the outcomes of interest on multivariate analysis.
Conclusion: RVL are common in SLE patients with LN and may be associated with thrombotic events but the presence of RVL on initial renal biopsy was not independently associated with increased TE, ESRD or mortality.

145 Bone Health in Patients with Interstitial Lung Disease
Ganesh Subramanian (University of Alberta, Edmonton); Tripti Papneja (University of Alberta, Edmonton); Elaine Yacyshyn (University of Alberta, Edmonton)
Objective: Osteoporosis is a common condition in patients with end-stage lung disease, but little attention has been given to bone disease in patients with interstitial lung disease (ILD). The purpose of this study is to perform a systematic review of the literature to determine: (1) the prevalence of low bone mineral density(BMD) in patients with ILD, (2) identify correlates of osteoporosis/osteopenia in this special group of patients, (3) effects of treatment of low BMD in patients with ILD.
Methods: We reviewed the literature for all English language publications from 1950-September 2010 in PubMed, EMBASE, MEDLINE, and Cochrane database of systematic reviews. The articles were screened on title, abstract and full-text. In addition, reference lists were searched by hand. Trials evaluating prevalence, predictors and treatment of osteopenia/osteoporosis in patients with ILD were included. Data extraction was carried out by first reviewer and verified by a second reviewer.
Results: The prevalence of low bone mineral density varied 62–70% with 5–43% ILD patients having osteoporosis. Only one study compared the observed prevalence of osteoporosis and osteopenia in ILD patients to the expected prevalence in a normal population matched for age, gender, and race. ILD patients had similar observed rates of low BMD as the matched healthy controls, with the exception of a higher proportion of ILD men with lower BMD at the lumbar spine. Correlate of osteoporosis in ILD is mainly body mass index, although causality has not been proven. Effects of treatment of osteoporosis have not been investigated in ILD patients specifically.
Conclusion: There is lack of high-quality data evaluating the prevalence and predictors of osteoporosis in ILD patients exclusively. In addition, prospective comparative studies assessing the effects of treatment of osteoporosis in ILD patients only are warranted.

146 Panniculitis/Fasciitis due to a Drug-Induced Neutrophilic Dermatosis: A case report
Nathaniel Dostrovsky (McMaster University, Hamilton); Srinivasan Harish (McMaster, Hamilton); Madeleine Verhoosik (McMaster, Hamilton); Samih Salama (McMaster, Hamilton); Nader Khalidi (Mc Master University, Hamilton)

Case Report: Objectives: 1. To describe a case of a neutrophilic dermatosis presenting with panniculitis/fasciitis of the feet. 2. To review the musculoskeletal manifestations of neutrophilic dermatoses. A 56 year old man presented for evaluation with a one year history of progressive pain and swelling in his feet. The pain and swelling began after he started granulocyte-colony stimulating factor (G-CSF) for idiopathic neutropenia. Other symptoms included fatigue, hoarseness of voice and recurrent bullous skin lesions. On examination, there was diffuse swelling and tenderness over the plantar aspects of both feet. Laboratory investigations were significant for elevated ESR (96mm/hr) and CRP (49.7mg/L). C3 and C4, ANA, p and c ANCA, RF and anti-CCP were all negative. Ultrasound and MRI of his feet showed swelling and hyperemia consistent with panniculitis as well as some fasciitis, but there was no evidence of synovitis, myositis or abscesses. Ultrasound-guided percutaneous biopsy of the inflamed plantar fat was performed. This demonstrated heavy inflammatory infiltration of the tissue including with neutrophils in keeping with a panniculitis/fasciitis. The patient was started on 30mg/day of prednisone and the pain and swelling in his feet dramatically improved. His hoarseness of voice, fatigue and skin lesions also resolved. Additionally, his neutropenia improved and he no longer requires G-CSF. Musculoskeletal involvement, notably arthritis and arthralgia, is a relatively common manifestation of neutrophilic dermatoses such as Sweet’s syndrome. However, this case is unusual in that the primary presenting feature was panniculitis and fasciitis. This case exemplifies the contributions of clinical, radiological and histological assessments in making the appropriate diagnosis and guiding further management.

147 Focus Group to Review a Pilot Education Program for Inflammatory Myositis
Anita Dey (University of Alberta, Edmonton); Lois Flakstad (University of Alberta, Edmonton); Kathy Cotton (University of Alberta, Edmonton); Stephanie Keeling (University of Alberta, Edmonton)

Objective: The main objective of this study was to review a pilot education program for patients with inflammatory myositis through the use of a patient focus group. The hypothesis was that an education program for inflammatory myositis would improve patient understanding of their condition, efficacy and quality of life.

Methods: Edmonton area rheumatologists were invited to refer their inflammatory myositis patients to participate in a pilot education program and a follow-up focus group. Inclusion criteria included a rheumatologist’s diagnosis of either “polymyositis” or “dermatomyositis” and age over 17 years. The main exclusion criteria included inability to speak English and severe disease that would limit participation. Of the nine patients referred to the program, six attended the education program and five agreed to participate in the focus group. The focus group was conducted over 2 hours and was recorded by video camera. A list of pre-specified questions to review the education program was created after conducting a literature search to identify optimal focus group methodology. The rheumatologist (SOK), physiotherapist (LF), and occupational therapist (KC) did not attend the focus group session that was arranged and conducted by the medical student (AD) in order to avoid influencing the responses.

Results: Three main areas of interest emerged from this focus group. (1) Patients felt that disease information provided by this program would serve them better if delivered closer to the time of diagnosis. (2) The patients felt that instruction on how to exercise more effectively was extremely valuable. (3) Continued contact between patients in a support group format after the program was finished ranked highly. Areas for program improvement included: i) increased use of electronic resources such as a website; ii) the inclusion of information on nutrition; and iii) the individualization of exercise programs. Further discussion of the impact of disease on “return to work” was also requested by participants.

Conclusion: The focus group reviewing a pilot education program for inflammatory myositis revealed that such programs are extremely important in improving patient quality of life. This work suggests that education enhances disease management strategies over standard-of-care and may have long-term impact on patient outcomes. Patients were assessed one month prior to the program for objective measures of disease activity and quality of life measures and follow-up data will be available upon reassessment of these patients in November 2010.

148 Quality of Life Before and After Joint Replacement Surgery
Jacek Kopec (University of British Columbia, Vancouver); M Mushfiqur Rahman (Arthritis Research Centre of Canada, Vancouver)

Objective: The purpose of this study was to describe the level of health-related quality of life (HRQL) among persons with osteoarthritis prior to and following joint replacement surgery (JRS).

Methods: We used administrative data from the British Columbia Linked Health Database (BCLHD) 1986–2007 linked by a unique identifier to the BC component of the Canadian Community Health Survey (CCHS, 2001, 2003, and 2005). The BCLHD includes diagnostic codes for all visits to doctors and hospital admissions and procedure codes for patients undergoing surgery. Health-related quality of life was measured in all cycles of the CCHS using the Health Utilities Index 3 (HUI3). We compared the median and mean HUI3 levels for persons grouped according to the time between the date of the CCHS interview and the date of JRS.

Results: There were 25,658 individuals in the linked dataset. Of those, 223 patients with OA had a date of JRS after the date of the CCHS interview. The median HUI3 was 0.78 (mean=0.71, SD=0.27, min=0.12, max=1.0). When patients were grouped according to time from HUI3 assessment to JRS, the median (mean) HUI3 were as follows: time >4 years (N=49), median HUI3=0.89 (mean=0.92); time 3–4 years (N=35), 0.86 (0.79); time 2–3 years (N=21), 0.91 (0.71); time 1–2 years (N=48), 0.67 (0.67); time <1 year (N=70), 0.66 (0.62). We have identified 340 cases assessed in the CCHS after their JRS. When they were grouped according to time between their JRS and CCHS interview, the median (mean) HUI3 were as follows: time <1 year (N=50) median HUI3=0.73 (mean=0.67); time 1–2 years (N=32), 0.74 (0.71); time 2–3 years (N=42), 0.74 (0.66); time 3–4 years (N=23); 0.84 (0.68); time 4–5 years (N=42), 0.71 (0.59); time 5–7 years (N=41), 0.71 (0.64); time 7–10 years (N=54), 0.73 (0.68); time 10–15 years (N=42), 0.80 (0.69); time >15 years (N=22), 0.47 (0.53). Adjusting for age and gender did not change the results significantly.

Conclusion: Linking administrative and survey data provides an alternative method for assessing the long-term trajectory of HRQL before and after JRS. These data suggest a strong decline in average quality of life starting about 2–3 years before surgery. HUI3 after JRS is higher than <2 years prior to surgery and stable for up to 15 years, but does not achieve levels comparable to those 4–5 years before surgery. Individual variation in HUI3 in these patients is very large.

149 Results of a Needs Assessment for Canadian Systemic Lupus Erythematous Guidelines: A New CANIOS Initiative
Stephanie Keeling (University of Alberta, Edmonton)

Objective: The Canadian Network for Improved Outcomes in Systemic Lupus Erythematous (CANIOS) is planning on developing Canadian Guidelines for the diagnosis and/or management of systemic lupus erythematosus (SLE). These guidelines would (1) have a Canadian-based focus

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on SLE treatment to help governing bodies approve future agents and (2)
provide Canadian Rheumatologists with the best-evidence in the manage-
ment of these complicated patients to improve standard-of-care. The main
objective of this study was to conduct a needs assessment of Canadian
rheumatologists to identify the utility of such guidelines in the diagnosis
and/or management of SLE.

Methods: A systematic review of the literature was conducted in order
to identify existing guidelines and review their content. A draft survey mon-
key questionnaire was devised to determine the level of interest and need
of the Canadian rheumatology community for such guidelines. The draft
questionnaire was reviewed by 2 CaNiOS subcommittees and co-chair of the
CRA Therapeutics Subcommittee. The final 10-question survey was sent
by email to the CRA membership and responses collected over a 2.5
week period at the end of September/early October 2010.

Results: Of the 133 CRA members who responded to the questionnaire,
88.6% (n=117) were adult and 11.4% (n=15) were pediatric rheumatolo-
gists, while 66.4% (n=87) had academic/university practices compared to
33.6% (n=44) with community practices. The majority of respondents saw
a total of “1–3 SLE patients” per week (38.6% (n=51)) and “1–3 new SLE
patients” per month (40.9% (n=54)). The most common SLE manifesta-
tions seen in clinic included arthritis (54.7% (n=70)) and cutaneous (38.5%
(n=50)) followed by nephritis (31.6% (n=36)). 84 respondents (63.2%) felt
that the guidelines would be helpful to their practice, with the “manage-
ment of lupus nephritis” ranked highest followed by the “management
of pregnancy in SLE” and “existing therapeutics in SLE”.

Conclusion: In Canada, SLE patients constitute a significant percentage of
adult and pediatric rheumatology practice. A need does exist for the develop-
ment of SLE guidelines, with specific interest in lupus nephritis and
pregnancy. Distinction between adult and pediatric SLE populations will be
important. Future directions include focusing the goals of SLE guidelines and
evaluating their impact on patient care, implementation of the algorithm should be accom-
panied by appropriate educational information for ordering physicians.

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Long-Term Safety of Rituximab (RTX): Rheumatoid Arthritis (RA)
Clinical Trials and Retreatment Population
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Fleischmann (University of Texas Southwest Medical Center, Dallas);
Daniel Furst (Rheumatology Division, UCLA Medical School, Los
Angeles); Katherine Macey (Roche Products Ltd, N/A); Marianne
Sweetser (Biogen Idec Inc, N/A); Patricia Lehane (Roche Products Ltd,
N/A); Pam Farmer (Genentech Inc., N/A); Simon Long (Roche Products
Ltd, N/A)

Objective: To assess the long-term safety of RTX in RA patients (pts) in
clinical trials.

Methods: Safety data from a global clinical trial program were pooled and
analyzed to evaluate safety in pts treated with RTX + methotrexate (MTX).
RTX retreatment was offered to all pts based on physician’s decision of clinical need, including assessment of active disease. Pts receiving placebo
during placebo-controlled study periods were pooled to provide a placebo
population.

Results: As of September 2009, 3189 pts had been treated with RTX, for a
total exposure of 9342 pt-years (yrs). The analysis contained >9 yrs of follow-
up with up to 15 courses of RTX. Over 1500 pts were followed for >3 yrs and 587 pts for >5 yrs, with 1724, 1392, 1036 and 656 pts receiving ≥3,
≥4, ≥5 and ≥6 courses, respectively. The safety profile of RTX was compa-
rable to the placebo population or general RA populations, with the excep-
tion of infusion-related reactions (IRR). The most frequent adverse event
(AE) in RTX patients was IRR; most were CTC grade 1 or 2 and occurred
after the first infusion of the first course (23%), with 0.5% considered seri-
ous (over all courses). Generally, rates of serious AEs and infections
remained stable over time and over multiple RTX courses, and in pts in
long-term follow-up (≥5 yrs). Similar overall rates of serious infection were
observed between RTX and placebo populations [4.35 (3.19 in ≥5 yrs fol-
low-up) vs. 4.29 events/100 pt-yrs, respectively]. Lower respiratory tract
infections were the most frequent serious infections, with pneumonia being predominant (2%). Serious opportunistic infections were rare, with a rate comparable to the placebo population (0.04 vs. 0.01/100 pt-yrs, respective-
ly). Myocardial infarction and stroke rates in the RTX group (0.49 and 0.25
events/100 pt-yrs, respectively) were consistent with rates in the general
RA population (0.34–0.59 and 0.112–0.76 events/100 pt-yrs, respectively).

Conclusion: Data from long-term follow-up of RA pts treated with RTX in
clinical trials indicate that RTX continued to be well tolerated over time and
over multiple courses, with safety profiles similar to that of the placebo
population and consistent with published data on pts with moderate-
to-severe RA. No new safety signals were observed in both the all-exposed population and the >5 yrs exposure group.

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Risk of developing Myocardial Infarction among Uveitis patients.
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Rahman (Arthritis Research Centre of Canada, Vancouver); Jaafar Aghajanian (University of British Columbia, Vancouver); Kevin Wade (University of British Columbia, Vancouver); Hyon Choi (Arthritis Research Centre of Canada, Vancouver); Kam Shojania (University of British Columbia, Vancouver)

Objective: To find an association between uveitis and myocardial infarction.

Methods: Based on the understanding of an association between systemic inflammation and increased risk of myocardial infarction, we considered that there may also be an association between uveitis and myocardial infarction. We conducted a prospective cohort study using information from Population Data BC, a pan-provincial population health data service in British Columbia. Hospital admissions and office visits covered by the Medical Services Plan of BC for calendar years 1991 to 2004 were analyzed. Incident uveitis cases were determined by tracking diagnostic code descriptions (ICD9 code 364) between April 1, 1996, and March 31, 2004.

The case definition was a subject 20 years of age or older with two or more ophthalmologist visits anytime during the study period separated by seven days, based on the corresponding ICD9 code. Cases were included if they did not have a diagnosis of ischemic heart disease (IHD) prior to the diagnosis of uveitis. Cases were excluded if uveitis was initially diagnosed from 1991 to 1996 to ensure that the diagnosis of uveitis in our subjects was new. For each uveitis case, five controls were selected after matching for age, sex and year of diagnosis. None of the controls had a diagnosis of IHD prior to the index date. A Cox proportional hazard regression model was used to estimate the relative risks. The process was repeated with a second case definition of two ophthalmologist visits within one year separated by seven days with the corresponding uveitis ICD9 code.

Results: We found 9,386 uveitis cases between 1996 and 2004, of which 52 percent were women. The incidence rate of uveitis was three cases per 100,000 person-years. The mean age was 51 years with a standard deviation of 16.7 years. After adjusting for age and gender, the relative risk (RR) of myocardial infarction was 1.11 (95% confidence interval (CI) 0.93–1.33). Using the second case definition, we found 7,941 uveitis cases. For this case the RR was 1.15 (95% CI 0.96–1.39).

Conclusion: From this prospective cohort study, no statistically significant correlation between uveitis and myocardial infarction was obtained. A further study with a different database is needed to support this argument.

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Postal Survey of Pregnancy in Rheumatoid Arthritis and Systemic Lupus Erythematosus Patients

Michelle Teo (University of Alberta, Edmonton); Stephanie Keeling (University of Alberta, Edmonton)

Objective: Pregnancy in women with rheumatoid arthritis (RA) or systemic lupus erythematosus (SLE) is heterogeneous, with variable effects of disease on pregnancy and pregnancy on disease. Pre-conception counselling will help limit disease flares, avoid medication-related teratogenicity and help towards a healthy pregnancy. The objective of this study was to describe the impact of RA and SLE on pregnancy and whether it affected future pregnancies.

Methods: A group of female RA and SLE patients under the age of 70 were identified during a chart review for another study of nine academic rheumatologists. A self-report questionnaire was created to review all pregnancies (including miscarriages and terminations) in SLE and RA patients and quantify disease activity and medication use during pregnancy. The questionnaire was mailed to 180 RA and 40 SLE patients with a postage-paid return envelope.

Results: Of 220 mailed questionnaires (180 RA, 40 SLE patients), 43 (24%) RA and 12 (30%) SLE patients returned their completed questionnaires. Thirty-eight (88%) RA and 10 (83%) SLE patients had been pregnant, where 15 (39%) RA and 5 (50%) SLE patients developed their disease prior to pregnancy. The number of miscarriages in RA patients and SLE patients during the first, second and third trimesters respectively was: 16 (17%), 2 (2%), 0 and 4 (14%), 3 (10%) and 0. Eight (53%) RA and 1 (20%) SLE patient reported active disease during pregnancy. Eleven (73%) RA patients continued DMARD therapy, including 1 (2.6%) on methotrexate, 2 (5.3%) on sulfasalazine, 5 (13%) on anti-malarials, and 5 (67%) took prednisone during their pregnancy. None of the 5 SLE patients continued their medications or took prednisone during their pregnancy. Four (27%) RA patients decided to not pursue further pregnancies as a result of increased disease activity during pregnancy and/or postpartum. One SLE patient aborted her last pregnancy because of increased past disease activity and 1 SLE patient had a tubal ligation. Four (9%) RA and 1 (8%) SLE patient reported difficulties with becoming pregnant.

Conclusion: In this descriptive study, many RA and SLE patients had pregnancies predating their disease onset. SLE patients appeared more reluctant to continue therapy compared with RA patients. Despite literature supporting improved RA disease activity in pregnancy, half of the pregnant RA patients reported continued activity during pregnancy. The impact of SLE or RA disease activity on future pregnancies could not be reliably assessed due to low numbers. Comprehensive preconception discussions and close monitoring peripartum are required.

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Comorbidity is Commonly Reported in Early Inflammatory Arthritis

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Objective: To determine the prevalence of co-morbid medical conditions in patients with recent onset inflammatory arthritis.

Methods: Patients in CATCH are age >16 years old, have symptoms for ≥ 6 weeks but <12 months, have ≥ 2 swollen joints or ≥1 swollen metacarpophalangeal or proximal interphalangeal and ≥1 of: positive rheumatoid factor (RF), anti-cyclic citrullinated peptide (anti-CCP), morning stiffness > 45 minutes, response to non-steroidal anti-inflammatory drug or painful metatarsophalangeal squeeze test. Comorbid medical conditions are self-reported at baseline and new diagnoses identified at each visit. Patients in the CC cohort have inflammatory arthritis involving at least 2 joints of less than 1 year duration; comorbidity is assessed annually by patient self report (SR) and physician reported Charlson comorbidity index (CCI).

Results: Baseline comorbidity data was available for 803 CATCH subjects (74% female; 81% Caucasian, mean age 53; mean symptom duration 5.5(3.2) months; mean DAS28(3)CRP 4.34 (1.31), 539(67%) reported at least one comorbid medical condition (median 1, range 0–8). The following non-rheumatic conditions were reported at baseline: hypertension (213(27%), hypercholesterolemia (112(14%), diabetes (DM) 65(8%), thyroid disease (101(13%), CVD (angina, other heart disease, stroke) 89(11%), neurologic disease(73(9%), respiratory (107(13%), hematologic (56(7%), gastrointestinal 94(12%) and cancer (51(6%). CATCH subjects reporting at least one comorbid condition had higher baseline DAS28(3)CRP (4.44 vs 4.13 p=0.003) and higher baseline HAQ scores (1.05 vs 0.85 p<0.0001). In the CC cohort (75% female, mean age 49 years, DAS28(3)CRP 3.74 (1.37); self report comorbidity data was available at baseline (n=291), and at one year (n=143). At least one non-rheumatic comorbid condition was reported by 239(82%) median 3 range 0–14; hypertension 55(19%), DM 24(8%), CVD (any cardiac and stroke) 26(9%), neurologic (neurologic conditions, any headache)123(42%), any respiratory 73(25%), hematologic 36(12%), gastrointestinal 76 (26%), and cancer 9(3%). The physician reported baseline CCI was median 0 range 0–5;MI (2%), cerebrovascular disease (0.4%), ulcer (3.2%), diabetes (4.4%), diabetes with complications (1.2%), end stage renal disease (0.4%), tumor (1.6%), leukemia (0.4%). Paired baseline and one year CCI were available for 101 subjects and were similar. New diagnoses (SR or CCI) at one year included: hypertension (6) heart disease (2), diabetes (1), cancer (3), respiratory (7), gastrointestinal(7).
Conclusion: Comorbid medical conditions are common in early arthritis and may be associated with more active disease. Further longitudinal followup is needed to determine the extent of comorbidity accrual in early disease.

Does Moderate or Severe Knee Strain Affect the Progression of Radiographic Osteoarthritis?
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Objective: Knee injuries increase progression of radiographic osteoarthritis (ROA). Such injuries include knee ligament, patella or meniscal trauma ("specific" injuries). Less physiologically quantifiable injuries can be called "strain". The purpose of this study is to understand the effect of moderate and severe knee strain on ROA progression.

Methods: We recruited a population-based sample with knee pain “on most days of the month at any time in the past and any pain in the past 12 months”, aged 40 to 79 (weighted mean=57.6), stratified by age and sex, from Vancouver, Canada. Baseline was between 2002 and 2005, follow-up 2.5 to 5.6 years later (mean=3.3) (N=163); 54% were female. Average BMI was 26.1 (18.1–43.2). Study knee was the more painful knee. Radiographs were taken using fixed-flexion anteroposterior view and skyline view.

X-rays were graded using the Kellgren Lawrence (KL) scale (0–4). Grades 0 and 1 were collapsed and progression was an increase in grade. Specific knee injury was self-reported cruciate ligament tear, collateral ligament tear, meniscal tear or patellar injury. Other knee injuries were considered strain. Injury severity was either severe (requiring a walking aid for at least 1 week) or moderate. Logistic regression was used to model ROA progression. The model included the 3-level variables specific knee injury and strain (levels none/moderate/severe). An additional model collapsed them into two levels (yes/no). Both models were controlled for baseline age, sex, BMI, and follow-up time.

Results: 39.4% had baseline ROA. Specific injury/strain history was absent, moderate (7.8/24.4%) or severe (11.0/10.8%). Duration of the oldest injury/strain ranged from 1/0 to 58/70 years. Two-level models had a post-hoc power of 88% to detect an odds ratio (OR) of 3.0. Consistent with previous findings, specific injury had a significant effect on ROA progression (OR=3.26; 95% CI=1.29, 8.22). However, strain did not show an effect in the multivariable model (OR=1.09; 95% CI=0.52, 2.29). In 3-level models, the effects of specific knee injury were monotonic, and severe injury significant: moderate injury OR=1.32, 95% CI=0.32, 5.41; severe injury OR=5.80, 95% CI=1.83, 18.35. Knee strain showed no effect: moderate injury OR=1.23, 95% CI=0.52, 2.90; severe injury OR=0.66, 95% CI=0.19, 2.30.

Conclusion: We find no evidence that history of moderate or severe knee strain (including those severe enough to require a walking aid for at least 1 week) affects the progression of radiographic knee OA in a population with knee pain, after controlling for specific knee injury, age, sex, BMI and follow-up time between radiographs.
MEXICAN COLLEGE OF RHEUMATOLOGY

Podium
1

Relationship Between the Glycosylation Profile of Peripheral Blood Mononuclear Cells and Clinical Activity of Patients with Rheumatoid Arthritis

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Introduction: Changes in glycosylation of cell surface proteins has an impact on biological function, but little is known about the specific role that this process plays in inflammatory processes. The characterization of the glycosylation profile of patients with RA would allow for the identification of new disease biomarkers or potential therapeutic targets.

Objective: To compare the glycosylation patterns of peripheral blood mononuclear cells (PBMC) of patients with RA and healthy controls and evaluate their possible relationship with disease activity.

Methods: Patients included into the study complied with the 1987 ACR criteria for RA. All the patients received treatment based on methotrexate, predosine ≤10 mg/kg and did not receive biologics. Control samples were obtained from healthy donors at the local blood bank. The glycosylation patterns were evaluated using lectins: ECL, PNA, SNA, MAA and Gal-1, through flow cytometry. Cell populations were characterized using a CD3/CD4/CD8 kit. Statistical associations were measured using Chi2, Mann-Whitney and Pearson correlation tests.

Results: 56 patients with established RA were included and 32 healthy donors. When comparing PBMC of patients and controls, we observed a significant reduction in the terminal glycosylation of galactose β1-4 (60%, PNA), galactose β1-3 (50%, ECL), sialic acid α2,3 (40%, MAA) and N-acetyl-galactosamine β1-3 (30%, Gal-1). On the contrary, presence of sialic acid α2,6 was increased in patients (45%, SNA). While the changes in glycosylation were similar in the CD3+/CD4+ T cells and CD3- cell populations, the loss of galactose β1,3 was mainly seen in CD3+/CD4+ T cells. When comparing with its clinical activity, we observed that low galactosa 2,3 (40%, MAA) and α2,6 levels were associated with low inflammatory activity. No association was seen between the time since the onset of disease and the glycosylation pattern.

Conclusion: These results suggest that during the development of RA there are significant changes in the glycosylation patterns of PBMC, modifications which may be related to disease activity.

2

Effect of Tocilizumab Therapy on the Capability of Dendritic Cells to Induce the Differentiation of Th17 Lymphocytes in Patients with Rheumatoid Arthritis

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Introduction: Therapy with biological agents is effective in different autoimmune diseases. Th17 lymphocytes play an important role in the pathogenesis of chronic inflammatory diseases through their capacity to release cytokines (IL-17A, IL-17F, IL-22) that induce the synthesis and secretion of different mediators of inflammation. Likewise, T regulatory (Treg) lymphocytes exert a key role in the pathogenesis of inflammatory autoimmune diseases. AIM: To study the effect of therapy with Tocilizumab on the capacity of myeloid dendritic cells (DC’s) to induce the differentiation of Th17 lymphocytes, and to analyze the effect of this therapy on the number of Treg cells in patients with rheumatoid arthritis (RA).

Methods: The percentage of Treg cells and Th17 lymphocytes was analyzed in the peripheral blood from 14 patients with RA before and after (0, 4, 12 weeks) administration of Tocilizumab by flow cytometry. The in vitro differentiation of Th17 lymphocytes was induced by autologous DC’s with the addition or not of exogenous cytokines. In these cultures was detected the differentiation of Th17 lymphocytes, and the production of IL-17 by ELISA at 0, 4, 12 weeks after Therapy.

Results and Discussion: Tocilizumab therapy was not associated with a significant change in the proportion of different subsets of Treg cells. Likewise, no apparent changes in the levels of CD4+IL-17+ lymphocytes in venous blood was observed. However, we detected a significant diminution in the in vitro induction of Th17 lymphocytes by autologous DC’s at week 4 of Tocilizumab therapy. We also detected a significant reduction in the in vitro synthesis of IL-17 at the week 12 of therapy.

Conclusion: Tocilizumab therapy appears to affect the capacity of DC’s to induce the differentiation of Th17 cells in patients with RA. This effect could significantly contribute to the therapeutic effect of this biological agent. In contrast, the beneficial effect of Tocilizumab therapy does not seem to be related with the levels of Treg cells.

3

Detection of sequences of genes IS6110 and HupB of Mycobacterium tuberculosis and bovis in the aortic tissue of patients with arthritis of Takayasu


Introduction: Takayasu's arteritis (TA) is a chronic inflammatory disease affecting the large arteries and their branches; its etiology is still unknown. Arterial inflammation is subclinical, progresses to stenosis and/or occlusion, leading to organ damage and affecting prognosis and survival. A relation of TA with Mycobacterium tuberculosis has been informed. A relation of TA with Mycobacterium tuberculosis has been informed in case series, but few systematic studies focusing on this association. The insertion sequences, IS6110 and gene HupP, identify the Mycobacterium tuberculosis complex and differentiate between M. tuberculosis and M. bovis. Our objective was to search these sequences in aorta tissues of Takayasu's arteritis.

Methods: We chose aorta tissues embedded in paraffin from 5760 autopsies, patients with TA were classified by the American College of Rheumatology (ACR) criteria. Two control groups, one with tuberculosis and other with atherosclerosis; their tissues were blinded to the procedures. DNA was extracted and amplified and we analyzes the IS6110 and HupB gene sequences.

Results: Of 181 selected, 119 fulfilled the criteria, 33 corresponded to TA, 33 to tuberculosis (TB) and 59 to atherosclerosis. Average age for each group 22 ± 13, 41 ± 19, and 57 ± 10, respectively. Sequences of gene IS6110 and HupB through nested PCR for M. tuberculosis were found in 23 (70%) in TA, 27 (82%) in TB vs. controls with atherosclerosis 16 (32%); p = 0.004 and 0.0001, respectively. The analysis with predictive factors (socioeconomic level, body mass index, exposure to tuberculosis, and time of evolution) vs explicative variables (type of tuberculosis, sequences IS6110, and HupB, group of disease and presence of granulomas, The variables with statistical significance we included on a model of canonical correlation, which revealed a significantly high correlation between the first (0.8704) and second (0.6894) pair (p=0.0000).

Conclusion. Our findings support an association of M. tuberculosis infection with aortic tissue of Takayasu's arteritis. Arterial damage could be extra-pulmonary tuberculosis The results allow proposing new study hypotheses within the study of the pathogenesis of TA and in the research of its therapeutic management with antibiotics agents, perhaps addressed to the latent infection by M. tuberculosis.
Unusually High Prevalence of Anti-Mi-2 Autoantibodies Associated with High Levels of Muscle Enzymes in Mexican Patients with Dermatomyositis

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**Purpose:** Various autoantibodies specific or associated with polymyositis/dermatomyositis (PM/DM) have been described including anti-Jo-1 (histidyl tRNA synthetase) and other synthetases, SRP, Mi-2, PM-Scl and others. Each of these autoantibodies is associated with a unique subset of PM or DM. Specificities of autoantibodies and associated clinical manifestations in PM/DM are known to be affected by both genetic and environmental factors. Since most available data are based on studies in North America, Europe, and Japan, the current study examines autoantibodies and clinical manifestation in Mexican PM/DM.

**Methods:** Forty-seven Mexican patients with PM/DM were studied. Protein autoantigens recognized by sera were analyzed by immunoprecipitation using 35S-methionine labeled KS62 cell extract and associated RNA detected using unlabeled cell extract followed by urea-PAGE and silver staining. Immunofluorescence anticellular antibodies were tested using HEp-2 cell slide. Clinical information was from database and chart review.

**Results:** DM (n = 35) was more common than PM (n = 12). Anti-Mi-2 was the most common specificity found in 44% in PM/DM, followed by anti-155/140kDa (6%); however, anti-Jo-1 that is the most common specificity in most PM/DM studies was only 4%. Anti-SRP and PM-Scl were one case each. When autoantibody profile was analyzed in DM and PM separately, DM had a surprisingly high 54% prevalence of anti-Mi-2 (P = 0.0067 vs PM), followed by anti-155/140kDa (9%) and Mi-2 (6%). All 3 anti-155/140kDa and 2 anti-Mi-2 were DM and 75% of PM had no identifiable myositis autoantibodies (DM 20% vs PM 75%, P = 0.0011).

Clinical feature of anti-Mi-2 (+) DM (n = 16) vs anti-Mi-2 (-) DM (n = 12) was compared. Male was more common in anti-Mi-2 (+) vs (-) (44% vs 17%). Shwach sign (82% vs 58%) and weight loss (56% vs 25%) were more common in anti-Mi-2 (+) DM than anti-Mi-2 (-) DM. High CPK (> 2000) (86% vs 45%; P = 0.08) was more common in anti-Mi-2 (+) and levels of muscle enzymes were higher in anti-Mi-2 (+) group than anti-Mi-2 (-) group (CPK P = 0.15, LDH P = 0.02, AST P = 0.04, ALT P = 0.06). Dyspnea was noted in 25% of anti-Mi-2 (-) but none in anti-Mi-2 (+).

**Conclusion:** In contrast to 5–10% prevalence reported in the literatures, anti-Mi-2 was found in 44% of Mexican PM/DM (54% in DM). Anti-Mi-2 was associated with male DM with shawl sign consistent with literatures. However, levels of muscle enzymes in anti-Mi-2 (+) DM were significantly higher than those of anti-Mi-2 (-) DM, in contrast to milder muscular involvement described in the previous studies.

Genic Expression of Cytokines related to NALP3 Inflammasome, Vascular Mediators and TGFß, in the Skin of Systemic Sclerosis Patients

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**Objective:** Systemic sclerosis (SSc) is an autoimmune disease, identified by vascular dysfunction and fibrosis, associated to increase in plasmatic endothelin-1 (ET-1) and abnormal metabolism of nitric oxide. Recent studies suggest stimulation of autoimmunity and fibrosis by innate immune sensors (NALP3) in SSc. NALP3 cytosolic protein complex located in macrophages and neutrophils that activate caspase-1 for the processing of proinflammatory cytokines IL-1ß, IL-18 and IL-33, allowing triggering of an immune response against external or internal threats.

The aim of this study was to correlate the expression of NALP3 with proinflammatory cytokines, with transforming growth factor beta (TGFß), ET-1 and with nitric oxide synthase (NOS) expressions, in the skin of SSc patients.

**Methods:** We analyzed 55 skin biopsies obtained from 42 patients with SSc (21 limited and 21 diffuse) and 13 control subjects. Genic expression of cytokines related to NALP3: caspase-1, IL-1ß, IL-18, IL33; profibrotic: TGFß; and vascular mediators: ET-1, NOS [inducible (iNOS) and endothelial (eNOS)] were measured by real-time PCR.

**Results:** Mean age was 49.3 ± 12.9 vs 44.6 ± 13.8 years, time of evolution was 7.6 ± 5.6 vs 6.8 ± 4.8 years (limited vs diffuse respectively). NALP3 relative expression in the skin of patients with SSc was increased compared with controls (6.2-fold in limited, 1.6-times in diffuse, p <0.01), which directly and positively correlated with the expressions of IL-1ß, IL-18 and IL-33 (p <0.01). The relative expression of ET-1 correlated positively with IL-18, IL-33 and TGFß (r = 0.8, 0.79 and 0.81 respectively, p <0.01). The expression of both eNOS and iNOS was significantly higher compared with controls. Only in the diffuse group, NALP3, IL-33 and TGFß positively correlated with the expression of eNOS (p <0.05).

**Conclusion:** The induction of differential expression of cytokines related to NALP3 in the skin of diffuse and limited forms of SSc, and the correlation to the high expression of ET-1, NOS and TGFß, suggest that NALP3 may play a central role in the pathophysiology of SSc.

Cardiac Fibrosis and Microvascular Damage Are Hallmark of Cardiac Involvement in Patients with Systemic Sclerosis (SSc). Prevalence and Patterns of Cardiac Damage in Patients with SSc


**Introduction:** Heart disease in SSc has been described in 37–80% of patients, depending on the diagnostic methods and the inclusion criteria used in different studies.

**AIMS:** To determine prevalence of cardiac involvement in a cohort of SSc patients; to identify frequency, patterns, distribution and extension of heart fibrosis, to evaluate myocardial perfusion, to correlate these data with clinical variables.

**Methods:** We included 62 patients (47% diffuse cutaneous SSc (dcSSc), 53% limited cutaneous SSc (lcSSc)), >17 years old, without overlap syndromes, nor cardiovascular risk factors. Medical history and physical exam were updated, they were tested for CPK, CPK-MB, CRP, ANA, SSc specific antibodies, antiphospholipids and anti-beta 2 glicoprotein-1. EKG, coronary artery CT scan and cardiac MRI (rest and with adenosine for perfusion) were performed. Statistic analysis was performed using SPSS v.15 software.

**Results:** We included 60 (97%) women, mean age 40.9 years and median evolution 9.7 years. Prevalence of cardiac fibrosis was 42% (52% dcSSc, 34% lcSSc, ns), and it was associated to lower left ventricle ejection fraction (LVEF) (62% in patients without fibrosis vs. 56% in patients with fibrosis; p=0.001). The patterns of fibrosis were: patchy 9%, band 41%, subendocardic 14%, transmural 9% and mixed 27%. The distribution of...
fibrosis was: 29% in the base, 26% in middle and 17% in the apex. The percentage of fibrosis in the myocardium was 14% in dcSSc and 5% in lcSSc patients (p=0.05). Abnormal myocardial perfusion (microvascular damage) was found in 85% of patients. Coronary artery CT scan showed non-significant atherosclerosis in 9 patients, without association neither to cardiac fibrosis nor to perfusion abnormalities.

**Conclusion:** Prevalence of cardiac fibrosis in our patients is 42%; percentage of fibrotic myocardium is higher in dcSSc than in lcSSc patients; cardiac fibrosis is associated to lower LVEF; cardiac fibrosis patterns in SSC are diverse and it is more frequent in the base, then in the middle segments and then in the apex; fibrosis is not associated to coronary atherosclerosis; SSc patients have high frequency of cardiac microvascular damage (85%). MRI is a reliable and noninvasive method to detect cardiac damage in SSC.

7 Abnormal Cerebral Blood Flow in Neurologically Asymptomatic Primary Antiphospholipid Syndrome Patients

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**Introduction:** Neurological manifestations are varied in primary antiphospholipid syndrome (PAPS) patients. In the general population, abnormalities in cerebral blood flow are associated with stroke risk. In PAPS, cerebral blood flow has been little studied.

**Objective:** To evaluate cerebral blood flow abnormalities in neurologically asymptomatic primary antiphospholipid syndrome (PAPS) patients.

**Methods:** We included 28 PAPS patients neurologically asymptomatic at the time of study and 28 healthy controls. Clinical data comprised information of traditional cardiovascular risk factors, history of cerebrovascular ischemia, carotid doppler ultrasound, and echocardiographic evaluation. Transcranial Doppler ultrasonography measured mean flow velocity (MFV) in carotid siphon, middle, anterior, posterior, intracranial vertebral arteries, and basilar artery. Abnormal result was considered when MFV was out of normal range according to age and/or flow asymmetry.

**Results:** The mean age of patients was 41.4 ± 11.2 and 39.3 ± 8.6 years in controls. Disease duration was 11 ± 2.7 years. A significant increase in MFV in 7/11 cerebral arteries in PAPS was found in patients compared to controls mainly in the middle and anterior cerebral arteries. We did not find association between abnormal MFV, with abnormal echocardiography, arterial hypertension and carotid intima-media thickness. However, an association between history of stroke and obesity with a greater number of affected arteries was found (p<0.05).

**Conclusion:** Asymptomatic patients with PAPS have meaningful increase in MFV. These alterations were observed in patients below 50 years of age and may be the consequence of PAPS vasculopathy rather than atherosclerosis. Whether these findings may represent a risk for stroke in PAPS patients has to be addressed in prospective studies.

8 Lymphopenia Related CD4+ Lymphocyte Subsets Quantitative and Functional Profiles in Systemic Lupus Erythematosus Patients

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**Introduction:** Lymphopenia constitutes a common finding among Systemic Lupus Erythematosus (SLE) patients. However, its physiopathogenic role and the contribution of different T cell subsets have not been fully addressed. The aim of this study was to characterize quantitatively and functionally T cell subsets and their relationship with lymphopenia and azathioprine in SLE.

**Methods:** We included 84 SLE patients and 84 healthy controls. We selected 20 patients for longitudinal analysis (6 months). Further subanalysis was performed to evaluate azathioprine effect on T lymphocyte subsets. PBMC were isolated and T cell subsets were analyzed by flow cytometry. Functional analysis included autologous and allogeneic co-cultures.

**Results:** Our data shown persistently lower CD4+CD25high (Tregs) (1.9 ± 5.2, p<0.01) and CD4+CD69+ (activated) (3.2 vs 9.3, p=0.02) absolute numbers in SLE patients with lymphopenia. Lymphocyte numbers correlated with CD4+CD25high (r=0.523, p<0.01) and CD4+CD69+ (r=0.364, p<0.01) T cell absolute numbers. Lymphopenia increased the risk for decreased CD4+CD25high T cells (RR 1.80, CI 95% 1.10-2.93; p=0.003). Besides, azathioprine related lymphopenia was characterized by lower CD4+CD69+ and CD4+IL-17+ absolute numbers in comparison to disease activity lymphopenia. Functional assays revealed that SLE effector T cells showed higher proliferation without suppression by autologous Tregs and azathioprine was related to diminished Tregs suppression.

**Conclusion:** In summary, deficient CD4+CD25high and CD4+CD69+ cells absolute numbers and resistance to suppression shown by effector T cells are related to lymphopenia, which could contribute to the altered immune regulation characteristic of SLE. In this context, azathioprine effect is related to decreased CD4+CD69+ and CD4+IL-17+ absolute numbers and Treg suppression.

9 Expression and Functional Role of HLA-G in Immune Cells from Patients with Systemic Lupus Erythematosus

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**Introduction:** HLA-G is a class I non-classical HLA molecule with an important regulatory role on the immune response. Recently it has been described that monocytes and a small percentage of T lymphocytes and dendritic cells (DCs) express this molecule. Expression of HLA-G can be up-regulated by IL-10 and IFN-γ. Trogocytosis is a phenomenon that consists in the contact dependent rapid recapture of membrane associated molecules. It has been recently demonstrated that T cells can acquire HLA-G from antigen presenting cells by trogocytosis. HLA-G acquisition confers them a regulatory phenotype. It is well known that SLE patients display high levels of type I interferon and IL-10; however the possible role of this molecule in the pathogenesis of SLE has not been explored. The aim of this study was to explore the expression and function of HLA-G in peripheral blood monocytes and in vitro generated DCs from SLE patients and control subjects, as well as the HLA-G transference by trogocytosis on SLE and healthy donors.

**Methods:** We studied 37 SLE patients and 25 healthy subjects. Peripheral blood monocytes, and in vitro generated dendritic cells (DCs) were analyzed for HLA-G expression by flow cytometry. Monocytes were cultured in the presence of IFN-γ and IL-10 to induce HLA-G expression. Trogocytosis of this molecule by lymphocytes was analyzed by flow cytometry. We evaluated the proliferation and suppressive function of HLA-G+ lymphocytes. We also studied the function of HLA-G+ monocytes.

**Results:** We found that monocytes from SLE patients as well as mature CD83+DCs showed a diminished expression of HLA-G compared with healthy controls. In addition, monocytes from SLE patients showed a diminished induction of HLA-G expression in response to stimulation with IL-10. Furthermore, functional assays showed that these monocytes pre-treated with IFN-γ exhibited a diminished capability to inhibit the proliferation of autologous lymphocytes. Finally, lymphocytes from SLE patients tended to display a lower acquisition of HLA-G (by trogocytosis) from autologous monocytes compared to controls.

**Conclusion:** Our results might have implications for the immune abnormalities observed in patients with SLE.

10 Prevalence and Risk Factors for Rheumatic Regional Pain Syndromes in Mexico. A Population Based Case-control Study

**Introduction:** Rheumatic regional pain syndromes (RRPS) are between the most prevalent musculoskeletal conditions worldwide in Mexico. Its prevalence and risk factors have not been yet studied.

**Objective:** To assess the prevalence and risk factors for RRPS in three geographical regions of Mexico.

**Methods:** We performed a biphasic study: In a first step, a randomised, stratified, and polyetapic sampled community based survey was done on 12,686 adults (43.6±17.3 years old; women: 61.9%) from the Mexican states of Nuevo León (n=4,172); Yucatán (n=3,915); and Mexico City (n=4,059). Using the COPCORD screening questionnaire, we selected every subject with non-traumatic limb pain in the last 7 days, who underwent a clinical examination for diagnosing upper (Southampton group criteria) and lower (expert consensus ad hoc developed criteria) limb RRPS. Finally, using randomly selected COPCORD negative controls (3:1) extracted from the same studied population, we assessed the effect of a series of clinical (comorbidities) and demographic (age, gender, type of residence [urban vs. rural], having a remunerated job, level of physical demand/repetitiveness on the job, socioeconomical status, having medical insurance, and educational level) on the risk for RRPS.

**Results:** Six hundred and forty cases of RRPS were detected; prevalence: 5.0% (95% CI: 4.7-5.4). An upper limb RRPS was diagnosed in 620 (4.8%), and lower limb RRPS in 153 (1.2%) subjects. After logistic regression, identified RRPS risk factors were: female gender (p<0.001; OR: 1.95 95% CI: 1.59-2.39); diabetes (p=0.01; OR: 1.38 95% CI:1.07-1.79); remunerated job (p<0.001; OR: 2.06 95% CI:1.62-2.62); and older age (p<0.001; OR: 1.03 95% CI: 1.02-1.04). The same variables were independently associated to upper (p<0.001) and lower (p<0.001) limb RRPS: diabetes (p=0.009; OR: 1.43 95% CI:1.09-1.87); female gender (p<0.001; OR: 1.96 95% CI:1.57-2.45); older age (p<0.001; OR: 1.03 95% CI: 1.02-1.04); and remunerated job (p<0.001; OR: 2.16 95% CI:1.66-2.62). For lower limb, only older age (p=0.008; OR: 1.01; 95% CI:1.00-1.03); female gender (p=0.009; OR: 1.82 95% CI:1.16-2.86); and remunerated job (p=0.007; OR: 2.16 95% CI: 1.23-3.79) were identified as independent risk factors.

**Conclusion:** In Mexico, the prevalence of RRPS was 5.0%. Female gender, diabetes, having a remunerated job and older age were identified as risk factors for RRPS (all and upper limb). The risk profile for lower limb RRPS was restricted to female gender, having a remunerated job and older age.

11 The Prevalence of Osteoarthritis (OA) in Mexico. A COPCORD-based Study


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**Objectives:** To estimate the prevalence of OA in four regions across Mexico and identify the variables that predicted such diagnosis

**Methods:** This is a cross-sectional study carried out in Mexico City and Nuevo León, Sinaloa, and Yucatán states. Sampling in Mexico City was by census whereas in the three participating states by multistage (stratified and by conglomerate). The study followed the methodology of the guidelines of the phase 1 WHO-ILAR Community-Oriented Program for the Control of Rheumatic Diseases (COPCORD). Communities were surveyed with the Mexican adaptation of COPCORD by trained interviewers. A “positive case” was defined as an individual with non-traumatic musculoskeletal pain (MSKP) >1 on a visual analog scale (VAS) from 0 to 10 in the last 7 days or at some point in their life. Positive cases were referred to specialists in internal medicine and/or rheumatology for examination, classification and diagnosis.

**Results:** In total, 17,556 individuals (mean age 43.12 years; 10,666 [60.72%] females) were included in the study. 4,357 (24.8%) individuals had MSKP; of these, 2,706 (15.38%) had a rheumatic disease of whom 1,681 (62.1%) had OA. Thus, the prevalence of OA was 9.5% [95% CI 9.1, 10.0] and was higher in females than in males (6.6% vs 2.9%, p<0.01). By age group OA occurred in 4.8% (95% CI 4.4, 5.2) before the age of 45 years, 14.0% (95% CI 1.0, 15.0) between 46 to 65 years and 21.4% (95% CI 19.7, 23.2) after the age of 66 years. More patients with OA had ≥4 pain in the last seven days than individuals without OA (6.1% vs. 3.4%, p<0.01) and more physical limitations (9.6% vs. 4.0%; p<0.01).

The variables associated with the presence of OA were female sex (OR=1.5, 95% CI 1.3, 1.7), higher pain intensity (OR=2.7, 95% CI 2.5, 3.0), current physical limitation (OR=1.6, 1.5, 1.8), HAQ score greater than 2.0 (OR=3.6, 2.5, 5.1), and high consumption of NSAIDs (OR=4.3, 95% CI 3.8, 4.7).

**Conclusion:** OA is a disease with a high prevalence. Female sex, pain intensity, physical limitation and consumption or NSAIDs are variables that are associated with the presence of OA at the community level.

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12 Diagnostic Value of the Chronic Gout Diagnosis (CGD) Proposal


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**Introduction:** MSU crystal demonstration is the gold standard for the diagnosis of gout but, in clinical practice the diagnosis is frequently based in clinical data. Based in the ACR proposal and EULAR recommendations for the diagnosis of gout, we previously reported the CGD proposal in 549 patients. CGD ≥4/8 items have better performance compared to ACRp and EULAR in regular gout patients attended by rheumatologists.

**Objective:** To evaluate the diagnostic value of the CGD proposal as individual items or as the entire proposal in patients with gout, rheumatoid arthritis (RA), osteoarthritis (OA) and Spondyloarthritis (SpA).

**Methods:** We looked for the presence of CGD proposal items: Current or past history of 1) ≥2 attacks of acute arthritis, 2) mono/oligoarthritis attacks, 3) rapid progression of pain and swelling (<24h), 4) podagra, 5) erythema , 6 unilateral tarsitis, 7) probable tophi and 8) hyperuricemia. CGD= ≥4/8. Other variables studied were demographics, associated diseases, if MSU crystal search and culture were performed. Two hundred and four patients were included: 30 RA, 31 OA, 31 SpA and 112 with gout (75/112 MSU crystals were demonstrated, this group was considered the gold standard). Gout group included 36 females, 14 patients with young onset gout (<25 years) and 16 with secondary gout. Statistical analysis included diagnostic test evaluations (sensitivity, specificity, LR+ and ROC curves).

**Results:** Mean age (SD) and the percentage of males in each group was: Gout 56.1 (16.6) and 68%; RA 41.6 (12.2) and 7%; SpA 40.3 (15) and 42%; OA 56 (9.5) and 10%. The percentage that had ≥4/8 CGD criteria in each group was: Gout 97% RA 3%; SpA 6.5% and OA 3%.

Sensitivity, specificity, LR+ and area under the curve for each item are: >1 arthritis attack: 94.6%, 33.7%, 1.4, 0.63; mono/oligoarthritis attacks, 97.3%, 67.4%, 2.9, 0.82; acne <24h : 82.5%, 98.9%, 77.5,0.91; podagra 71.4%, 94.6%, 2.9, 0.82; acme <24h : 82.5%, 98.9%, 77.5,0.91; podagra 71.4%.
including physical examination, joint symptoms). Relatives with symptoms had rheumatology assessment structured interview (COPCORD core questionnaire and inflammatory markers) and were asked to invite their colleagues with arthritis to participate in this study. The study population comprised relatives with and without rheumatic symptoms. Relatives with symptoms were examined by a rheumatologist, and serum IgM-RF (nephelometry) and anti-CCP antibodies were measured. Results: A total of 777 consanguineous relatives from 283 RA patients were included; IgM-RF was detected in 78 (10.0%) and anti-CCP in 27 (3.5%) of the relatives. After a mean follow-up of 1.80 ± 0.33 years, 24 subjects developed arthritis (16 UA and 8 RA). Conclusions: IgM-RF and anti-CCP antibodies are independent predictors of the development of arthritis in relatives of RA patients. The presence of IgM-RF and anti-CCP antibodies may identify healthy individuals at higher risk to develop RA.

15 Human Papilloma Virus Infection (HPV), in Patients with Rheumatoid Arthritis (RA) and Systemic Lupus Erythematosus (SLE) Patients

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Introduction: Susceptibility to HPV is increased in SLE patients, even though, the immunopathogenic mechanisms in this patients, are not totally understood.

Methods: We evaluate SLE and RA patients and healthy women controls (HW) through clinical data including current or previous body common warts, and genitalia HPV infections (warts and cervical smear alteration), besides peripheral blood T, B, NK and CD335 lymphocyte subpopulations by flow cytometry. Results: We assessed 125 HW, 104 SLE and 401 RA patients, under DMARD therapy and 140 under biological therapy (BT: 122 RA and 18 SLE). Forty DMARD-RA patients (9.9%) had evidence of HPV, 16 common warts (CW), 6 flat warts (FW), 17 high-grade cervical intra-epithelial neoplasia (CIN-2-3) and one HPV associated neoplasia. Twenty SLE patients (19.23%) showed HPV (9 CW, 4 FW, 1 myrmecia, 1 Heck’s disease, 4 CIN 2-3 and one HPV associated neoplasia). In contrast, only 8 HW (6.4%) had HPV (3 CW, 2 low-grade intraepithelial neoplasia, 2 CIN 2-3 and one with PVI-associated neoplasia (p=0.0061). We did not find association of HPV infection with DMARD neither with biological therapy. SLE patients with HPV showed less B lymphocytes and NK cells number than HW (P <0.001). There were differences between SLE-DMARD patients without HPV compared with SLE patients with HPV, in B and NK cells (P<0.05). The NK cells percentage was not different among RA patients (under DMARD vs BT) neither HW, however RA patients with HPV treated with DMARD and BT had lower percentage of B cells than HW (P<0.05).

Discussion: HPV occurs more frequently in SLE than HW and RA patients. This infection probably is related to decreased levels of B lymphocytes and NK cells. The association of SLE with these characteristics abnormalities seems to increase susceptibility to develop HPV infection in SLE.

16 Prevalence of Endothelial Dysfunction in Rheumatoid Arthritis Patients. Association with Disease Activity, Treatment and Metabolic Syndrome

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Introduction: Cardiovascular disease is found as one of the main causes of morbidity and mortality in Rheumatoid Arthritis (RA). Patients with RA and metabolic syndrome have higher levels of disease activity. An association between inflammation and endothelial dysfunction has been proposed.
The aim of the present study was to assess the prevalence of endothelial dysfunction and its relation with metabolic syndrome, disease activity and treatment in Mexican patients with RA.

**Methods:** 36 patients with RA and 36 sex and age (+/- 3 years) matched controls were included in the study. 50 clinical and 33 laboratory variables were analysed, among them: demographic, anthropometric, traditional and non traditional cardiovascular risk factors, disease-related, metabolic (lipid profile, glucose, insulin, HOMA), functional (HAQ), disease activity (DAS-28), emotional (IDARE), endothelial dysfunction assessed by endothelial dependent flow-mediated dilation (ED-FMD), intima media thickness (IMT) and specific biomarkers. Statistical analysis: We used independent t test and chi square to compare cases and controls for different variables. Two-sided p values of ≤0.05 were considered statistically significant.

**Results:** 36 patients diagnosed with RA were included, mean of 6 years of evolution and a mean of DAS-28 of 3.59. There was no demographic or epidemiologic difference between groups, exception made of education level, which was higher in controls (p=0.002). Both Patients and Controls had increased Body Mass Index (x/SD, 25.9/5.4 versus 25.6/5.7 p=0.84), Glucose was higher in patients (105.9/33.2) versus controls (97.6/16.9, p=0.22) , HDL patients 44.8/12 vs 46.1/11.3 p=0.58, Triglycerides 147.2/69.1 vs 149.8/59.1 p=0.30, IMT mm 0.6/2 vs 0.8/1.5 p=0.19, ED-FMD No/Yes (%) 11/25 (69.5%) vs 14/22 (62%) p=0.61, Metabolic Syndrome No/Yes 23/13 vs 22/14 p=0.08. We did not find an association among metabolic syndrome, disease activity and treatment. (p > 0.05).

**Conclusion:** We did not find a statistical nor a clinical difference between controls and RA patients. This information should be taken cautiously. Larger periods of follow up may be needed to detect a difference.

17 Down-regulated Expression of Toll-like Receptor 9 (TLR9) mRNA in Peripheral Leukocytes from Patients with Systemic Lupus Erythematosus

**Introduction**


**Methods:** We evaluated TLR9 gene expression in 20 SLE patients and healthy controls. The ACR criteria and 17 healthy controls. IL-10 mRNA expression was used as molecular marker for quality control. TLR9 and IL-10 mRNA transcripts levels were measured in duplicate on peripheral blood leukocytes by RT-qPCR using assays of LNA hydrolysis probes in combination with target-gene specific primers for TLR9 mRNA (NM_017442) forward 5´-CCAGACCCTCTGGAGAACAC-3´ reverse 5´-GATGAAAGCAGGCGAGG AGGTT-3´, IL-10 mRNA (NM_000572) forward 5´-TGCGGCAAGAC CTTGAACGC-3´ reverse 5´-ACAGGGAAGAATCGATGACA-3´, and GAPDH mRNA (NM_002046) forward 5´-AGCCACATCCGTCCAGA CAC-3´ reverse 5´-GCCAACATCCGACAAATCC-3´ as reference gene.

**Results:** Relative mRNA expression of TLR9/GAPDH was decreased in SLE compared to controls (mean ± SD, 5.45±2.51 vs. 9.28±4.09; p=0.001).

**Conclusion:** TLR9 expression is higher in healthy than in SLE. TLR9 mRNA expression inversely correlates with SLE disease activity, suggesting a protective role for TLR9 in the induction and/or maintenance of the disease, although it appears to be unrelated to anti-dsDNA antibodies.

18 Fetal Outcome in Lupus Women Treated with Azathioprine During Pregnancy

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**Introduction:** Azathioprine has been associated with an increased risk of preterm birth and intrauterine growth restriction in several diseases, including systemic lupus erythematosus (SLE).

**Objective:** To examine the risk of adverse fetal outcome among newborns of SLE women exposed to azathioprine during pregnancy.

**Methods:** We included SLE (ACR criteria) pregnant women attend at outpatient clinic. We selected 51 pregnancies exposed to azathioprine (Group 1) and were compared with 52 pregnancies not exposed to it (Group 2). Fetal outcomes recorded included liveborns, spontaneous abortions, stillbirth, term delivery, preterm birth (<37 weeks), low birth weight (<2,500 g), and congenital malformations. Statistical analysis included Student t test, Mann-Whitney U-test, Fisher exact test, odd ratios and multivariable analysis.

**Results:** The maternal characteristics of the Group 1 and Group 2 differed with regard to maternal age (25.3±5 vs 27.8±5.1 years, p=0.01), frequency of first pregnancy (62.7% vs 30.7%, p=0.001), and previous renal involvement 54.9% vs 19.2% (p=0.002).

**Conclusion:** This study suggests that azathioprine can be used in SLE pregnancy if the maternal condition requires use of a cytotoxic drug; on the other hand, azathioprine was not associated with poor fetal outcome, including preterm delivery and congenital malformations in the exposed infants.
Results: Mean (SD) SLEDAII-2K scores among patients in cNPSLE, pNPSLE, non-NPSLE, SLE surgical and SLE meningitis were 15.3(8.2), 12.5(9.8), 12.4(8.2), 3.8(1.5), 6.6(4.6) respectively. cNPSLE manifestations included: : seizures 16, acute confusional state 8, severe refractory headache 7, cerebrovascular disease 4, and psychosis 1. cNPSLE manifestations included: multiple mononeuropathies 2, transverse myelitis 1, and polyneuropathy. Cytokines and chemokines levels in serum and CSF were higher in all SLE patients than non-autoimmune patients. In serum, IFN-α, IP-10, MCP-1, IL-8 and IL-6 levels did not differ between cNPSLE patients and any of the other SLE groups. In CSF, IFN-α levels were also similar in cNPSLE and the other SLE patients, including patients with infectious meningitis. However, as we had described previously, IP-10, MCP-1, IL-8 and IL-6 were higher in cNPSLE patients than pNPSLE and surgical SLE, but significantly lower than SLE patients with infectious meningitis. Six months later, serum levels of IFN-α, IP-10, MCP-1, IL-8 and IL-6 did not show any difference with baseline levels. CSF levels of IFN-α also remained stable; however, as previously described levels of IP-10, MCP-1, IL-8 and IL-6 had a significant reduction.

Conclusion: IFN-α, IP-10, MCP-1, IL-8 and IL-6 did not show any potential utility as serological biomarkers of cNPSLE. In CSF, IFN-α levels did not increase during the outbreak of cNPSLE, as had previously described with IP-10, MCP-1, IL-8 and IL-6.

20 Identification of Serological and Non-serological Risk Factors for Rethrombosis in Patients with Primary Antiphospholipid Syndrome (PAPS)
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Objective: To ascertain the serological and non-serological factors for rethrombosis in patients with PAPS.
Methods: We studied patients with PAPS that had at least one thrombotic episode. Patients were excluded if they had a history of hereditary thrombophilia or SLE. We divided patients in 4 groups. 1: Patients on oral anticoagulants (OA) that after discontinuation developed a new thrombotic event. 2: Patients on OA that after discontinuation did not have a new thrombotic event. 3: Patients on continuous OA that have remained thrombosis-free. 4: Patients on OA that developed a new thrombotic event. We studied: age at time of thrombosis, time for rethrombosis, BMI, comorbidities (DM2, hypertension, dyslipidemia), pregnancies, bedridden, hormonal contraception, estrogen replacement, perioperative period, infections, tobacco use, prednisone, aspirin, immunosuppressives and INR during thrombosis. We evaluated: the frequency of aCL (IgG-IgM), anti-ß2GP-I (IgG-IgM), lupus anticoagulant (alone or combined) and persistently positive antibody titers. We used ANOVA, X , Student’s t test or odds ratio (95% CI).
Results: We studied 95 patients (70 women, 74%): 32 (group 1), 25 (group 2), 29 (group 3) and 10 (group 4). Their overall mean age at time of study was 41.7 ± 14 years with a median follow-up of 4.5 years (0.3–26). Follow-up time was shorter for group 1 (2.8 years, p < 0.05) than the other groups. LA and triple markers were more prevalent in group 1 than in group 2: 67 vs. 31%; OR= 4.5; 95% CI= 1.3–14.9; p= 0.01; and 57% vs. 27%; OR= 6.6, 1.7–25.2; p=0.03. These two variables remained associated with recurrence of thrombosis after comparing groups 1 & 4 with group 2: LA 62% vs. 31%, OR= 3.6; 95% CI= 1.1–11.2, p=0.03; LA + aCL + anti-ß2GP-I (triple marker): 75% vs. 27%; OR= 8.0; 95% CI= 2.4–29.8; p=0.04. Patients from group 2 were more frequently on aspirin than those from group 3 (62.4% vs 31%); OR= 0.27; 95% CI= 0.08–0.84; p=0.02. We found no significant difference between the INR of our patients on oral anticoagulants (Group 3, INR= 2.7 vs. group 4 = 2.3). Neither titers nor persistently positive antibody markers were associated with rethrombosis. Other studied clinical variables were not associated with recurrent thrombosis.
Conclusion: Our study showed that LA, alone or combined with aCL and/or anti-ß2GP-I, is a risk factor for recurrent thrombosis in patients with PAPS regardless of therapeutically effective oral anti-coagulation.
Objective. To determine the interobserver concordance rate in classifying individuals with IBP detected in the community as SpA.

Methods. Paper-cases based on real cases with IBP identified in a community study of 4,059 individuals were sent on-line to 32 experts on SpA for classification as SpA or no-SpA (ESSG criteria). Case information included: sex, age, HLA-B27, CRP level, familial aggregation, arthritis, enthesisis, Schober’s test, chest expansion, sacroiliac joint radiographic classification, and back pain characteristics. Evaluators were selected from the ASAS and RESPONDIA groups of experts in AS. A three-round, Delphi exercise with cut-off levels of agreement of 66% and 50% was set on-line for response and analysis.

Results. There were 22/32 (68.7%) participants in the study. Overall, 49(40.5%) cases were classified as SpA, 70 (57.8%) as non-SpA, and two (1.6%) were non-classifiable. Classification by expert’s group was variable: ASAS, 31 (25.6%) as SpA and 69 (57.6%), as non-SpA, and 21 (17.3%) as non-classifiable. RESPONDIA, 43 (35.5%) as SpA, 69 (57.0%) as non-SpA, and 9 (7.5%) as unclassifiable. The rate of concordance between experts and ESSG criteria was 0.46 (p<0.000). Sensitivity, specificity, and +likelihood ratio of expert opinions vs. ESSG was 85.7, 72.1, and 3.1, respectively.

Conclusion. The rate of concordance between experts’s in SpA in classifying individuals with IBP detected in the community as SpA in this study was relatively low. Compared with ESSG criteria, the specificity of expert’s opinion is low.

23 Efficacy of the combined therapy with Rituximab plus Cyclophosphamide versus Cyclophosphamide as Monotherapy in Systemic Sclerosis-Associated Interstitial Lung Disease


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Introduction. Cyclophosphamide (CYC) is considered as the “gold standard” for the treatment of Systemic Sclerosis-associated Interstitial Lung Disease (SSc-associated ILD); although, there is a relevant rate of treatment failure. Case-reports shows that rituximab (RTX) seems to be effective for some patients with this entity. Nevertheless, to date there is a lack of controlled clinical trials showing its efficacy.

Objective. To evaluate the efficacy of the combination RTX plus CYC versus CYC as monotherapy in SSc-associated ILD.

Methods. Study design: Randomized, controlled-trial. Study development: Were included 15 women with SSc-associated ILD according to 3 criteria: a) Forced vital capacity (FVC) <80% of predicted, b) High-resolution computed tomography with evidence of interstitial lung disease, and c) exclusion of other causes of ILD. Evaluations included: Pulmonary function test, clinical variables associated to SSc-associated ILD severity and others. After the randomization, 2 groups were assembly: a) RTX (1000 mg 2 weeks apart) + intravenous CYC (0.5g/m2 monthly for 6 months), or, b) intravenous CYC as monotherapy (same schema as above). Efficacy was defined as the rate of responders by group (improvement in FVC ≥10% or reaching values ≥80%).

Results. None of the patients withdrew the study. Primary outcome: There were no differences in the rate of responders between both groups: (83% in CYC versus 78% in RTX+CYC, p=1.0). Patients in the group of CYC as monotherapy showed significant improvement in FVC (72% at basal vs. 82% at 6-months, p=0.04), whereas in the RTX+CYC group had a trend for improvement but without achieve statistical significance in FVC (66% at baseline vs. 77% at 6-months, p=0.16). The frequency of adverse events was similar between groups: relative risk (RR) of any adverse event with RTX+CYC vs CYC: RR=0.20 (95%CI: 0.84–1.72, p=0.40).

Conclusion. This study did not show evidence of a higher efficacy with the combination RTX+CYC versus CYC in SSc-associated ILD treatment. Therefore we do not justify the strategy of initiate treatment using combined therapy with RTX+CYC instead of CYC in this disease. Further studies should assess if this combined schema can add benefit in patients with primary failure to CYC as monotherapy.

24 Clinical Features, Disease Activity and Damage Accrual in Systemic Lupus Erythematous Patients. Data from a Cuban cohort.

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Introduction: systemic lupus erythematous (SLE) is a chronic disease with flares–up and remission episodes. An active disease may lead to damage accrual. The aim of this study was to determine the prevalence of the activity and damage accrual using data from a SLE cuban cohort.

Methods. SLE patients from two centers were recruited and followed-up longitudinally. Demographic characteristics, accumulative clinical manifestations, laboratory data, disease activity using both SLEDAI and MEX-SLEDAI indexes (at diagnosis, 3, 6 and 9 years of follow-up) and Systemic Lupus International Collaborating clinics damage index (SLICC/ACR), were compared between patients in univariate (UN) and multivariate (MV) logistic regression models.

Results: of the 102 patients included in this study, 93.1% were female. The mean age at disease onset was 28 years (SD10) and at diagnosis was 32 years (SD10). The mean disease duration was 9 years. One hundred percent of the patients fulfilled ACR criteria at the time of diagnosis. Disease activity evaluation using SLEDAI and MEX-SLEDAI showed active disease at the time of diagnosis in 100% of the patients by both indexes), at 3 years: 60.7% and 59.8%, 6 years: 35.3% and 37.2% and at 9 years: 19.6% and 16.7% respectively. Medium SLEDAI and MEX-SLEDAI scores at diagnosis were: 10 and 5, and at 3 years: 4 and 2 respectively. The result of the evaluation at 6 and 9 years of follow-up was 0 by both indexes. The UV analysis performed to evaluate associated risk factors to lupus activity showed a significant association only with non-Caucasian ethnicity (O.R. 2.54, CI: 1.06–6.18). Five-hundred and six flare-up episodes were registered in a 732 cumulated years. An incidence of 0.69 flare-up/patient/year was observed. UV analysis and MV logistic regression analysis showed significant association between damage accrual with non- Caucasian ethnicity (O.R. 3.19, CI: 1.23–8.38), a disease of more than 5 years (O.R.: 3.25, CI: 1.09–10.12) and with ≥ 3 flare-up during 1 year (O.R. 3.70, CI: 1.26–10.96).

Conclusion. In this cohort, active disease was present of 100% of the SLE patients at diagnosis but in less than 20% at the end of follow-up. Non-Caucasian ethnicity was the only risk associated with active disease. Damage accrual was significantly associated with non-Caucasian ethnicity, a disease of more than 5 years and 3 or more flare-up in 1 year.

25 Cross-cultural Adaptation and Validation of the Juvenile Arthritis Multidimensional Assessment (JAMAR) in Mexican Mestizo Patients with Juvenile Idiopathic Arthritis. Preliminary Results

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Introduction: Several instruments have been developed to measure functional capacity (FC) and recently, health-related quality of life (HRQL) as an outcome measures for juvenile idiopathic arthritis (JIA), patients in clinical trials. The JAMAR is a multidimensional instrument with the advantage that includes the measurement of FC and HRQL.

Objective. To develop the cross-cultural adaptation process of the JAMAR and to evaluate preliminary evidence of validity in mexican mestizo patients with JIA.

Methods. Project divided in two phases: 1) Cross-cultural adaptation process and 2) Construct validity. The JAMAR includes: Juvenile Arthritis
Posterior synechiae 9 (56.2%), band keratopathy 8 (50%), cataract, five (50%). Eyes with uveitis 29 (90.6%), eyes with complications 16 (55.2%): onset was 3 years, 14 (87.5%) girls and 2 (12.5%) boys. Oligoarthritis 12 (18.8%). Positive ANA in 12 (80%). Treated with biological therapy on 8 (75%), Polyarthritis 4 (25%), Systemic arthritis 0 (0%), Undifferentiated Oligoarthritis: 4.41 odds ratio (confidence interval: 1.24 to 15.75).

Results: The cross-cultural adaptation process of the JAMAR followed the international guidelines published and was applied to a 125 mexican-mestizo parents/patients (65 females) with diagnosis of JIA according with ILAR criteria. With a mean age of diagnosis de 6.5 ± 4.3 and a mean age of disease onset of 6.9 ± 3.4. All parents/patients reported that the JAMAR was easy of understand and to complete in < 10 minutes. The correlation of the different componentes of the JAMAR with the ACR-ped-30 and the Steinbrocker’s functional class was moderate.

Conclusion: In this preliminary study in mexican Mestizo patients the JAMAR showed adequate construct validity. Longitudinal studies should be performed in order to prove evidence of responsiveness.

26 Prevalence of Ocular Manifestations in Patients with Juvenile Idiopathic Arthritis
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Introduction: Juvenile Idiopathic Arthritis (JIA) is a heterogeneous group of chronic inflammatory arthropathies of unknown etiology, affecting children under 16 years of age.

Chronic anterior uveitis is present on 10 to 30% of the patients with JIA. It is common in girls with oligoarthritis and positive antinuclear antibodies (ANAs). It may be developed during the course of the JIA or be the initial manifestation. It is of insidious onset and sometimes asymptomatic with involvement of one or both eyes. The most frequent ocular complications are: cataract, secondary glaucoma, band keratopathy and iris synchia.

Objective: Provide information about the presence of uveitis in the Mexican children with JIA, clinical features, ocular manifestations and complications.

Methods: This was a longitudinal and retrospective study that included patients with diagnosis of JIA of the Pediatric Rheumatology Clinic of the University Hospital “José Eleuterio González” between July 1986 and February 2010. The diagnosis and classification of the disease were made according to the ILAR criteria.

The data was obtained through a retrospective review of clinical files. The ophthalmologic evaluation included: best visual acuity corrected and converted to logMAR, external and slit lamp biomicroscopy examination, IOP measurement (tonometry Goldman and / or Perkins), fundoscopic examination with indirect ophthalmoscope.

We performed a descriptive statistical analysis of the demographic data, the presence of uveitis, complications, serology and treatment. Univariate analysis of variables associated with the development of uveitis and Multivariate analysis with logistic regression system to determine the absolute risk of developing uveitis.

Results: We studied 98 patients, mean age of onset of arthritis was 7.4 years, 71(72.4%) girls and 27 (27.5%) boys, (ratio 2:6:1). Oligoarthritis in 44 (44.9%), Polyarthritis 36 (36.8%), Systemic arthritis 16 (16.4%), Undifferentiated arthritis 2 (1.9%). Positive ANA in 53 (55.8%). Treated with biologic therapy 24 (24.48%). Uveitis in 16 (16.3%), mean age of onset was 3 years, 14 (87.5%) girls and 2 (12.5%) boys. Oligoarthritis 12 (75%), Polyarthritis 4 (25%), Systemic arthritis 0 (0%), Undifferentiated arthritis 0 (0%). Bilateral Uveitis in 13 (81.2%) and unilateral in 3 (18.8%). Positive ANA in 12 (80%). Treated with biological therapy on 8 (50%). Eyes with uveitis 29 (90.6%), eyes with complications 16 (55.2%): posterior synchiae 9 (36.2%), band keratopathy 8 (30%), cataract, five (31.2%), glaucoma 5 (31.2 %). Risk of developing uveitis with Oligoarthritis: 4.41 odds ratio (confidence interval: 1.24 to 15.75).

Conclusion: Chronic anterior uveitis is the most common extraarticular feature of JIA. We recommend an early diagnosis and a multidisciplinary approach, especially in girls with oligo or polyarthritis of early onset and associated with ANA.
if they contribute in the genetic component of SLE in Mexican pediatric population.

Methods: We performed a case control association study in 328 Mexican pediatric SLE, 269 (82%) were female and 59 (18%) were male. As a healthy control group we included 403 gender matched bank blood donors (85% female and 15% male). Determination of CNVs of TLR8 and TLR9 genes were performed by real time PCR using the ∆∆Ct method. Expression levels of TLR8, TLR9 and INF-α were determined in 31 patients. Additionally, to test the activity of INF-α, we stimulated in vitro Wish cells with the serum of patients and determined the expression levels of three genes specifically induced by INF-α: MX1, PKR and IFIT1.

Results: We found a significant increase in the relative TLR8 gene copy number (CN) in pediatric SLE patients compared with controls (P = 0.0065). However, when we stratified by gender, logistic regression analysis showed an association only in the female group (P = 0.0008). Female patients having > 2 copies of TLR8 (3 to 5) showed an OR = 1.66 (95% CI = 1.39–1.98). On the other hand, despite CNVs of TLR9 were found, no significant differences were observed between cases and controls (P = 0.529). TLR8 and TLR9 mRNA levels correlated significantly with TLR8 and TLR9 CN (P = 0.002, r = 0.55; P = 0.0001, r = 0.65, respectively). Nevertheless, only TLR8 expression levels correlated with INF-α expression levels (P = 0.017, r = 0.49) and with the INF-α activity (P = 0.008, r = 0.54).

Conclusion: Our results show that the gene dosage of TLR8 but not of TLR9 is a risk factor for pediatric SLE and suggest that TLR8 may be involved in the pathogenesis of SLE through the induction of INF-α.

29 Novel Ultrasound Scale to Assess the Severity of Knee Osteoarthritis


Objective: To design a valid and reliable ultrasound (US) scale for the assessment of severity in knee OA (OAR).

Methods: We included 104 female patients clinically with OAR. Mean age 60.4 ± 9.0 years. Mean weight 67.1 ± 12.7 kg. Mean height 1.52 ± 0.06 m. BMI 28.8 ± 4.8. Content validity was obtained by an expert rheumatologists’ contest, initial design of the US scale was of 66 items then reduced to 8. Criterion validity was established with the WOMAC scale and construct validity with KL.

Results: US scale of 8 items (bilateral, medial and lateral, femoral and tibial osteophytes) has a score from 0 to 40 according to 0 = no osteophytes, 1 = presence; size: 1 small, 2 medium, 3 large, 4 large; with mild OAR ranges from 0–10, 11–20 moderate OAR, severe OAR 21–30 and 31–40 severe OAR. The scale showed a Cronbach alpha of 0.84 (95% CI 0.79–0.88, p = 0.0001) overall and for both knees. The global score and for each knee (104 right, 102 left) had normal distribution (Kolmogorov-Smirnov Z 1.1, p = 0.14 right, 0.99, p = 0.27 left). The total US scale score of 8 items correlated with knee stiffness (r = 0.190, p = 0.05), knee function (r = 0.281, p = 0.005) and total WOMAC (r = 0.263, p = 0.009), age (r = 0.299, p = 0.003), height (r = 0.252, p = 0.013) and OAR disease duration (r = 0.246, p = 0.02). The US scale discriminated adequately between the degrees of the scale OAR - KL: p = 0.0001.

Conclusion: The US scale proposal meets qualifications for a potential diagnostic test and monitoring tool. It’s advantages are: it is not invasive, quick and simple to perform, inexpensive, reliable, with an adequate convergent validity and predictive, and discriminate an acceptable OAR grades compared to KL, finally it can be obtained an overall score for each knee.

30 Joint and Tendon Subclinical Involvement Suggestive of Gouty Arthritis in Asymptomatic Hyperuricemia: an Ultrasound Controlled Study


Introduction: To investigate characteristic changes seen in gouty arthritis on ultrasonography (US) in the hyaline cartilage, joints and tendons from asymptomatic individuals with hyperuricemia.

Methods: Cross-sectional, controlled study including US examinations of the knees and 1st metatarsal-phalangeal joints (1st MTPJs) as well as tendons and enthesis of the lower limbs. Differences were estimated by chi-square or unpaired t tests as appropriate. Associations were calculated with the Spearman’s correlation coefficient rank test.

Results: Fifty asymptomatic individuals with hyperuricemia and 52 normouricemic subjects were included. Hyperuricemic enhancement of the superficial margin of the cartilage (double contour sign) was found in 25% of the 1st MTPJs from hyperuricemic individuals, in contrast with none in the control group (p=0.001); similar results were found on the femoral cartilage (17% vs 0; p<0.001). Patellar enthesopathy (12% vs 2.9%; p<0.01) and tophi (6% vs 0; p=0.01) as well as Achilles’ entheseopathy (15% vs 1.9%; p=0.0007) were more frequent in hyperuricemic than in normouricemic individuals. Intra-articular tophi were found in 8 hyperuricemic individuals but in none of the normouricemic subjects (p=0.003).

Conclusion: These data demonstrate that morphostructural changes suggestive of gouty arthritis induced by chronic hyperuricemia frequently occur in both intra and extra-articular structures of clinically asymptomatic individuals.

31 Enthesopathy Prevalence in Patients with Established Gout

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Introduction: Ultrasound abnormalities such as periarticular tissue deposits of monosodium urate have been previously described in joints of patients with gout. Enthesal thickening and intra-tendinous hyperchoeic bands with or without acoustic shadowing are indicative of enthesopathy. Calcifications have been found in the quadriceps, patellar and Achilles tendon; but its prevalence is unknown considering these are the most often affected regions.

Objective: To investigate the prevalence of enthesopathy in the lower extremities of patients with established gout.

Methods: Patients of two rheumatology out-patient clinics in México City diagnosed with gout by intraarticular presence of monosodium urate crystals underwent an ultrasound evaluation of their knees and ankles as described in the literature. An Esaote MyLab25 ® ultrasound machine was used with 10–18 MHz probe. Explorer was blinded to the patients’ clinical characteristics (disease duration, affected sites on a recurring basis, treatment and uric acid levels), the images were saved and revised by another rheumatologist sonographer who evaluated the sonographic findings.

Results: Seventy knees and 70 ankles from 35 male patients were examined, mean age 58±14 years; 60% of the group was uric acid overproducers. The mean uric acid level was 6.9±2 mg/dl, with mean disease duration of 7±3 years. None of the individuals had an acute attack of gout during examination. Calcifications in the quadriceps tendon insertion were observed in 29 (41%) of the evaluated knees, as well as, 38 (54%) in the patellar tendon, more frequently found in the distal insertion rather than proximal (33% vs 21%) and predominantly in the left side (30 vs. 24%); and in 15 (21%) Achilles tendon. The calcification pattern most frequently observed was a hyperchoeic band without acoustic shadowing, followed by bands with acoustic shadow and less frequent “stipling”. Correlation was found between the presence of tophus and calcification of the patellar tendon (Spearman correlation r=0.32, p=0.0221), but no correlation between uric acid levels, age, disease time of the duration and the presence of calcifications.

Conclusion: The prevalence of monosodium urate deposits in the entheses of the lower limbs is high, even with borderline uric acid levels. This find-
32 Identification and Characterization of Anti-monomosodium Uurate (MSU) Antibodies in Joint Samples from Patients with Gout

Introduction: The establishment of diagnosis of crystal arthropathies is done by microscopic sinovial fluid analysis and identification of MSU crystals. On the other hand, the immune system involvement in the formation of MSU remains controversial. The nucleation process to the formation of MSU from uric acid and anti-MSU antibodies has been proposed. In murine models has been demonstrated the presence of anti-MSU after being inoculated with uric acid suggesting a T independent response.

Objective: Identify and characterize the anti-MSU in joint samples from patients with gout.

Methods: We analyze 5 joint samples from gout’s patients (3 sinovial fluids (SF) and 2 tophus). The MSU crystals were identified by polarized light microscopy. To obtain the anti-MSU the joint samples were treated with uricasea. The analysis was done by PAGE-SDS, Western blot, dot blot and ELISA. Anti-MSU reactivity was evaluated by ELISA.

Results: We purified proteins extracts from all joints samples (0.55±0.21 vs 3.8±3.7 μg/μl; tophus vs SF respectively). The electrophoresis analysis showed proteins bands with molecular weight similarly to heavy/ligth immunoglobulins chains (MW~58/23 kD). By dot blot we detected IgM in the thopus and IgG/IgM in joint samples of SF. Anti-MSU antibodies and IgM concentration was higher in tophus (1.19±0.26 and 0.92±0.21 OD) vs SF (0.63±0.16 and 0.51±0.1 OD). We observed a dose-response effect in anti-MSU IgM by capture ELISA.

Conclusion: The presence of anti-MSU/IgM antibodies in joint samples from patients with gout favors the theory of nucleation process in the articular synovium of these patients, with subsequent formation of UMS crystals.

33 Analysis of FAS-670 A/G Promoter Polymorphism in the Fas Receptor Gene in Primary Sjögren’s Syndrome
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Introduction: Primary Sjögren’s syndrome (pSS) is a chronic autoimmune disease characterized by progressive lymphocytic infiltration of exocrine glands, mainly the lachrymal and salivary, resulting in reduced secretory functions, and oral and ocular dryness. Apoptosis of their epithelial cells may play a role in the initiation phase and occurs in the effector phase of this disease. Epithelial ductal cells in minor salivary glands have shown an increased expression of Fas death receptor. In the FAS gene promoter has been reported the ~670 A>G single nucleotide polymorphism. It has been proposed that A>G transition affects the receptor expression and therefore could modify the degree of glandular apoptosis, and thus the pathogenesis of pSS.

Objectives: To determine the frequency of FAS-670 A>G polymorphism and its association with soluble Fas levels and clinical manifestations in Mexican pSS patients.

Methods: We performed a cross sectional study that included 82 pSS patients classified according to American-European criteria and 84 healthy subjects (HS). Questionnaire for ocular and oral sicca, and SSSA/SSDDI activity and damage indexes were applied to pSS patients. Genotypes were identified by PCR-RFLP technique using the ScrFI enzyme. Soluble Fas levels were quantified by ELISA technique. Statistical analysis was performed using SPSS v. 17; p<0.05 was considered statistically significant.

Results: The genotype frequency for FAS-670 A>G polymorphism was: in pSS 25% (A/A), 43% (A/G), 32% (G/G) and in HS: 24% (A/A), 50% (A/G), 26% (G/G). The G allele was more frequent in both groups: 53% in pSS patients and 51% in HS. Elevated soluble Fas levels in pSS patients compared to HS was found (p=0.037). Patients with A/A genotype showed the highest levels of sFas (p=0.036 vs G/G genotype), the highest number of lymphocytic infiltrate foci (p=0.008), the least amount of tear evaluated by Schirmer’s test and a higher value for SSDDI index, including increased oral and neurological damage (p=0.0034 vs G allele) than patients who carried G/G or A/G genotypes.

Conclusion: Our findings suggest an association of the A/A genotype of FAS-670 A>G polymorphism with a severe form of the disease in patients with pSS.

34 Time of Presentation of Extraglandular Features Regarding the Glandular Manifestations in Primary Sjögren Syndrome
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Objective: To assess the time of presentation of extraglandular features regarding the onset of glandular manifestations in primary Sjögren syndrome (pSS).

Methods: We retrospectively evaluated 99 patients with pSS and registered the following features: arthritis, Raynaud, vasculitis, adenopathies/splenomegaly, fever (non attributed to infection or malignancy), pulmonary (fibrosis, neumonitis), renal (proteinuria>0.5 g/d, tubular acidosis, interstitial nephritis, GMN), gastroenterological (autoimmune hepatitis or pancreatitis, PBC) and neurological (polyneuropathy, mononeuropathy, cranial pars, desmyelinization, disautonomy) involvement. We defined a concomitant extraglandular feature, when it presented at the same time or during a 6 months period after the onset of the glandular manifestation. We assessed oral and ocular symptoms, parotid enlargement, Schirmer test, NSWFs, fluorescein test, RF, anti-Ro and anti-La antibodies, and the pSS cronicity index. We used descriptive statistics, X², t student, U-Mann Whitney test and LR (with SPSS).

Results: The disease median duration was 8 years (0.25–51). Eighty six patients (86.8%) had at least one extraglandular manifestation [median 2 (1–7)]. Forty patients had a concomitant extraglandular feature (Group 1) and 46 presented it during the follow up (Group 2). The median of extraglandular presentation in Group 2 was 6 years(0.71–23.9). There was no difference among groups regarding gender (97,93%), age at diagnosis(45±6.12±10), oral (92,100%) or ocular symptoms (97,100%), parotid enlargement (62,69%), Schirmer test (86,90%), abnormal NSWFs (80,78%) and fluorescein test(71,67%). There was no difference in the presence of Raynaud(17,22%), vasculitis(10,6%), adenopathies/splenomegalia(52,37%), renal (12,11%) neurological(35,32%), gastroenterological(10,11%) or articular involvement(50,37%), neither in the prevalence of RF (71,73%), anti-Ro (87,82%), anti-La (57,46%) antibodies or in the cronicity index(median 5 [1–12] vs 4 [2–8]). The prevalence of fever (37 vs 9%, p=0,001), pulmonary involvement (30 vs 6%, p=0,004) and the number of extraglandular features (3 [1–5] vs 2 [1–6]), p=0,006 was higher in Group 1. At the LR, the fever (p=0,01) and the pulmonary involve- ment (p=0,03) remained significant.

Conclusion: Fever and pulmonary involvement were more frequent at the onset of the glandular manifestations. The rest of the extraglandular features may present at glandular onset or during the follow up of these patients.

35 Oxidative Stress in Takayasu’s Arteritis
Villarreal Ortega A, Vázquez Zaragoza MA, Camargo-Coronel A, Chávez A, Gallardo J, Barile Fabris L. Hospital de Especialidades CMN SXXI, IMSS

Introduction: Takayasu arteritis (TA) is a granulomatous vasculitis of
unknown etiology and its pathogenesis is poorly understood, it affects the aorta, pulmonary artery and its major branches. The term endothelial dysfunction refers to the loss of bioavailability of nitric oxide (NO). Lipid peroxidation alters the functions of the cell membrane as it is the end product malondialdehyde (MDA) which causes inflammation.

**Objectives:**
1. Demonstrate the presence of MDA and changes in the concentration of NO in patients with AT.
2. To rate the association between MDA NO and AT activity.

**Methods:** Outpatients (px) from the vasculitis clinic at clinical specialties Takayasu’s of Centro Médico Nacional Siglo XXI for the period May to October 2009. They all met the classification criteria of the ACR for AT. The clinical characteristics and disease activity were determined based on the criteria of Kerr of the NIH of the United States, rating them as active and inactive.

The control group consisted of healthy subjects. We determined serum MDA and NO in px and controls. Statistical analysis was performed with T tests with a Rima V4.0 software.

**Results:**
We included 21 px. The average concentrations of MDA were 148.01μM in px and 17.95 μM in controls (p <0.001). The average concentration of NO was 14.28 μM 41.08 μM in px vs controls (p <0.001).

There was no statistically significant difference in active and inactive MDA (MDA 200.1 μM vs 10.8.8 μM and NO 20.4 μM vs 9.6 μM).

**Conclusion:** The high presence of MDA and decreased values of NO in px with AT, indicate inflammation and endothelial dysfunction, respectively, regardless of the degree of disease activity. Based on our results, it is important to determine these markers in a standardized way in a larger population and in various stages of the disease. We believe that these molecules should be measured in px with AT regardless of evolution, because their changes may suggest vasculitis activity.

36 Increasing Age and Sex Specific Rates of Hip Fracture in Mexico. Projections for 2050
Helena Johansson, Patricia Clark, Fernando Carlos, Anders Olden, Eugene McCloskey and John Kanis.

**Introduction:** Hip Fractures account for a large component of the morbidity, mortality and cost of osteoporosis. In 2006 the direct cost for hip fractures in Mexico was estimated to be over 97 million dollars. The aim of the present study was to determine the trends of this type of fractures and to project the estimated number of hip fractures for the year 2050.

**Methods:** With all hip fractures cases in subjects 50 years and over registered at the second and tertiary hospitals from the Mexican Institute of Social Security incidence was estimated. International codes included were: S72.0, S72.1 y S72.2. To compute the number of hip fractures, incidence rates were applied to the population of Mexico for 2005, and for hip fracture projections the expected population up to the year 2050.

**Results:** Between the years 2000 y 2006, the incidence of hip fracture was incremented for men and women in 1% per year (p=0.016 y p=0.001 respectively). In 2005, 29,732 hip fractures were estimated 68% in women. Assuming no change in the age and sex specific incidence of hip fracture, the number of hip fractures was expected to increase markedly with time to 155,874 in 2050. Assuming that the age specific incidence continues, the number of hip fractures in men and women would increase by a further 46% (226,886 hip fractures)

**Conclusion:** Demographic changes in Mexico indicate that the annual number of hip fractures will increase markedly in the following years and up to 46% of increments are expected for the year 2050. This data should alert the Mexican Health authorities and should be used by decision makers in order to allocate resources to develop prevention programs for fragility fractures in our population.

**Posters**
37 Characterization and Prevalence of Anti-CCP in Plasma from Mexican Healthy Donors
García Hernández J.L., Hernández N.*, Hernández Ramírez DF, Olivares Martínez E, Cabral AR, Núñez-Álvarez CA, Cabiedes J.

**Introduction:** Rheumatoid arthritis (RA) is a chronic inflammatory autoimmune disease from multifactorial etiology. Currently is unclear the role of different autoantigens involved in the increased of immune response. Previously, has been described the presence of anti-citrullinated protein antibodies (APCA) and RF in serum of healthy subjects several years before to developing the RA. In addition, the screening of the autoantibodies in plasma of healthy donors is not done and plasma transfusion is not restricted.

**Objective:** Analyze the prevalence and immunochemistry characteristics of anti-CCP in plasma from healthy donors.

**Methods:** We analyzed 315 plasmas from healthy donors against to CCP-IgG (second generation) by ELISA. Samples with higher titers of anti-CCP were tested against to mutated citrullinated vimentin (MCV) and RF-IgM by ELISA. As control group we included serum samples from RA patients (5) and early RA (3) with higher titers of anti-CCP (>500 U/mL)

**Results:**
The mean age of our study group was 33 (8–63 years, 69% male and 31% female). The cut off was established with 90th percentile to 30.9 U/mL. The mean value of anti-CCP antibodies were 9.3±20.6 U/mL with a prevalence of 1.27% (4/315) (anti-CCPs: s1: 32.1, s2: 338.2, s3: 153.7 and s4: 52.2 U/mL). Only 25% (3/4) showed reactivity against to MCV vs 100% observed in the AR patients, in addition, the RF activity were absent in plasma from healthy donors.

**Conclusion:** In this study we found a seroprevalence of 1.3% to CCP (second generation) and is similar to other reports. The APCA reactivity identified in these healthy donors is different to APCA reactivity identified in RA patients, so it is likely to have different immunological characteristics in comparison with autoantibodies detected in AR patients.

38 Disease Remission, Normalized Physical Function and Radiographic Non-progression Are Achieved by the Majority of Patients with Early Rheumatoid Arthritis (RA) Treated with Abatacept (ABA) + Methotrexate (MTX): Results from the 2-year Agree Trial
R. Westhoven, P. Durez, H. Genant, M. Robles, J. C. Becker, A. Covucci, J. Bathon

**Introduction:** Rheumatoid arthritis (RA) is a chronic inflammatory autoimmune disease from multifactorial etiology. Currently is unclear the role of different autoantigens involved in the increased of immune response. Previously, has been described the presence of anti-citrullinated protein antibodies (APCA) and RF in serum of healthy subjects several years before to developing the RA. In addition, the screening of the autoantibodies in plasma of healthy donors is not done and plasma transfusion is not restricted.

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sion at Yr 2. The rate of HAQ-DI normalization was maintained over 2 yrs for the T1, with 49.1 and 54.7% at Yrs 1 and 2; rates for the T2 were 35.6% at Yr 1 and 47.6% at Yr 2 after addition of ABA. Patients randomized to T1 had significantly less structural damage progression in Yr 2 than in Yr 1 (mean change in TS: 0.65 from baseline to Yr 1 vs 0.18 from Yr 1–2; p<0.001). For patients randomized to T2, mean change in TS was 1.48 from baseline to Yr 1 vs 0.25 from Yr 1–2; p<0.001. Mean changes from baseline to Yr 2 was significantly lower for the original T1 vs those who switched at Yr 1; 0.84 vs 1.75, p=0.001. The rate of non-progression over 2 yrs was 56.8% in the T1 vs 43.8% in the T2; 91.1% of patients randomized to T1 who were non-progressors at Yr 1 remained non-progressors at Yr 2. Adverse events, including serious infections, malignancies and autoimmune events, during Yr 2 were consistent with those reported in Yr 1.

Conclusion: Early introduction of T1 results in greater sustainable clinical and radiographic benefits and normalization of function in the majority of MTX-naïve early RA patients vs T2, supporting the use of T1 earlier in disease.

39 Validation of the Spanish Translation of the Conchin Hand Function Scale in Patients with Rheumatoid Arthritis (RA)

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Introduction: RA is a systemic disease, but its greatest effect occurs in the hands. Despite this fact, the most of scales evaluate the disease in global form without instruments designed to assess the level of rheumatoid hand functional handicap. The CFHS is a scale designed for that purpose with its original version elaborated in French and then in English, for which it is pertinent to validate in Spanish.

Objective: Validate the Spanish version of the CHFS scale in patients with RA.

Methods: The study was performed in two phases. The first phase consisted of an initial translation carried out by two bilingual individuals whose native language is Spanish, followed by a retro-translation by two bilingual individuals whose native language is English. The final version was applied to a pilot group of 20 patients with RA to evaluate the cross-cultural equivalence. The second phase consisted of the validation of the scale, for which all patients with RA treated at BIÓCEM between June and December of 2009 were included. Patients were also evaluated by a rheumatologist to determine the level of disease activity through the application of the Visual Analogue Scale (VAS) for pain, VAS of disease activity by the subject and by the physician, VAS of the global disease severity, Health Assessment Questionnaire (HAQ), painful and inflamed joint count (DAS-28). Finally a blood sample was drawn to test high sensitive C reactive protein (HS-CRP) and erythrocytosedimentation (ESR).

Statistical analysis: Using values obtained in HAQ, RCP, HS-CRP and ESR as a point of reference, internal consistency was estimated with Cronbach’s α Reliability test; convergent validity and equivalent validity were evaluated using Spearman’s rank correlation coefficient. Group validity or discriminant validity using an ANOVA test, for which patients were stratified into four groups according to level of disease activity. Intrasubject variability was quantified by the intraclass coefficient (ICC) of 95%. Significant two-tail p-value was established at p<0.05.

Results: We included 130 patients with RA, 124 women (95%) with an average age (±SD) of 45.4 ± 13.2 years, with RA duration of 6.0 ± 6.0 years. At the time of evaluation, the majority of the patients were receiving Methotrexate (83.8%), steroids (63.8%), and biological therapy (20.8%). The final score of the CHFS was 21.9 ± 22.0 points. Internal consistency valued at 0.970 and we found a high correlation with other similar scales like the HAQ (r=0.884, p<0.0001) and DAS-28/RCP (r=0.532, p<0.0001). Comparison of the four different disease activity groups demonstrated a statistically significant difference (p=0.007). The intrasubject variability had a 95% ICC value of 0.876 (p<0.0001).

Conclusion: The Spanish version of the CHFS scale is useful in evaluating the level of functional disability of the rheumatoid hand for Spanish-speaking patients with RA.

40 Gout in Women. Variable Clinical Presentation According to Age and Disease Duration


Introduction: Gout typically occurs in post-menopausal women associated with hypertension, diuretics and chronic renal failure (CRF). In most previous reports, women with gout are older than men.

Objective: To describe the clinical characteristics of women VS men with gout, matched by age and disease duration.

Methods: Case-control study of consecutive patients with diagnosis of gout in the last 10 years. Cases: Women with this diagnosis, for each case we included one male control matched by age ±5 years and disease duration ±3 years. Variables: Demographic, clinical and paraclinical. ATP III and ADA definitions for metabolic syndrome and diabetes mellitus. The glomerular filtration rate (GFR) was determined by 3 methods: urine creatinine clearance in 24 hours (CrC), MDRD and Cockcroft-Gault. CrF: GFR <60 mL/min. Statistical analysis: t test and x2.

Results: We included 23 women and 38 men with gout. The current age and age at onset were similar (59.6 ±12.5 VS 61.3 ±15.4 years and 44.2 ±17.8 VS 46.0 ±13.1 respectively) as well as the duration of disease (14.8 ±12.5 VS 15.5 ±7.7 years). Eighty (30%) women had ≤40 years at the onset of the disease, all were pre-menopausal and none had a family history of gout. The comparison of the main results between women (n=23) VS men (n=38) with gout are: Uric acid (mg/dL, X/DE) 4.6/2.7 VS 7.2/1.8, p=0.18; urea (mg/dL, X/DE) 46.4/19.1 VS 38.4/19.9, p=0.14; creatinine (mg/dL, X/DE) 1.10/0.5 VS 1.20/0.5, p=0.86; abdominal circumference (cm, X/DE) 97.7/13.2 VS 103.4/11.8, p=0.18; obesity, (%) 17 (73) VS 14 (36.8), p=0.15; hypertension (%) 16 (69.6) VS 18 (47.4), p=0.11; diabetes or hyperglycemia (%) 4 (17.4) VS 8 (21.1), p=1.00; hypertriglyceridemia (%) 8 (34.8) VS 19 (50.0), p=0.29; CRF (%) 9 (39.1) VS 12 (31.6), p=0.58; lithiasis (%) 1 (4.3) VS 0, p=0.19; CrC (mL/min, X/DE) 42.7/23.1 VS 65.6/25.5, p=0.00; MDRD (mL/min, X/DE) 63.8/30.9 VS 74.9/24.8, p=0.20 and Cockcroft-Gault (mL/min, X/DE) 63.3/38.9 VS 73.1/24.8, p=0.13.

Conclusion: One third of women with gout started before 40 years and had no family history. Although arterial hypertension, metabolic abnormalities, the use of diuretics and CRF tend to be more common in women VS men with gout, they are not significant when controlling for age, duration of disease and when gender is considered for the determination of renal function.

41 Preliminary Identification of Rheumatoid Arthritis Biomarkers by Means of Proteomics

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Introduction: A major need in current medical practice is the availability of biomarkers that could allow us to distinguish among disease states, as well as predictors of therapeutic response. There is no useful means to identify rheumatoid arthritis (RA) patients more likely to respond to a given therapeutic agent. Presently available RA biomarkers, such as C reactive protein (CRP), anti-citrullinated peptide antibodies (anti-CCP) and the DRB1 shared epitope (SE) are useful to assess disease activity (CRP) or severe disease (SE), but are of little use for therapeutic decisions.

Objectives: To identify new cellular biomarkers in RA patients by means of proteomics.

Methods: Patients with RA (ACR criteria) classified as active or inactive (DAS28) not receiving biologic, cytotoxic or DMARD agents, except for methotrexate and chloroquine. Patients receiving corticosteroids >5
mg/day prednisone or equivalent were excluded. A sample of peripheral blood was collected and mononuclear cells were isolated by ficoll-hypaque gradients, lysed and protein extracts were differentially labelled with Cy2, Cy3 or Cy5 fluorochromes. Pools of samples comparing patients vs. matched healthy controls were run in 2D gels and proteins were visualised by means of differential gel electrophoresis (DIGE, GE healthcare). Images were captured in a typhoon apparatus and analysed by the DeCyder software to identify quantitative and qualitative differences.

**Results:** Of >1000 protein bands identified by DIGE, there were at least 16 that were clearly differentially expressed between RA patients and healthy individuals. Of these, four were under-expressed and 12 over-expressed in RA. We are currently extending the observation to compare active vs. inactive RA and either group vs. healthy controls. Individual bands (candidate biomarkers) are being identified by means of MALDI-TOF-TOF mass spectrometry.

**Conclusion:** Peripheral lymphoid cells of RA patients appear to have a reproducible pattern of expression of several intracellular proteins, which differs from that of healthy individuals.

### 42

**Effect of Clinical and Sociodemographic Factors on Drug Treatment Adherence in Rheumatoid Arthritis**

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**Introduction:** Treatment adherence has been identified as a prognostic factor for life and function in rheumatoid arthritis (RA). Sociodemographic and clinical variables, some of them modifiable, have been associated to the level of treatment adherence in RA. However, those issues remain relatively unexplored in RA Mexican patients.

**Objective:** To assess the level of pharmacological treatment adherence, besides its the level of association with some sociodemographic and clinical variables in Mexicans patients with RA.

**Methods:** A cross-sectional study was carried out in RA patients (ACR 1987). The level of drug treatment adherence was assessed by two methods: the average of concordance (AC) between the treating physician prescription and the real drug treatment received by the patient; and the Green-Morinski-Levine test (GMLT). Sociodemographic: age, gender, marital status, family income, educative level, family function (FACES III and family APGAR); and clinical variables: disease duration, received daily pill count, comorbidity, HAQ-DI, DAS-28 and use of complementary/alternative medicine were also collected.

**Results:** One hundred and twenty five patients (age: 47.9±12.1 years old; disease duration: 10.3±8.4 years; female:116) RA patients were included. The level of adherence was fair: by AC: 74±27% (range 0–100); by GMLT: 6.7±1.2 (range 2–10). No correlation was found between both methods used for drug treatment adherence assessment: r = 0.11 (p = 0.21). Having a comorbidity (yes: 69±27%; no: 83±23%; p = 0.004), and older age (r = −0.23; p = 0.01) associated to higher adherence assessed by AC. After multiple linear regression adjustment, only having a comorbidity retained its statistical significance (p = 0.02). Drug treatment adherence assessed by GMLT was only associated to the number on swollen joints (r=0.19; p = 0.03).

**Conclusion:** The level of drug treatment adherence in RA Mexican patients was just fair. The assessment of drug treatment adherence by AC seems to be better than those done by GMLT. The presence of comorbidity seems to negatively affect the level of drug treatment adherence in RA Mexican patients.

### 43

**Comparative Study of DAS28 Modified in a Cohort of Early Rheumatoid Arthritis**


**Introduction:** The evaluation of the activity of rheumatoid arthritis (RA) is critical for a treatment decisions and to establish the prognosis of the disease. Currently we have various measuring instruments, among: the index of disease activity (DAS28), the simplified index of activity (SDAI) and the rate of clinical disease activity (CDAI), which does not include PCR for measurement. However, all measures of disease activity have some limitations. In some health services and epidemiological research, there is no acute phase reactants (ESR and/or CRP) limiting the inclusion of patients in studies, and evaluate the patient in a global matter. Recently at the University of Massachusetts, USA developed and validated the DaS28 modified replacing ESR and/or CRP for measurement.

**Objective:** To compare the mDAS28 and DAS28 and in our population to see if it can be applied.

**Methods:** The study was conducted in Early Arthritis Cohort (CAT) of the Hospital Universitario “Dr. José Eleuterio González” with 38 patients 35 women and 3 men, average age of 43 years, with an average evolution of the disease of 8.5 months, in whom we analyzed and compared DAS28 and mDAS28 at 3, 6 and 9 months, the average after 3 months DAS28 was 4.83 and mDAS28 was 4.58, at 6 months 4.25 and 3.99 respectively, to 9 months 3.65 and 3.23. The average of mDAS28 was 4.10 and of DAS28 was 4.39 with p = 0.24 without significant difference between the two measures.

**Conclusion:** The mDaS28 is a tool that can be used when not there are no reactants of acute phase.

### 44

**Latinamerican Survey on the Use of Glucocorticoids in Rheumatoid Arthritis. Patients’ and Rheumatologists’ Perspective**


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**Introduction:** Corticosteroids are frequently used in RA patients. Patients’ and clinicians’ perspectives on such important medication are relevant.

**Objectives:** To know a) the opinion on corticosteroid use described by patients and rheumatologists, b) the most commonly cited side-effects, c) the agreement with the EULAR recommendations on glucocorticoid therapy (1) and d) the comparison with a recently published European survey (2).

**Methods:** The instrument: was translated by a bilingual rheumatologist, expert in questionnaire development. It has demographic data, positive and negative feelings, list of 37 side effects, EULAR recommendations to be rated in a 0–10 scale. Respondents: Rheumatologists from 11 countries. They were asked to identify 5–10 rheumatologists and up to 30 RA patients on steroids to fill out the questionnaires. Information was sent to a coordinator center. Statistical analysis: Descriptive statistics.

**Results:** Results from 142 rheumatologists and 349 RA patients are presented as mean/SD. Rheumatologists had 139 years of experience. Low dose oral prednisone (< 10 mg/day) was the most frequently used (83%). Patients were mainly female (84%), 50/14 years of age and a mean time on steroids 65/84 months. Positive aspects: Clinicians mentioned the anti-inflammatory effect (34%) and fast action (31%) while patients described improvement in pain and inflammation (65%). Negative aspects: Clinicians rated side effects (76%) and difficulty to stop steroids (13%) as the most relevant and patients described weight gain (18%) and Cushing’s face (9%). Side effects: Lists from patients and rheumatologists of the 10 most commonly described side effects were compared. Only one item was in both lists (weight gain). Clinicians rated Diabetes/glucose intolerance (18%) and osteoporosis (17%) while patients described weight gain (15%).
mood changes (9%) and hearing loss (7%). Level of agreement with EULAR recommendations: Rheumatologists rated high (>8) most recommendations except for the use of glucocorticoid card (7.8/2.6) and safety in pregnancy (6.8/2.8) and patients rated low the item on safety in pregnancy (5.4/4.4). Comparison with EULAR survey: data from Latinamerican rheumatologists were quite similar to the European survey.

Conclusion: Corticosteroid use in RA patients is very common in Latinamerica. Clinicians and patients value its efficacy but share concerns on side effects. Educational opportunities have been identified in our region.

45 Time Elapsed Between the Beginning of Symptomatology and Diagnosis of Rheumatoid Arthritis in the “Dr. José Eleuterio González” University Hospital

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Introduction: Rheumatoid Arthritis (RA) is a chronic inflammatory disease, which can cause physical handicap. Previous studies had estimated that the delay in diagnosing RA, ranges from 1 month to 10 years.

Objective: To evaluate the impact between the time elapsed from the beginning of symptomatology to the diagnosis of RA, and the relationship between the medical profile of the first contact physician and the treatment given to patients diagnosed with RA in a university hospital.

Methods: This is a retrospective, observational study. One-hundred seven-teen consecutive patients attending clinics at the division of Rheumatology in our hospital were included. Inclusion criteria were fulfilling the 1987 American College of Rheumatology criteria of RA. A face-to-face and telephone interview was made to the subjects gathering the following data: time of the beginning of the symptomatology, date of RA diagnosis, number and medical profile of the personnel who took part with any therapeutic scheme related to RA and previous medical prescription to diagnosis.

Results: From 117 patients, 90.6% were women with an average age of 49.11 years and 9.4% were men, with an average age of 43.77 years. The difference in years between the beginning of the symptomatology and diagnosis was 2.22 years (SD ± 4.89). The average age of RA diagnosis was 40.84 years (SD ± 13.12). In 87.2% of patients, the first contact physician was a general practitioner, followed by a 17.1% of specialists (Family doctor, Internist, General surgeon and Orthopedist) and in 16.2% subspecialists (Dermatologist, Allergist and Immunologist). 89.7% of the patients were treated with NSAIDs, 31.6% with glucocorticoids and 5.1% with alternative medicine.

Conclusion: It is necessary to educate the first contact physicians so they can refer highly suspected patients of being diagnosed of RA to a third level of hospital attention, because diagnosis and the early treatment implementation allow to limit the articular damage and the functional handicap.

46 Pulmonary Function Test: Its Correlation with Pulmonary High Resolution Computed Tomography in Patients with Rheumatoid Arthritis

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Introduction: Rheumatoid Arthritis (RA) is a chronic inflammatory disease, which can cause physical handicap. Previous studies had estimated that the delay in diagnosing RA, ranges from 1 month to 10 years.

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Conclusion: It is necessary to educate the first contact physicians so they can refer highly suspected patients of being diagnosed of RA to a third level of hospital attention, because diagnosis and the early treatment implementation allow to limit the articular damage and the functional handicap.

47 Factors Associated with Vertebral Fractures in Mexican Patients with Ankylosing Spondylitis


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Introduction: The rate of vertebral fractures in ankylosing spondylitis (AS) varies from 4 to 18%, although, recent information suggest that prevalence could be higher. Nevertheless, there is lack of studies evaluating the variables related with this complication.

Objective: To evaluate the factors associated to vertebral fractures in AS.

Methods: Cross-sectional study. Ninety-two patients with AS from a secondary-care hospital were evaluated. The assessment includes: a) Epidemiologic risk factors for osteoporosis and fractures, b) clinical variables of the disease, c) clinimetrics. The identification of vertebral fractures was made using morphometry with the Genant’s method by DXA. A multivariate logistic regression was used in order to compute adjusted odds ratios and 95% confidence intervals for factors that were significant at the univariate analysis.

Results: Vertebral fractures were observed in 32 patients (34.8%). On analysis univariate, the presence >2 fractures was associated with osteoporosis by DXA (p<0.04); body mass index (BMI) <30 (p<0.01); longer disease duration (p<0.01), occipit to wall distance >15 cm (p<0.003), tragus to wall distance >15 cm (p<0.001), tip of the finger to floor distance >20 cm (p<0.001). In adjusted analysis, the associated factors that remain associated with vertebral fracture were tragus to wall distance (OR 1.2 95% CI 1.1–1.4, p= 0.002) and tip of finger to floor distance (OR 1.05 95% CI 1.003–1.1, p= 0.04).

Conclusion: Clinics measures as tragus to wall distance and occipit to wall distance were associated with vertebral fractures defining a possible high risk subgroup. Longitudinal studies are required to investigate incidence for new fractures in groups with different levels of risk in patients with AS.

48 Fibrocartilage Sonographic Alterations in Knee Patients with Gout.

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Introduction: Ultrasound has proven useful to discriminate between the deposit of monosodium urate crystals and calcium pyrophosphate dehydrate (CPP) distribution in different tissues. It has been observed condylar fibrocortilage calcification in patients with chondrocalcinosis that are not visible by conventional radiography. One recent study had not found meniscal calcification in knees of patients with gout, only in CPP, disease.

Objective: To investigate whether there is involvement of knee menisci in patients with gout.

Methods: We evaluated patients with gout diagnosed by the presence of intra-articular monosodium urate crystals, which were treated in Rheumatology of two centers. The knees of all patients were examined with ultrasound in a standardized way (medial and lateral transverse scan with patient in supine position with the knee in neutral extended in order to evaluate the external portion of the menisci). We used an ultrasound probe Esote MyLab 25 with 7.5 to 12 mHz. The images were taken by a scanner and then reviewed by other rheumatologist sonographer. A questionnaire was used to determine the age, gender, duration of the disease and uric acid levels.

Results: We explored 70 knees of 35 patients, men with mean age 58 ±14 years. The mean uric acid level was 6.9 ±2 mg / dl, with a mean disease evolution of 7 ±3 years. Calcification of medial meniscus was observed in 19 (27%) and in lateral meniscus in 5 (7%) of the knees. Some calcifications were observed in the periphery of the meniscus, like a “V”, a different pattern to that observed in pseudogout. There was significant correlation between the presence of calcification of the medial meniscus with the presence of tophi using Spearman’s correlation (r = 0.641, p = 0.0002, CI 95%).

Conclusion: These observations suggest that monosodium urate crystal are deposited on surface of fibrocortilage of knee. Further studies will require to evaluate these findings. Leer fonéticamente

49 Prevalence of Musculoskeletal Disorders in Sinaloa State (Mexico) Using COPCORD Methodology

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Introduction: In various regions of Mexico have done studies to determine the prevalence of musculoskeletal disorders (ME), using the questionnaire COPCORD because statistics are scarce in our country.

Objective: Establish the prevalence of pathology ME and rheumatic in rural and urban environment in Sinaloa State, on the use of the questionnaire COPCORD because statistics are scarce in our country.

Method: Study descriptive, transversal, analytical, CBO, with mixed sampling, multistage, without replacement, which is applied a household questionnaire to subjects > 18 years of age, with trained interviewers, choosing those with a positive questionnaire (non-traumatic pain) during the last 7 days, for diagnostic confirmation by a rheumatologist and general physician titration certificate.

Results: Analyzed 4879 questionnaires; 2814 (57.58%) were women; the average age of respondents subjects was 41.7 ± 16.5. The 4.77% were illiterate, 25% reached preparatory and 22.1% undergraduate studies. The 39.06% perceived < $2,598.00 monthly income and the 48.53% reported maximum monthly income of $5,196.00. The 9.53% agreed to have pain ME in the 7 days prior to the interview, when it was excluded trauma prevalence was 8.36%; history of pain ME 10.67% (521); pain at the time of the evaluation EVA averaged 6.3 ± 2.3; regarding limitation 8.3% (64) noted it at the time of the application, 15.25% (117) in the past and 76.40% (586) said to have never been limited; 530 (10.86%) using any medications for pain; 82% prescribed by physician. 559 (1145%) subjects presented some disorder ME or rheumatic, identified diagnoses were: Osteoarthritis 23.61%, rheumatoid arthritis, 14.3%, anklyosing spondylitis 6.97, 9.8 appendicular regional pain syndromes %, upset ME 13.05%; osteoporosis 3%, LES 0.35%, gout and Fibromyalgia 0.53%.

Conclusion: The prevalence of musculoskeletal ailments and rheumatic in Sinaloa State was the 11.84%. Intends to bring together the results of this population base in North, Central and southern regions for statistical actual prevalent in our country.

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50 Parvovirus B19 Associated Arthritis: Report on a Community Outbreak

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Introduction: A frequent cause of viral arthritis in adults is parvovirus B19 infection (P-B19). It is usually polyarticular, symmetrical, with an acute onset and is localized in hands, wrists, knees and ankles. Arthritis lasts for 1 to 3 weeks and is self-limited; it presents predominantly in adults and in contrast to the pediatric population, cutaneous rash is usually not associated. Diagnosis is made through detection of anti-parvovirus B19 antibodies of the IgM subclass as well as detection of its DNA in patient’s serum.

Objective: To report an outbreak of parvovirus B19 arthritis in the community near our hospital.

Methods: We performed a retrospective record review of 5 patients with the diagnosis of parvovirus B19 arthritis confirmed by positive serologic testing.

Results: Five patients presented parvovirus B19 arthritis from April to June 2010. All of them were females between 37 and 45 years old with an average of 42.2 years. Arthritis lasted between 2 and 6 weeks with an average of 23 days. Joints were affected symmetrically with a predominance of hands, an average of 19 joints were affected. Four patients presented with rash. Diagnosis was confirmed in all patients by means of a positive serology anti parvovirus B19 IgM. Complete blood count, rheumatoid factor and anti-CCP antibodies were requested according to the treating physician criteria with varying results. All patients were treated with NSAIDs with an adequate resolution of symptoms except for one of them who required low-dose steroids with an excellent therapeutic response.

Conclusion: We present an outbreak of 5 confirmed cases of parovirus B19 arthritis. All patients presented between April and June 2010 and all were native of Huixquilucan, Estado de México. The course was favorable in general, although in one patient conservative treatment with NSAIDs failed, but responded to treatment with steroids without prolonging viral infection. Epidemiological data corresponds with previous reports in the literature, except that four of our patients presented with rash.

51 Should We Measure Long Term Morbidity in Juvenile Idiopathic Arthritis (JIA) in Terms of Functional Disability?. Comparison Between the Traditional Measure of Functional Status and a Valid Measure of Damage


Introduction: Long-term morbidity in JIA should be assessed by a damage instrument aimed to evaluate irreversible components of the disease instead of the current measurement of functional disability, which is highly influenced by reversible factors.

Objective: To compare the measurement obtained by an instrument of functional status with those obtained with a valid damage tool in the assessment of long term morbidity in children with JIA.

Methods: Cross sectional study of patients with JIA according with ILAR criteria. Functional status evaluated by the Childhood Health Assessment Questionnaire (CHAQ) and damage assessed with the Juvenile Arthritis Damage index (JADI) (composed of 2 parts that measures articular (JADI-A) and extra-articular damage (JAD-E)); were correlated
(Spearman’s Rho) with several measures of active disease and disease damage such as the number of joints with limited range of motion, Poznanski radiological index, Steinbrocker’s functional class and two VAS for the evaluation of disease damage by the attending physician and the parents.

**Results:** A total of 125 Mexican-mestizo patients (65 females) were included with JIA according to LAR, with a mean age at diagnosis of 6.5 ± 4.3 years and a mean disease duration of 6.9 ± 3.4. The correlations obtained for the JADI-A for measures of disease damage were higher than those obtained for the CHAQ including the number of joints with limited range of motion (0.60 vs 0.49); the Poznanski radiological index (–0.47 vs –0.17); the Steinbrocker’s functional class (0.54 vs 0.45); the VAS of disease damage by the attending physician (0.60 vs 0.55) respectively.

**Conclusion:** The functional status measured with the CHAQ correlate fairly to moderate with several measures of disease damage; however the correlation obtained with the JADI was higher. Long term morbidity in JIA patients should be evaluated measuring damage with valid tools such as the JADI, instead of the traditional measurement of functional disability with the CHAQ.

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**–383 Tumour Necrosis Factor Receptor 1 (TNFR1) Polymorphism and Bone Mineral Density in Ankylosing Spondylitis**

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**Introduction:** To date a limited number studies have evaluated the possible association of the tumour necrosis factor receptor 1 (TNFR1) polymorphisms on the pathogenesis of specific manifestations in ankylosing spondylitis (AS).

**Objective:** To evaluate if –383 A/C TNFR1 polymorphism is associated to low bone mineral density (LBD) in AS.

**Methods:** Patients with AS from a secondary care hospital in Guadalajara, Mexico were included in the study. The assessment included: a) antecedents of epidemiological and clinical factors associated with LBD and osteoporosis, b) clinimetrics. All the patients were evaluated by DXA at lumbar spine and femoral neck. Patients were labeled according to the DXA results in: a) group of LBD and b) group of normal bone density. The –383 A/C TNFR1 polymorphisms were genotyped using PCR-RFLP. A comparison in allele and genotype frequencies was performed, and odds ratios (OR) and 95% confidence intervals were computed.

**Results:** From 38 patients assessed, 58% had LBD and 42% normal bone density. The genotype frequencies of –383 TNFR1 polymorphism were distributed as follows: In the group of LBD: AA genotype 90.9%, genotype AC 9.1% and CC was not observed. In the group of normal bone density: genotype AA 93.8%, AC 6.2% whereas, the genotype CC was not observed. Being AC genotype considered as risk factor for LBD there was no significant differences in the genotype frequencies (OR=1.5, 95%CI 0.90–46.33, p=0.6).Neither in the comparison of allele frequencies C allele was not observed associated with higher risk of LBD (OR=1.48, 95%CI 1.04–43.19).

**Conclusion:** This study shows no association of the –383 TNFR1 polymorphisms with the presence of LBD in AS patients. Further studies with other polymorphism are required in order to determine their influence on the LBD in these patients.

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**Anti-mutated Citrullinated Vimentin Antibodies (Anti-mcv) and Anti-cyclic Citrullinated Peptide Antibodies (ANTI-CCP): Association with Disease Activity Measures in Rheumatoid Arthritis**

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**Introduction:** Some auto-antibodies in rheumatoid arthritis (RA), are associated with poor prognosis. Further information is required regarding to the role of the anti-cyclic citrullinated peptide antibodies (anti-CCP) and anti-mutated citrullinated vimentin antibodies (anti-MCV), as biomarkers for disease activity and functional impairment in RA.

**Objectives:** To identify if there is a correlation between titers of antibodies anti-MCV and anti-CCP with clinical parameters disease activity in RA.

**Methods:** Study design: cross-sectional. Study development: Patients with RA (ACR 1987) were included. Assessments: Clinical characteristics of the disease at the time of the study, DAS-28 score, morning stiffness and perception of disease activity (visual analogue scale 0–100mm), HAQ-DI, CR-Reactive Protein (CRP). Serum titers of anti-MCV and anti-CCP were assessed by ELISA and rheumatoid factor by nephelometry.

**Results:** From 57 patients included 50 (88%) were females, the mean disease duration was 3 years (range 1 to 30 years). The prevalence of the autoantibodies was RF 63%, anti-CCP 74%, and anti-MCV 75%. There was a significant correlation between the titers of anti-MCV and the titers of anti-CCP (rho=0.86, p<0.001). Titers of anti-CCP and anti-MCV did not show significant correlation with DAS-28, severity of the disease, morning stiffness, CRP levels and HAQ-DI score.

**Conclusion:** In this study, the titers of anti-CCP and anti-MCV antibodies did not correlate well with disease activity measures. Nevertheless, a limitation is the cross-sectional design, therefore, prospective cohort studies are required in order to establish if an increase in their titers increase the risk for other outcomes. Grant IMSS: Project number FIS/IMSS/PROT/502

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**Spine Fractures in Patients with Ankylosing Spinal and Functional Disability**


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**Objective:** To evaluate the association between osteoporotic spine fractures and functional disability in patients with ankylosing spondylitis.

**Methods:** In a cross-sectional study, were included for evaluation 72 patients with AS (New York 1984) and compared with 59 controls matched by age and gender. For patients with AS the assessment included: BASDAI, BASFI, HAQ-S, spine mobility and other clinical characteristics. Both groups were evaluated with bone mineral density using DXA at lumbar spine, femoral neck and forearm. In order to identify spine fractures vertebral morphometry was performed by DXA using lateral spine views. Using the Genant’s method only fractures grade II or III were considered as “positive” for this study.

**Results:** Presence of at least one or more osteoporotic vertebral fractures was identified in 21/72 (29%) AS patients, and in none of the controls (p = 0.001). Low bone density LBD (T-score lower –1.5 SD) was observed in the following order: spine in 20 (28%), hip in 21 (29%), and forearm 19 (26%). Osteoporosis (T-score lower –2.5 SD) was observed only in 7 (10%) in AS vs. 1 (2%) in controls (p = 0.05). The group of AS with vertebral fractures in comparison with AS without fractures had a significant increase in Poor Prognosis. Further information is required regarding to the role of the anti-cyclic citrullinated peptide antibodies (anti-CCP) and anti-mutated citrullinated vimentin antibodies (anti-MCV), as biomarkers for disease activity and functional impairment in RA.
body mass index (median 29 vs. 26 respectively, p=0.02), increase in disability (76% vs. 48% respectively, p=0.03), lower spinal mobility (Schober 2.5 vs. 4 centimeters respectively, p=0.04). Fractures were not associated with differences in the BASDAI score.

Conclusion: This study observed a high prevalence of vertebral osteoporotic fractures in AS. These fractures are associated with higher scores for disability in the HAQ-S index and decrease in spinal mobility. Patients with AS should be assessed for this complication in order to provide opportune treatments with the aim of improving the impact of vertebral fractures on the decreasing of functioning and quality of life.

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Fifteen-year Trends of Long-term Disability and Sick Leaves in Ankylosing Spondylitis

Objective: To assess trends in work disability and sick leave in ankylosing spondylitis (AS).

Methods: In 1993 and 2007, patients diagnosed with AS that attended secondary- or tertiary-care outpatient rheumatology clinics were evaluated for demographics, disease characteristics, axial mobility, working status, and work days missed due to sick leave or permanent disability. Factors that impacted labor status were identified by multiple regression analysis.

Results: In 1993, 91 study individuals (mean age 35, mean disease duration 10±8 years) included 28 (31%) on permanent disability and 63 currently working; of these 63, 42 (66%) had missed at least 1 work day in the previous 12 months (mean 69±63 days). In the next 5 years, the annual permanent disability was 3%. In 2007, 185 study individuals (mean age 42, mean disease duration 12±10 years) included 53 (39%) on permanent disability and 132 active workers: 35 (66%) out of 53 began permanent disability and 132 active workers; 35 (66%) out of 132 active workers missed at least 1 work day in the previous 12 months (mean 52±63 days).

Only age predicted disability, with 10% and 11% increases in risk per year in 1993 and 2007, respectively (hazard ratios 1.09 and 1.11, respectively; p=0.03 for both).

Conclusion: Although the impact of AS on work seems to decrease slightly during the last fifteen years, the actual impact is still substantial. An important proportion of patients went on permanent disability in the 3 decades before retirement. Extrapolating these results to official data for the year 2005 we may infer that between 1.3 million and nearly 15 million working days were missed that year due to AS.

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Prevalence of Metabolic Syndrome in Mexican Systemic Sclerosis Patients
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Introduction: Metabolic syndrome (MS) is a group of risk factors that include derangements of the metabolism of glucose (diabetes mellitus, altered fasting blood sugar and hyperinsulinemia) dyslipidemia, central obesity, arterial hypertension and endothelial dysfunction, among others, which lead to a higher risk of cardiovascular disease. From the pathophysiological point of view it is associated to insulin resistance (IR). The prevalence of MS according to the World Organization (WHO) criteria in the Mexican population is 13% and it has been little studied in systemic sclerosis (SSc).

Objective: To determine the prevalence of metabolic syndrome in Mexican systemic sclerosis patients.

Methods: Fifty five patients with SSc (32 limited and 23 diffuse) with mean age 52±12.9 years were studied. The prevalence of MS according to the WHO criteria was investigated. Demographic and anthropometric data were registered. Blood pressure was taken. The following laboratory tests were performed: blood glucose, total cholesterol, high density cholesterol triglycerides and serum insulin to calculate HOMA; 24 hour urine protein was measured, and in patients with normal fasting blood sugar, a glucose tolerance test was done to identify glucose intolerance and diabetes mellitus.

Results: The prevalence of MS was 36.4%. There was no difference as to gender or type of SSc. Diabetes mellitus and insulin resistance presented a significant association with the MS (OR 15.7, CI 95% 2.5–95.6, p=0.006 and OR 8.6, CI 95% 2.4–30.96 p=0.004 respectively). Also, hypertriglyceridemia and the abnormal gird/waist index were significantly associated with MS (OR 28.3, CI 95% 2.7–289.7 p=0.013 respectively).

Conclusion: The prevalence of MS in SSc is high (36.4%) and greater than the one observed in the Mexican population.

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Antioxidant Treatment with N-acetylcysteine in Systemic Sclerosis Patients: a Prospective Observational Study of 18 Patients
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Introduction: Antioxidant therapy with acetylcysteine, in patients with Systemic Sclerosis (SSc) is safe, has a durable effectiveness on SSc, and preserves vital capacity (VC) by restoring glutation(sulphydryls) in pulmonary tissue of patients with idiopathic pulmonary fibrosis.

The aim of this study was to report the efficiency of acetylcysteine to decrease the biochemical markers of oxidative stress, to keep the VC and to reduce the thickness of the skin in SSc patients.

Methods: Eighteen patients (2 men, 16 women) with SSc in a prospective cohort were included in the study. The inclusion criteria were: severe diffuse SSc, of over 3 years of evolution, with pulmonary fibrosis and poor response to usual treatment. All patients received acetylcysteine 1.8g/day orally, divided in 3 doses, during 6 months. The patient had been on prednisone 10mg/day and penicilamine 300mg/day, which were continued. Biomarkers of oxidative stress (malondialdehyde, sulphhydrils and carbonyls) were measured by spectrophotometry; vital capacity by spirometry, and skin thickness by 20 Hz ultrasonography of face, chest, hands, forearms and legs at baseline and at 6 months.

Results: The mean age was 52±17 years. Time of evolution was 7±3.2 years. Concentration of malondialdehyde and carbonyls diminished after 6 months of treatment with acetylcysteine, but only the sulphhydrils had a significant decrease (4.4±2.89 vs 1.6±0.84nmol/mg, p<0.001). The VC showed slight improvement (2.6±0.77 vs 2.8±0.71liters, p=0.03). The skin thickness improved at 6 months: in face(from 1.24±0.24 to 1.12±0.25mm, p<0.01); thorax(from 1.38±0.24 to 1.3±0.22mm, p<0.01); legs(from 1.28±0.17 to 1.2±0.14mm, p=0.03). Forearms and arms did not have changes. Six patients needed high doses of proton pump inhibitors in order to tolerate acetylcysteine. Two patients died during follow up; one of them due to a myocardial infarction, and the other one to a previous severe pulmonary hypertension. In addition, all patients presented an increase in body weight of 4.2±1.2kg.

Conclusion: The treatment with acetylcysteine added to low doses of prednisone and penicilamine, improves VC, dermic fibrosis and reduces the oxidative stress associated to severe diffuse SSc.

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Risk Factors Associated with Poor Prognosis in the Autoimmune Origin Peripheral Neuropathy
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Introduction: Peripheral neuropathy is a frequent manifestation of autoim-
Physical examination and nerve conduction velocity (NCV) are useful in the diagnosis. First line treatment includes corticosteroids and immunosuppressive drugs; the final outcome is variable, going from total recovery to irreversible damage. Systemic vasculitis may affect vasa nervorum, causing neuropathy in 15 to 75% of the patients. Polyneuropathy is more common than multiple mononeuropathies, and damage may be axonal or demyelinating, and sensitive or motor.  

Objective: To identify factors associated with a poor prognosis in autoimmune-associated peripheral neuropathy.  

Methods: Patients more than 18 years old with SLE or systemic vasculitis, according to the ACR criteria, who had peripheral neuropathy diagnosed by clinical manifestations and NCV study, were included. The following variables were measured: disease time of onset, delay time in the diagnosis and treatment; by NCV study: nerve type affected (sensory or motor) and type of damage (axonal or demyelinating). Peripheral neuropathy was evaluated by medical history and physical examination. Patients were classified according to their response to treatment: poor response (group 1) and good response (group 2). Descriptive statistics was used: chi square test for dichotomous variables and Wilcoxon test for comparison before and after treatment. SPSS 17.0 program was used.  

Results: Twenty one patients were included, 15 had SLE and 6 had systemic vasculitis (3 with Wegener’s Granulomatosis and 3 with polyarteritis nodosa). Mean age was 47.48 ± 10.12 años; 71% were female (n=15); time of diagnosis: 111.14 ± 83.15 months, delay in the diagnosis: 2.38 months, and delay in the onset of treatment: 1.81 months. The poor response group received a higher prednisone dose (22.4 vs 7.9 mg per day, p<0.05), the immunosuppressants used were: mycophenolate mofetil (n=7, 33%), azathioprine (n=8, 38%), IV cyclophosphamide (n=5, 24%), and cyclosporine (n=1, 5%). After treatment, 7 patients persisted with peripheral neuropathy. There was partial response in 43% of the patients (n=9) and complete response in 57% (n=12). There was a correlation between the delay of treatment, higher doses of prednisone and demyelinating axonal damage with poor prognosis (p=0.003, p=0.05 y p=0.04, respectively).  

Conclusion: There was a correlation between the delay of treatment, higher doses of prednisone and demyelinating axonal damage with poor prognosis. None of the immunosuppressants was superior to the others in offering a better response.  

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Assessment of Renal Function in Systemic Lupus Erythematosus (SLE) Patients. Futility of Creatinine Clearance (CCI)  


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Introduction: Iothalamate renal clearance is one of the ideal tests to estimate glomerular filtration rate (GFR). Cystatin C (cys) is one of the most reliable to determine GFR. Renal involvement in SLE occurs in 60% of patients and GFR should be assessed periodically. Our study is the first describing, the best equation to estimate GFR in SLE patients, beginning with a gold standard test (iothalamate).  

Objective: To find the best equation based on serum creatinine (SCR) to estimate renal function in SLE patients.  

Methods: The study was divided into 2 phases. Phase 1: GFR was assessed with iothalamate in 14 SLE patients to define and validate the best cys based equation (7 cys based equations evaluated). Phase 2. The best cys based equation in phase 1, was taken as a gold standard to assess CCI and 5 SCR based equations (CKD-EPI: Chronic Kidney Disease Epidemiology Collaboration study equation, CG: Cockcroft Gault, CGi: with ideal weight, Mayo Clinic quadratic equation and simplified MDRD study equation). In both phases, bias (median differences) accuracy or P30 (percent-age of estimates within 30% of measured GFR) and precision or differences in interquartile range (dIQQR=IQQR of (measured GFR–estimated GFR)) were evaluated. The best equation is the one which has: The highest P30, lowest bias and dIQQR.  

Results: In the first phase, Stevens et al, equation was selected as the best equation and this was taken as gold standard to compare creatinine-based equations. In phase 2, 56 SLE patients were evaluated (51 women) of 38.8 ± 14 years old on average. The best equation to evaluate GFR was CKD-EPI. (P30: 94.5%, Bias: −2.1 ml/min/1.73 m2, dIQQR: −2.1 ml/min/1.73 m2). CCI one was of the worse (P30: 80.4%, Bias: 4.6 ml/min/1.73 m2, dIQQR: 4.6 ml/min/1.73 m2).  

Conclusion: In clinical practice to assess the GFR in SLE patients, the best one is CKD-EPI, which requires only serum creatinine and age. CCI should be abandoned for their lack of accuracy and because it requires 24 h urine collection with a higher cost than CKD-EPI.  

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Adjusted Methylprednisolone Dosing to Serum Albumin Levels plus Cyclophosphamide in Patients with Lupus Nephritis. A Pilot Study  


Introduction: Renal involvement in systemic lupus erythematosus (SLE) is frequent and is commonly associated with decreased levels of serum albumin. Because methylprednisolone (MEP) binds to albumin, patients with low levels may require a lower dosing. It is important to re-plant treatment under these conditions considering that a major cause of death in lupus are infections and are directly associated to immunosuppressive therapy.  

Objective: Compare the benefit and safety profile of combined therapy with cyclophosphamide (CYC) plus MEP adjusted to serum albumin versus CYC plus MEP without adjustment to serum albumin in patients with proliferative lupus nephritis (LN).  

Methods: Patients with SLE and proliferative LN were enrolled in a randomized, uncontrolled, open label comparative trial and divided based on serum albumin levels to parallel groups of treatment: one group received CYC monthly plus adjusted MEP during baseline then continuing with high doses of prednisone while the other group CYC plus conventional doses of MEP followed by prednisone with follow up during 24 weeks and evaluated with intention-to-treat analysis.  

Results: We included 18 patients, 16 females y 2 males with a mean age of 29.1 ± 8.58 years, a duration of diagnosis of lupus 136.88 ± 201.16 weeks and of lupus nephritis 3.33 ± 3.46 weeks. Total renal response in both groups (10 patients in the adjusted group and 8 in the group of CYC plus MEP non adjusted to albumin) was 66.67%, 33.33% complete response, 33.33% partial response, and 33.33% of therapeutic failure. Complete response was present in the group of CYC plus MEP non adjusted to albumin in 37.5% vs 30% in the adjusted group (p=1), partial response 25% vs 40% (p=0.64) and therapeutic failure was present in 37.5% of the non adjusted group vs 30% in the adjusted group (p=1). Adverse events observed during the study were similar in both groups.  

Conclusion: It was demonstrated that combined treatment with CYC plus MEP adjusted to serum albumin had a similar therapeutic benefit and safety profile than combination of CYC plus MEP at conventional dose.  

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Validity of the ACR criteria and SLICC proposed criteria for the diagnosis and classification of Systemic Lupus Erythematosus  

Introduction. The current version (1997) of the ACR criteria for the classification of the SLE patients has not been validated. The 1982 version was validated for the classification of SLE patients, however although it has been used for diagnosing SLE, this application was never validated. Recently, the SLICC group has proposed a new set of criteria which still needs to be validated.

Objective. To validate the 1997 ACR and the SLICC proposed criteria for the diagnosis and classification of patients with SLE.

Methods: Group A. We included 55 patients who were hospitalized in our Institute for the diagnosis of systemic manifestations of recent-onset, ≤6 months. All the patients were evaluated by 2 physician with speciality in Internal Medicine who are in-training in Rheumatology. A complete physical examination was done, and pertinent studies were requested according to the medical condition. Also, in all the patients all the tests requested to evaluate the ACR and SLICC SLE criteria were done. The final diagnosis was established according to the treating physician(s) after 6 months of the clinical evaluation in order to have the final reports of all studies performed (laboratories, X-ray, pathology, etc) and looking after the robustness of the diagnosis. Group B. Included 51 consecutive patients, participating in a cohort of patients with SLE of recent-onset (<12 months) according to the 1982–1997 ACR criteria. In this group we looked for the fulfillment of the proposed SLICC criteria within 6 months of enrollment into the cohort. Group C. Included 35 patients participating in cohort of an early inflammatory arthritis and 3 patients with Sjögren’s syndrome. The validity of the ACR and SLICC criteria for the SLE diagnosis was evaluated in Group A, and the validity for classification in all the patients.

Results: Patients in group A had a mean age 37±17 SD years-old, 40 were female. The reasons for hospitalization were: fever, weight loss, nephrotic syndrome, nephritic syndrome, generalized adenopathy, cytopenias, polyarthritis. Patient in group B had a mean age of 29±9.1 SD years-old, 43 were female. Patients in group C has a mean age 40±14 SD years-old, 30 were female. Their diagnosis were seropositive (RF+ and CCP+) inflammatory arthritis 16, seronegative inflammatory arthritis (RF- and CCP-) 16, and primary SS with extraglandular manifestations 3. In group A, 21/55 (38%) had a new diagnosis of SLE , and the observed agreement both sets of criteria was 87.3, kappa 74.5. Also, among all the patients in the three groups, the observed agreement for SLE classification was 92.2, kappa 84.3.

For diagnosis purpose, ACR criteria vs SLICC were sensitivity 85.7 (76–95) vs 90.5 (82.7–98.3), specificity 82.4 (72–92) vs 76.5 (70.8–82.2), PPV 74.5 (63–86) vs 70 (58–82), NPV 90.6 (83–98) vs 93 (88.0–99.7), respectively. For classification purpose ACR criteria vs SLICC were sensitivity 94.4 (89.2–99.7) vs 95.8 (91.2–100), specificity 88.4 (80.9–96.0) vs 85.5 (77.2–93.8), PPV 89.5 (82.6–96.3) vs 87.3 (80.0–94.7), NPV 93.9 (88.0–99.7) vs 95.2 (89.8–100), respectively.

Conclusion. The current ACR version and the proposed SLICC criteria are useful for the diagnosis and classification of SLE patients; however, they perform better for classification than diagnosis

62 Immunization Versus Influenza A H1N1 in Patients with Systemic Lupus Erythematosus


Introduction: SLE patients have a greater probability of develop preventable infections. Recently, influenza A H1N1 has been added to the list of those diseases. Nevertheless, the prevention of this infection will not be easy because in general the compliance with the vaccination schemes in this group of patients is suboptimal as was reported by our group and other investigators (1).

Objective: To settle the proportion of the SLE patients who had received the influenza A H1N1 vaccine through September 2010 in the outpatient clinic of our hospital.

Methods: Between January and September of 2010 we used a printed questionnaire and interrogated the SLE patients who attended to the outpatient clinic of rheumatology of our hospital. We asked if they had received the influenza A H1N1 vaccine and if that was the case if they had presented any complications.

Results: 71 patients (67 women and 4 males) with an average age of 42 years (24 to 72 years) and an average disease of 6 years of clinical evolution (1.5 to 19 years) were interrogated. 50 of the cases (70%) were receiving glucocorticoids per oral and 63 patients (87.5%) were receiving immunomodulators or immunosuppressants the highest proportion of which (50 cases) were antimalarials. 48 patients were in remission. 21 % of the total group had received the seasonal influenza vaccine and only 8 patients had received the influenza A H1N1 vaccine. Only three patients had received both vaccines. One of the patients could not remember which of the two vaccines was applied. No complications were reported by the patients. Exacerbations of the SLE were not observed in association with the injection of the vaccine.

Conclusion: The percentage of the patients who received the seasonal influenza vaccine were not significantly different from that observed in the previous report (18% en 2008 – 2009 versus 21% in the first 9 months of 2010) despite the recent pandemic of influenza A H1N1 which could have contributed to the awareness of the importance to be vaccinated. Until She date of this report the percentage of our patients who had been vaccinated versus the influenza A H1N1 was extremely low. One of the probable causes of this observation could be the unfounded belief about the possible exacerbation of the SLE that could occur with the application of the immunizations. The discussion of this topic must be part of the routinely medical interview in order to obtain better results that those here summarized. Reference: 1) Huerta GF, Chávez MA, Gallaga VA, Reyes A, Cruz Z. Inmunizaciones en Lupus Eritematoso Generalizado. Reumatología Clínica 2010 (Supl 1): 74.

63 Polymorphism 4g/5g of the PAI-1 Gene and Atherosclerosis Detection Using Carotid Ultrasound in Patients with Systemic Lupus Erythematosus

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Introduction: Atherosclerosis and coronary artery disease are recognized as causes of mortality in SLE. Atherosclerosis can be identified by carotid ultrasonography (US) measuring the intima-media thickness (IMT) and the presence of the carotid plaque (CP). The polymorphism 4G/5G in the promoter region of the plasminogen activator inhibitor type I (PAI-1) gene has been associated with atherogenesis and coronary arteriopathy. Aim. To establish the possible association between the polymorphism 4G/5G of the PAI-1 gene and the detection of atherosclerosis measuring the IMT and the identification of CP in patients with SLE.

Methods: Study design, cross-comparative. A group of 20 patients with SLE (ACR 1982) with a median age 42.5yrs, (range 21–64). Control group similar in age and gender; both groups were genotyped for the 4G/5G polymorphism by PCR/RFLP’s method using BstI as the restriction enzyme. High resolution carotid US was determined once measuring IMT and the presence or absence of CP (NV <1.0mm).

Results: The distribution of the allele and genotypic frequencies among SLE patients and control group were similar. Evolution time for SLE was 8 yrs (median) range 2–20; 84% of patients are currently receiving steroids. Median value for IMT was 0.5mm (range 0.44–2.44), only in one case was identified CP without any difference with control group. When comparing
Longitudinal Analysis of Bone Mineral Density in Pre-menopausal Women with Systemic Lupus Erythematosus


Introduction: Several cross-sectional studies have shown that pre-menopausal women with systemic lupus erythematosus (SLE) have a BMD loss. However, there are few longitudinal studies have evaluated this complication in patients with SLE.

Objective: To measure BMD changes for a year in pre-menopausal women with SLE and to identify factors associated with bone loss.

Methods: Women with SLE, who participated in cross-sectional study in 2007, were invited to participate in a standardized interview, chart review and BMD measurements lumbar spine and at femoral neck using dual energy X-ray absorptiometry.

Results: Thirty-nine women with a mean age of 39 ± 14 years and mean of disease duration of 7.7 ± 5.9 years participated. Thirty-one (93%) were exposed to steroids during this time with a mean of daily dose of 14 ± 10 mg. During follow-up, the entire cohort of patients showed a significant bone loss in lumbar spine (0.997 ± 0.130 vs. 0.880 ± 0.194; p = 0.002) and in femoral neck (0.959±0.154 vs. 0.829 ± 0.131; p = 0.003). In patients receiving prednisone > 7.5 mg/day (n=21), BMD loss in neck femoral was higher compared to those receiving 7.5 mg/day or less (0.209 ± 0.168 vs. 0.093 ± 0.069; p= 0.03); however, this significant difference was not found at the lumbar spine. Disease-related variables were not related to changes in BMD.

Conclusion: These results demonstrate the BMD loss over time in pre-menopausal women with SLE receiving steroids. Therefore, we suggest to closely follow the recommendations proposed for the prevention and treatment of osteoporosis in patients receiving steroids.

Percent Body Fat and Use of Prednisone in Systemic Lupus Erythematosus

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Introduction: Several factors may increase the total body fat in patients with systemic lupus erythematosus (SLE), although, there is inconsistent information about the correlation of this body fat mass with the use of medications.

Objective: To identify if percent body fat is correlated with prednisone doses and other clinical variables in patients with SLE.

Methods: In a cross-sectional study were evaluated Mexican Mestizo women with SLE (ACR 1984) and a group of controls with similar age. All the subjects were assessed with anthropometric measures. Body composition was evaluated by dual energy x-ray absorptiometry (DXA). Height, weight, waist and hip circumference were collected from all women. The weight in kg divided by height in meters squared was used to calculate body mass index (BMI). Both groups were compared using parametric statistics. Correlation between quantitative variables and percent of body fat was computed using Pearson’s correlation test.

Results: Forty SLE patients and 33 controls were evaluated. There were no differences between SLE patients and controls in age (42±11 vs 45±11, p=0.31), weight (68.1±13.7 vs 66.7±12.4, p=0.68), height (158.3±6.9 vs 154.7±28.7, p=0.45), BMI (26.9±4.4 vs 25.9±5.0, p=0.40), number of previous pregnancies (2±2 vs 3±2, p=0.6), sex and the SLE group the mean of disease duration was 9.7±7.7 years, prednisone doses was 17.2±5.6 milligrams. Patients with SLE had higher percent body fat compared with controls (45.1%±6.5 vs 41.1%±7.3, p=0.001). There was no difference in bone mass between SLE and controls (2.17±0.4 vs 2.23±0.6, p=0.26). A correlation was observed in SLE between percent body fat with BMI (r=0.70, p=0.01) and prednisone doses (r=0.37, p=0.05).

Osteoarthritis (OA) in Young Patients Due to Sport Knee Injury


Introduction: Anterior cruciate ligament (ACL) lesion with or without injury of the meniscus has been certainly related with the development of osteoarthritis in young patients. Women with Systemic Lupus Erythematosus (SLE) have higher risk of OA. This phenomenon is more frequent in women with SLE due to immunosuppressive treatment. The aim of our study was to identify if percent body fat is correlated with OA.

Results: We included a total of 154 patients (118 female and 36 male). Median age was 29.5 years old (y/o), although female patients were younger than men 27.5 vs. 30 y/o (p=0.04). We found higher OA prevalence of right knee 46.9 vs. left knee 34.3 (p=0.05) when we categorized by gender. Gender differences were observed in knee OA prevalence (36.7%) p=0.02. The most common mechanism of injury was forced valgus (57% male group, 50.6% female group). Body Mass Index was normal (26.9±4.4 vs 25.9±5.0, p=0.40), number of previous pregnancies (2±2 vs 3±2, p=0.6), prednisone doses was 17.2±5.6 milligrams. Patients with SLE had higher percent body fat compared with controls (45.1%±6.5 vs 41.1%±7.3, p=0.001). There was no difference in bone mass between SLE and controls (2.17±0.4 vs 2.23±0.6, p=0.26). The most common mechanism of injury was forced valgus (57% male group, 50.6% female group). Body Mass Index was normal in both groups (24.2 female vs. 25.6 male p=0.12). Medial cartilage OA (medial femoral condyle and medial tibial plate) had a higher prevalence than any other site in the knee; it was more obvious in the female (44.9%) than in male (36%) p= 0.05 (table 1). Medial meniscus injury was related to a higher knee OA prevalence than lateral did (p=0.02). Severity of OA was related to a greater time of evolution (>17 months), specially in the female group (p=0.002).

Conclusion: In young patients with ACL injury, female, medial cartilage and right side have the higher prevalence of knee OA. Meniscus lesion and evolution time are an important risk factors for Knee OA.

Ultrasonographic Evaluation of the Hands of Patients with Primary and Secondary Sjögren’s Syndrome

(4-Mann Whitney test) the IMT values from the patients with the genotype 4G/5G (n=9) against other genotypes 4G/5G and 4G/4G (n=11) 0.48, 0.44–2.44 vs. 0.52, 0.46–0.57 we did not find any significant difference. Conclusion: The morbi-mortality of atherosclerosis (evaluated by US as a surrogate study) in SLE, is time dependent. We did not identified differences in the association of the IMT values between the different genetic polymorphisms associated with PAI-1 gene.
Hofmann F (1), Amezcua-Guerra LM (2), Bernal A (3), Lopez-Reyez A (4), Marin-Ariaga N (5), Rodriguez-Henriquez PJ (6), Solano C (7), Vargas A (8), Hernandez-Diaz C (9), Pena A (10), Martinez-Lavin M (11), Pineda C (12) (1)3(4)5(9)(10)(12)Instituto Nacional de Rehabilitacion, (2)8(11)Instituto Nacional de Cardiologia, (6)Hospital General Dr. Manuel Gea Gonzalez, (7)Instituto Salvadorio del Seguro Social

Introduction: Sjögren’s syndrome (SS) is an autoimmune disease characterized by lymphocytic infiltration of the exocrine glands; extra-glandular manifestations include arthropathy. Several studies have pointed out the clinical and serological differences between primary Sjögren’s syndrome (pSS) and those associated with rheumatoid arthritis (RA) (secondary Sjögren’s syndrome [sSS]). pSS’s arthritis has classically been described as non-erosive. However, this characterization of arthropathy was made when conventional radiology was the imaging standard. Nowadays, with the use of musculoskeletal ultrasound (MUS), the paradigm of absence of erosive arthritis in some autoimmune systemic diseases has been challenged.

Objective: Compare MUS findings in the hands of pSS and SS patients.

Methods: Primary SS and sSS patients were evaluated using a Siemens Acuson Antares® ultrasound equipment. Longitudinal scans of the wrist, metacarpophalangeal and interphalangeal joints of both hands were obtained using a 7–12 MHz hockey-stick type probe. Synovitis (synovial hypertrophy and/or joint effusion), erosions, and Doppler signal were recorded. OMERACT definitions for ultrasonographic pathology were used.

Results: Seventeen pSS patients and 18 sSS patients were evaluated (97% were female) with a mean age 60.2 ± 11.91 yrs. Mean disease duration was 3 years for pSS, and 9.5 years for sSS range 5 – 21.5) years. Eight pSS patient’s (53%) and 11 (73%) with sSS had rheumatoid factor positive. Anti CCP antibody were positive en 7% in pSS vs 62% in sSS (p = 0.003). PFR median range was 1.9 mg/L (range 1.3 – 6.6) for pSS versus 7.7 (range 3.8 – 12) for sSS (p = N.S). In MUS synovitis in carpal joints was 21 (62%) in pSS vs 29 (81%) in sSS; erosion in carpal joints was 3 (9%) and 14 (39%) respectively (p = 0.004). Synovitis was statistically significant in 2 PIP and MCP when comparing pSS vs sSS.

Conclusion: Inflammatory activity demonstrated by synovitis was found in the same proportion and topographic location in both groups of patients. However, the results may confirm that the arthropathy in pSS has no erosions in contrast to the sSS, where they are frequently found.

68 Correlational Analysis of Heart Rate Variability Parameters with Fibromyalgia Symptoms


Introduction: Autonomic dysfunction has been proposed as a key pathogenic element for fibromyalgia (FM). Heart rate variability (HRV) analyses have shown changes consistent with persistent sympathetic hyperactivity coupled with sympathetic hypo-reactivity to stress. Nevertheless, little is known about the association of specific HRV parameters with different FM symptoms.

Objective: To seek association between different HRV parameters and outstanding FM symptoms.

Methods: We studied 21 adult women with FM according to the 1990 ACR criteria. None of them were on any medication that could affect autonomic nervous system activity. All participants filled out the following questionnaires: Fibromyalgia Impact Questionnaire (FIQ), that contains several visual analogue scales (VAS), Medical Outcome Sleep Scale (MOSS), Composite Autonomic Symptoms and Signs (COMPASS), Hospital Anxiety and Depression Scale (HADS), Multidimensional Assessment of Fatigue Scale (MAF) and Health Survey Short Form-36 (SF-36). All participants wore a Holter monitor during 24 hr while doing their routine daily activities. The following HRV parameters were extracted from the Holter recordings: the standard deviation of NN intervals (SDNN), the standard deviation of the average NN intervals calculated over 5 minutes (SDANN), and the percentage of NN intervals that differ by more of 50 ms from the adjacent NN interval (pNN50). Calculations were done during activity hours (6 to 24 hr) and during sleeping hours (0 to 6 hr).

Pearson’s or Spearman’s methods were used to search for correlations between HRV parameters and fibromyalgia symptoms severity. A p value < 0.05 was considered significant.

Results: Patients mean age was 32.7 ± 8 SD. Body mass index was 24.5 ± 4.4 SD. FIQ scores correlated with scores derived from the following questionnaires; COMPASS (0.4), SF-36 mental component (−0.5), and HADS (0.6). All correlations had a p value <0.05.

Decreased nocturnal SDNN, SDANN and pNN50 (all values pointing toward a state of sympathetic hyperactivity) had significant association with the following FM symptoms: FIQ-VAS for pain (p = 0.6), COMPASS gastroparesis (0.6), COMPASS constipation (0.5), SF-36 mental component (−0.6) and HADS depression (0.5). (p<0.05)

Conclusion: There is a correlation between different FM symptoms and HRV parameters indicative of sympathetic hyperactivity. These results reinforce FM dysautonomic paradigm.

69 Chemokine saliva levels in patients with primary Sjögren’s syndrome, secondary Sjögren’s syndrome, pre-clinical Sjögren’s syndrome and in patients with systemic autoimmune diseases


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Objective: To assess the saliva levels of CXCL13, CXCL10, CCL2, CCL3, CXCL12 and CCL5 in patients with primary Sjögren’s syndrome (SS), patients with secondary SS (sSS), patients with systemic autoimmune disease (SAD) without SS, preclinical SS and healthy controls.

Methods: We included 44 patients with primary SS (group A), 30 with sSS (group B), 49 with SAD without SS (group C), 14 patients with SAD and focal lip infiltrates but who do not fulfill SS criteria (group D “preclinical SS”) and 32 healthy controls (group E). Saliva samples were collected and analyzed for chemokines levels by luminometry. We used descriptive statistics and the U-Mann Whitney and Kruskall-Wallis tests.

Results: All the studied chemokines were found at low concentration in controls (CXCL13= 2.6 pg/ml [0–8.3], CCL5=3.2 pg/ml [3.2–12.8], CXCL12= 43.9 pg/ml [0–295], CCL3=27.8 pg/ml [3.2–46.9], CXCL10=70.6 [40.4–176.2]) with the exception of CCL2 (376.8 pg/ml [166–1108]). Patients with primary SS had higher levels CCL10 (110.6 pg/ml [3.2–10000]) and CCL2 (738.8 pg/ml [3.2–13772]) than controls (p<0.05). However, they had similar levels when compared with the group of patients with SS and SAD without SS of the following chemokines: CXCL13 (A=3.0 pg/ml [0–2.3], B=0 pg/ml [0–0.6], C=1 pg/ml [0–2.2]), CCL5 (A=3.2 pg/ml [3.2–12.8], B=3.2 pg/ml [3.2–18.8], C=3.2 pg/ml [3.2–9.7]), CXCL12 (A=0 pg/ml [0–136], B=0 pg/ml [0–88], C=0 pg/ml [0–101]), CCL3 (A=27.5 pg/ml [9–58], B=30.6 pg/ml [20.9–46], C=31.1 pg/ml [9–48.2]), CCL2 (B=1068 pg/ml [15–10802], C=784.5 pg/ml [60.4–14277]), and CXCL10 (B=117.7 pg/ml [70–500], C=141.1 pg/ml [56.8–1075]). Patients with preclinical SS had higher levels of CXCL10 (414.2 pg/ml [42.1–7803.8]) than patients with primary SS (p=0.03), sSS (p=0.04), and controls (p=0.001). CCL2 levels were higher in all patients with an autoimmune background when compared with controls (p<0.05 for each comparison).

Conclusion: We found no difference in salivary chemokines between patients neither with primary or secondary SS nor in patients with SAD. CCL2 and CXCL10 were increased in all patients with an autoimmune background. However, CXCL10 was notably increased in preclinical SS suggesting it could be an early inflammatory salivary biomarker.

70 Patients with and without Systemic Fungal Infections (SFI) in Inflammatory Rheumatic diseases (IRD): A Case-control Study

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Introduction: SFI are catastrophic diseases with a high mortality, which occur frequently in patients under immunosuppressive drugs for the management of IRD. Few cases of SFI have been described in IRD and its associated factors have not been completely recognized.

Objective: To evaluate associated factors with SFI in IRD patients.

Methods: Autopsies of IRD patients in the last 5 years were evaluated and compared with SFI patients (cases) and patients without fungal infection (controls). Demographic factors, evolution of IRD, and treatment in the last month were compared. Categorical variables are informed as percentages, continuous variables as median, minimum and maximum. Categorical variables were analyzed with Fisher’s exact test and continuous with Mann Whitney test.

Results: Fourteen patients with IRD were evaluated, (10 with systemic lupus erythematosus (SLE), one with juvenile idiopathic arthritis, 1 with thrombotic thrombocytopenic purpura and 1 with mixed connective tissue disease). Mean age was 33.3 years. Most of SFI patients were females; although there were not a significance on the statistical matter, we can recognize there was a lower mean on the value of leukocytes (10^{3}/µL) in cases vs controls (3.29 vs 6.4; p=0.232), also we observed, that there were higher creatinine levels (mg/dL) in SFI patients (median 2.8 vs 0.97; p=0.694). Nine patients (64.3%) were using glucocorticoids, 6 in the SFI group and 3 in the control group, reaching borderline statistical difference in prednisone doses (50 mg vs 10 mg; p=0.072). There were more patients on SFI group using methotrexate, azathioprine, and more SLE patients than in the control group (p > 0.05).

Conclusion: Patients with SFI had a longer history of the IRD, higher doses of methotrexate, azathioprine, steroids, mycophenolate mofetil and cyclophosphamide, mechanical ventilation and neutropenia-leukopenia. SLE patients per se have increased the risk of fungal infection.

71 Efficacy and Safety of Methylprednisolone Infiltration in Anserine Bursitis Treatment


Introduction: Anserine bursitis (AB) is a frequent cause of knee pain rodilla. Physiotherapy is commonly used, the use of anti-inflammatory drugs and correction of the predisposing factors are useful. Only infiltration with corticosteroids has been evaluated, although studies with poor methodological rigor.

Objective: To determine the efficacy and safety of the methylprednisolone infiltration for AB treatment, based on the WOMAC questionnaire at four weeks and the proportion of patients per group who had an adverse effect.

Methods: Randomized, double-blind, placebo-controlled study of 58 patients with BA, which an intra-articular pathology has been excluded to reflect pain in the medial aspect of the knee (meniscopathies, collateral ligaments, medial plica). Done in the Rheumatology Clinic University Hospital. After signing the informed consent, we evaluated the WOMAC scale for osteoarthritis of the knee in a baseline and then the patients were randomized to receive a radial infiltration at the site of most pain on the medial side of the knee with 2 mL of 2% lidocaine plus 40 mg of methylprednisolone acetate vs lidocaine plus distilled water. Both groups received 100 mg of diclofenac sodium PO qd for 10 days. WOMAC was performed at 4 weeks, and the presence of adverse events was recorded.

Results: The baseline characteristics table shows homogeneity in both groups for demographic variables and initial clinical evaluation. There were no statistical differences in the three domains of WOMAC assessment at baseline, and for each item of the test. The median baseline WOMAC in group 1 (experimental) was 32 points, in group 2 (placebo) was 25.5. At 4 weeks was 8 and 6.5 points, respectively. Both groups improved by 61.61 and 62.85%, respectively. The rest of the variables evaluated and the frequency of adverse events showed no difference.

Conclusion: The infiltration of 40 mg of methylprednisolone acetate plus 1 mL of 2% lidocaine in AB was as effective as placebo in patients taking 100 mg diclofenac qd for ten days, as measured by WOMAC at 4 weeks.

72 Diagnostic and Therapeutic Guidelines for the Clinical Management of Rotator Cuff Tendinopathy, Preliminary Report


Introduction: Rotator cuff tendinopathy is the most common regional pain syndrome, there is controversy about the diagnostic and therapeutic approach. There is no history of clinical guidelines based on review of scientific evidence to guide this approach.

Objective: To present the preliminary results of the ad hoc group created by the Mexican College of Rheumatology for the generation of clinical guidelines aimed at any level of medical care to standardize the approach of patients with rotator cuff tendinopathy.

Methods: We met a group of experts on regional pain syndromes. By adapting PICO methodology, there were generated questions based on clinical scenarios of controversy. We performed a search on PubMed, Cochrane Library and EMBASE for articles. Comparative, controlled trials and systematic reviews on the topics were identified. Finally, the presentation of results, discussion and final simple consensus generated evidence and recommendations for each of the clinical scenarios.

Results: We present evidence and recommendations on the following clinical questions in patients with rotator cuff tendinopathy: What are the most sensitive clinical maneuvers for diagnosis? What is the performance of imaging studies for diagnostic and therapeutic approach of patients in whom the clinical outcome is inadequate? What is the efficacy for reducing pain and improving functional capacity for the following therapeutic interventions? Systemic anti-inflammatory drugs, Physical Medicine and Rehabilitation, local injection with corticosteroids, acupuncture and surgery (open or arthroscopic).

Conclusion: Preliminary findings of the diagnostic and treatment guidelines based on the best scientific evidence.

73 Prevalence of Anti-ENA (RNP/Sm, Sm-Jo-1, Scl-70, SSA/Ro and SSB/La) Antibodies and Reference Values in Mexican Healthy Donors


Introduction: ANA testing by IFA is the gold standard test for suspected autoimmune disease. In samples with ANA positives is convenient to confirm with tests more sensitive and specific for identifying antigens as dsDNA, Scl70, etc. The presence of natural antibodies, ethnic difference and environmental factors directly influence the establishment of reference values in normal healthy subjects, and for it is important establish cut off values for the several tests conducted in the laboratory of autoimmunity.

Objective: To determine the reference value against to ENA detected by ELISA and analyze the prevalence of anti-ENA in mexican healthy donors.

Methods: We analyzed 100 serum samples from healthy donors who attended in the blood bank with not family history of autoimmunity, Anti-
Clinically Meaningful Improvements in Health-Related Quality of Life, Pain and Sleep Quality in Children with Polyarticular Juvenile Idiopathic Arthritis Treated with Abatacept over the Long Term

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Introduction: Despite the improvement in the diagnosis and treatment of systemic lupus erythematosus (SLE), lupus nephritis remains as an important cause of morbidity and mortality. Race, gender, age at onset, persistent hypertension, anemia, class IV nephritis, increased serum creatinine, nephrotic syndrome and low complement levels have been reported as prognostic factors predicting renal failure in children with lupus nephritis.

Methods: The medical records of all children with lupus nephritis seen between January 2001 and September 2010 were reviewed. The clinical manifestations, full laboratory data, renal findings on biopsy including WHO class as well as activity and chronicity indices, treatment and complications were recorded. A multivariate analysis was performed to determine the risk factors associated with progression to renal failure and mortality. Renal survival and patient survival were analyzed using Kaplan-Meier survival curves.

Results: Of a total of 124 patients with lupus nephritis, 111 (80% females) were eligible for the analysis. One hundred patients (90%) underwent renal biopsy and the most common lesion seen was class IV nephritis (63%). The mean time of follow-up was 3.6 years (range 0.17–11). All patients were treated with prednisone and 91% received therapy with pulse cyclophosphamide plus pulse methylprednisolone. At presentation, 63% had nephrotic range proteinuria (≥40 mg/m2/day), 24% serum creatinine >1.2 mg/dl, 80% erythrocyte count ≥10 per high power field and/or cellular casts, 29.7% persistent hypertension (≥6 months) and 33% anemia (≤10 g/dl). Only 5 patients progressed to renal failure (4.5%), and four of them died, making a total of 9 deaths (8.1%). The risk factors associated with death were renal failure (RR=16.1; IC 95%, 6.6–38.63) and persistent hypertension (RR=7.2; CI95%, 1.01–51.1). However, we did not find any risk factor associated with renal failure. Twenty one patients (18.9%) developed end stage renal disease and who had data available at the visit of interest (as-observed). Results: At study entry, subjects had considerably lower HRQoL than the general population. Mean changes in CHQ component scores were also presented for healthy children. Data up to Month 21 of the LTE are presented for subjects who entered the LTE (either NR from the open-label lead-in or subjects treated with abatacept during the DB period), and who had data available at the visit of interest (as-observed).

Conclusion: Treatment with open-label ABA for up to 31 months resulted in improvements in multiple aspects of HRQoL, to within the range of reference national for the Arthritis, Paris, France, 4Instituto de Salud del Niño, Lima, Peru, 5Hospital Universitario “Dr. E. Gonzalez”, Research Institute, Saint Paulo, Brazil, 15Hospital Universitario La Fe, Valencia, Spain, 16Hospital Universitario Hautepierre, Strasbourg, France, 17Hospital San Javier, Rheumatology, Guadalajara, Mexico, 18Bristol-Myers Squibb, NJ, USA, 19Bristol-Myers Squibb, Braine-l’Alleud, Belgium

Introduction: Systemic inflammation, chronic arthritis and possible joint damage can lead to functional impairment and diminished health-related quality of life (HRQoL) in children and adolescents with juvenile idiopathic arthritis (JIA). In a double-blind (DB), placebo-controlled, randomized withdrawal trial (RWT) in subjects with polyarticular JIA, abatacept (ABA) significantly improved multiple aspects of HRQoL, pain and sleep quality. Here we report follow-up data on these variables for up to 31 months of treatment, including 21 months of the long-term extension (LTE) of this trial.

Methods: Subjects in the RWT treated with abatacept who achieved an ACR Pedi 30 response in a 4-month open-label lead-in were randomized 1:1 to DB ABA or placebo for 6 months or until flare. Subjects eligible to enter the open-label LTE (10 mg/kg abatacept) included ACR Pedi 30 non-responders (NR) from the lead-in who did not enter the DB period, and subjects randomized into the DB phase who either flared or completed the 6-month DB period. HRQoL was assessed by the Child Health Questionnaire (CHQ), which includes 15 health concepts, sleep quality by the Children’s Sleep Habits Questionnaire (CSHQ) (score 0–100) and parent global assessment of pain by 0–100 mmVAS. Mean CHQ component scores are also presented for healthy children. Data up to Month 21 of the LTE are presented for subjects who entered the LTE (either NR from the open-label lead-in or subjects treated with abatacept during the DB period), and who had data available at the visit of interest (as-observed).

Results: At study entry, subjects had considerably lower HRQoL than the general population. Mean changes in CHQ component scores from baseline to Month 31 generally indicated improvements in both patient cohorts, with greater changes seen for DB abatacept patients compared with open-label NRs. Mean scores at Month 31 for each CHQ component were generally comparable to scores for healthy children. Reductions from baseline in CSHQ scores and pain also were comparable by Month 31 for the DB abatacept versus NR cohorts: mean (95% CI) changes in CHSQ total scores were −3.5 (−6.5, −0.5) versus −2.9 (−6.3, 0.6), and in parent global assessment of pain were −31.2 (−37.8, −24.6) versus −20.6 (−30.2, −10.9) (n=28, n=16, n=50 and n=22, respectively).

Conclusion: Treatment with open-label ABA for up to 31 months resulted in improvements in multiple aspects of HRQoL, to within the range of healthy children, for subjects with JIA, including those who were ACR Pedi 30 non-responders in the lead-in period. These data suggest that long-term ABA treatment can provide real-life tangible health-related benefits to children with polyarticular JIA.

Impact of Illness Perception in the Control of Fibromyalgia

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**Introduction:** Fibromyalgia (FM) is a complex and common chronic disease, characterized by persistent pain (alldynia and hyperalgesia), with many subjective symptoms such as sleep disorders, fatigue, anxiety and depression; cause of important socioeconomic burden, is difficult to treat because it requires a multidisciplinary management. In the last decade, a good perception of the illness has been identified as important in the successful management of FM.

**Objective:** The aim of the study was to evaluate illness perceptions in patients with FM, and to examine factors as part of the knowledge related to the illness, as well as physical activity, and the association with the control of the illness reported by patients.

**Methods:** A cross-sectional study including a sample of consecutive cases recruited in a FM patients meeting. If a patient expressed willingness to participate a set of questionnaires were applied containing: socio-demographic information, Brief Illness Perception Disease Questionnaire (BIP) and self-report perception about cause, control, treatment of the disease and physical activity. Analysis: correlation (rho Spearman) was calculated between domains of BIP, disease control, knowledge about the illness and physical activity. P<0.05 significant.

**Results:** 102 cases were analyzed, Mean of age 49.84 ± 11 yrs; 95%: Time of disease >5 yrs: 26%. In 66% a rheumatologist established the diagnosis; 31% of cases reported previous knowledge about FM. 72% performing physical activity. Factors reported as cause of FM were: stress 37.3%, emotional 29.4% and prior family crisis 24.5%. BIP mean score: 49 (good perception >80) and self-report about control of FM was 7 (0–10), good control >8). BIP score had significant correlation with physical activity (r = 0.23 p = 0.007) and illness control (r = 0.225 p = 0.025). Correlation between control of the illness and a useful treatment (r = 0.305 p = 0.003).

**Conclusion:** The illness perception in FM Mexican patients is low and is related to the level of control, the physical activity and the perception of a useful treatment. Stress, emotions and prior family crisis are the most common factors reported as causes of the disease.

**77 Lipoic Acid as a Nutritional Supplement with Antioxidant Effect and Reduction of Symptoms in Patients with Fibromyalgia**

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**Introduction:** Fibromyalgia (FM) is a chronic non degenerative disease characterized mainly by generalized muscular pain, fatigue and sleep disorders. FM has been related to a generalized oxidative state, which can be associated with the severity of the symptoms. Reducing symptom severity associated with the severity of the symptoms. Reducing symptom severity is related to the level of control, the physical activity and the association with the control of the illness reported by patients.

**Objective:** To evaluate the utility of the ACR 2010 criteria for FM in patients with rheumatic diseases.

**Methods:** This is a cross-sectional study. We included consecutive external patients of Reumathology service of the General Hospital of Mexico, with diagnoses established of rheumatoid arthritis (RA), Systemic Lupus Erythematosus (SLE), Spondyloarthropathies (SpA), osteoarthritis (OA), gout and FM. 20 patients were included in every group, except in SpA with only 19 patients. The diagnosis of FM was evaluated by either classification criteria ACR-1990 and ACR-2010. We studied 119 patients with a mean age of 44.6 ± 15.6 years. 68.9% were female. ACR-2010 criteria for FM show a sensitivity of 84.2% (95% CI 69.6–92.6%) and specificity of 81.5% (95% CI 71.7–88%) with an area under the curve of 0.83. Both tests correlated with r = 0.63 (p = 0.000). The frequency of diagnosis of FM either ACR-1990 criteria or ACR-2010 criteria by rheumatic disease was: in RA 30% and 50%, in SLE 20% and 25%, in OA 35% and 40%, in Gout 0% and 10%, in SpA 5.3% and 26.3%, in FM 100% and 85% and in all patients 31.9% and 39.5% respectively.

**Conclusion:** The ACR-2010 criteria for FM have good sensitivity and specificity, with good discriminatory power in patients with inflammatory and degenerative rheumatic diseases compared to ACR-1990 criteria.
Peripheral Ulcerative Keratitis: Ocular Manifestation of Rheumatic Disease

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Autoimmune rheumatic disease (ARD) is frequently the etiology of peripheral ulcerative keratitis (PUK).

Department of Rheumatology and in five patients (71.4 %) first contact was with the Department of Ophthalmology. Two patients presented PUK as the initial manifestation of ARD, average time of evolution between nonocular manifestations and PUK was 11.8 years. In four cases (40%), PUK was unilateral and in six cases (60%) it was bilateral; there was one case (10%) of scleritis. Pharmacological treatment in all cases was high-dose corticosteroids and immunomodulators (cyclophosphamide, azathioprin, methotrexate). Surgical treatment was required in five (50%) patients.

Conclusion: 1) ARD can express clinically at the ocular level in the peripheral cornea. 2) Prior to the presence of PUK, ARD must be ruled out.

Methods: This was an observational, retrospective and descriptive study. A sample of secondary sources was integrated (clinical files) from the Departments of Ophthalmology and Rheumatology of the Hospital Juárez de México with a diagnosis of PUK during the period from September 2008 to September 2010. The following variables were identified: demographic characteristics of the study patients, percentage of patients with PUK of central tendency were used.

Results: Ten patients with PUK were identified (9 females, 1 male) with ages ranging from 45–69 years (average age: 55.7 years). Seven patients (70%) had ARD: rheumatoid arthritis, 4 (40%); ANCA-associated vasculitis, 1 (10%); Sjögren syndrome, 1 (10%); and scleroderma, 1 (10%). In two patients (28.6%) with ARD, the first contact was with the Department of Rheumatology and in five patients (71.4 %) first contact was with the Department of Ophthalmology.

Objective. To identify patients with PUK and its association with ARD and to describe the characteristics of the ocular pathology and its treatment in a metropolitan general hospital.

1) ARD can express clinically at the ocular level in the peripheral cornea. 2) Prior to the presence of PUK, ARD must be ruled out.