ies decreased in all patients. At baseline, patients 5 and 6 had anti-dsDNA levels within the normal range. At 6 months, anti-dsDNA had become undetectable in patients 3, 5, and 6, and had decreased to within the normal range in patients 1 and 4. Treatment was generally well tolerated. Adverse events: mild transitory neutropenia with fever (1 episode), pyelonephritis (2 episodes), low IgM (3 patients), low IgG (1 patient). Further follow-up: patient 1 relapsed at 10 months with arthritis and fatigue but renal disease is still under control at 22 months; patient 2 relapsed at 6 months and was retreated; patient 3 remains well at 16 months with controlled renal disease and normal platelet count haemoglobin level.

Conclusions: These results look promising and Blyd should be considered in active refractory patients particularly with renal and haematological involvement. The optimal rituximab dose remains to be established. Formal controlled trials are needed to help determine the true efficacy and safety of Blyd in SLE.

Vasculitis

265. PREDICTING TEMPORAL ARTERITIS IN PEOPLE WITH PRESENTING POLYMYPALGIC SYMPTOMS
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Background: Introduction: Polymyalgia symtoms are associated with temp- oral artheritis(TA). The later can cause significant morbidity and therefore factors that might predict risk of TA would be clinically useful.

Methods: Aim: To identify baseline clinical and laboratory factors that predict development of TA in people who present with polymyaligic symptoms(PMS).

Method: 186 consecutive patients with PMS who developed TA (ACR 1990 criteria) or were diagnosed as polymyalgia rheumatica (Bird criteria) were enrolled into this prospective study. These patients were recruited between 1989 and 2000. Baseline clinical, laboratory data was compared (using non parametric statistics) between patients with PMS who did not develop TA and those who presented with PMS and subsequently developed TA. Patients were excluded from analysis if TA pre-dated PMS or if there was clinical evidence of TA when patient presented with PMS.

Results: 158 patients presenting with PMS had PMR only. 41 patients had PMS symptoms and TA, of whom 31 patients had PMS which pre-dated TA symptoms (time from onset of PMS to diagnosis of TA: median 17 months (range 1 - 135). No significant differences were identified between groups in their clinical symptoms or plasma viscosity at initial presentation. HLA-DRB1*04 was significantly more frequently found in the PMS-TA group(72%) compared to PMR only group(46%). A weak negative association between HLA-DRB1*02 allele and the subsequent development of TA in people with PMS was identified.

Conclusions: Although no baseline clinical features predicted TA in people presenting with polymyaligic symptoms, people who present with PMS and have HLA-DRB1*04 are more likely to develop TA.

266. PREDICTING DURATION OF ORAL PREDNISOLONE TREATMENT IN PEOPLE WITH POLYMOLYRIA RHHEUMATICA
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Background: Introduction: Polymyalgia symtoms are associated with temp- oral artheritis(TA). The later can cause significant morbidity and therefore factors that might predict risk of TA would be clinically useful.

Methods: Aim: To identify baseline clinical and laboratory factors that predict duration of steroid use in people with PMR.

Methods: 158 consecutive patients with PMR were enrolled in a prospec- tive study. These patients were recruited between 1989 and 2000. Clinical features, laboratory data and treatment were recorded regularly for a mini- mum of two years. Non parametric tests and Kaplan – Meier survival anal- ysis were undertaken on data from those who had successfully terminated steroid treatment (no PMR symptoms for at least three months after stop- ping steroids). Patient data was excluded from analysis if they subsequently developed temporal arthritis.

Results: 123 (77.8%) patients had stopped prednisolone treatment suc- cessfully. Median duration of treatment: 21.8 months(5.7 – 131.2). Median starting dose: 15mg (7.5 – 40). No significant differences were found between duration of prednisolone treatment and gender, base- line anaemia, raised viscosity, initial response to steroids, presence of os- teoarthritis and presence of HLA-DRB1 alleles.

Conclusions: Baseline clinical, serological and genetic factors did not pre- dict those with PMR who might need longer periods of oral prednisolone treatment.

267. THE PREVALENCE AND ASSOCIATIONS OF AN ABNORMAL ANKLE-BRACHIAL PRESSURE INDEX IN SYSTEMIC VASCULITIS: A PILOT STUDY
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Background: Cardiovascular disease may be increased in patients with sys- temic vasculitides (SV). The Ankle-Brachial Pressure Index (ABPI) is a reli- able non-invasive tool for the assessment of cardiovascular risk.

Objectives: To determine the prevalence of an abnormal ABPI in patients with SV and healthy controls and to assess possible associations between an abnormal ABPI with clinical and serological parameters.

Methods: We studied 54 consecutive patients (20 males under 55 years and 54 females under 60 years) attending our Vasculitis clinic and 49 healthy subjects. Patients were classified according to the ACR 1990 criteria and the Chapel Hill Consensus definitions. There were: 18 patients with We-gener’s granulomatosis, 8 Behcet’s disease, 7 Churg-Straus-ses disease, 3 polyarteritis nodosa, 3 Takayasu’s arteries, 3 p-ANCA associated vasculitis, 3 Hensch-Schönlein purpura, 3 primary uricarial vasculitis, 2 leucocyto- clastic angitis, 1 microscopic polyangitis, 1 primary angitis of central ner- vous system, 1 giant cell arteritis, 1 vasculitis secondary to Sjogren syn- drome. Blood was taken for glucose, lipid profile, CRP, hsCRP, ANCA and antiphospholipid antibodies (aPL). ABPI was measured according to a con- sensus statement on methodology. An ABPI < 1.0 was considered patho- logical.

Results: There were 34 (63%) females. The mean age was 45.4 years (SD 9.7) for female and 41.3 (SD 10.1) males; 83% were Caucasian, 11.1% In- dian, and 2 and 1 patients were Black and Asian respectively. The median disease duration was 48 months. The healthy controls were 40.96 (SD 11.7) years old. aPL were detected in 8 patients (14.8%). The ABPI was pathologi- cal in 11/54 (20.4%) patients and was significantly higher than the healthy controls (2/49 (4%); p< with Yates correction = 4.8, p < 0.03). In the vasculitis patients, there were more cardiovascular events in the abnormal ABPI group (11.6% vs. 45.5%, p = 0.001). Both groups were similar in age, sex and race distribution, prevalence of traditional risk factors and therapy. There were 31.5% patients with hypertension (82.4% on treatment); and 2 had diabetes mellitus. Hypercholesterolemia occurred in 34 (62%) of patients. 52% were current or ex-smokers: mean tobacco use was 15.8 pack-years. 37% of the patients reported cardiovascular events in their first degree relatives. Exces- sive alcohol consumption was seen in 9 (16.7%) and 25% of patients were obese (BMI < 30). Only 7 patients exercised regularly. Of 20 menopausal women only 2 were on hormone replacement therapy. 90.7% of patients were on corticosteroids and immunosuppressive therapy.

Conclusions: There was a high prevalence of an abnormal ABPI in patients with systemic vasculitides implying an increased risk of cardiovascular dis- ease.

268. DIAGNOSTIC CRITERIA FOR ANCA-ASSOCIATED PRIMARY SYSTEMIC VASCUITIS (AASV) IN PATIENTS PRESENTING WITH ACUTE PULMONARY AND/OR RENAL DISEASE: A PILOT STUDY
J.S. McLaren, C.J. Hall, R.A. Luqmani. Rheumatic Diseases Unit, University of Edinburgh, Edinburgh, United Kingdom

Background: A pilot study to assess the Birmingham Vasculitis Activity Score (BVAS) item checklist as a diagnostic tool for AASV.

Methods: 74 inpatients with new acute undiagnosed pulmonary and/or re- nal disease were prospectively recruited over a 10 month period until Sept 2003. Patients fulfilled 1 of the 3 inclusion criteria. 1. Respiratory: New res- piratory symptoms with haemoptysis and/or chest radiograph abnormalities AND new/worse symptoms/signs/investigations in another organ system; 2. Renal: New renal impairment with microscopic haematuria and/or protein- uria; 3. Pulmonary-renal: New presentation of haemoptysis/pulmonary inflam- ites with acute glomerulonephritis. All new items were scored on the BVAS checklist (59 items; 9 organ systems). Patients were grouped according to discharge diagnosis as either vasculitis (AASV) or non vasculitis. Based on published data, the expected frequency of vasculitis in these patients was 10%. Data were analysed by the Mann-Whitney test.
Results: Of the 43 patients, 7 had vasculitis (4 Wegener’s granulomatosis; 1 Churg-Strauss syndrome; 1 juvenile idiopathic arthritis; 1 crescentic glomerulonephritis). Of the 67 patients with non vasculitis, 53 had Respiratory presentations (30 pneumonia; 8 malignancy; 5 pulmonary embolism; 2 tuberculosis and 8 miscellaneous). 11 patients had Renal presentations (7 acute renal failure, 1 acute tubular necrosis and 4 miscellaneous), 3 patients had Pulmonary-renal presentations (pneumonia 2/brochietasis 1) with acute renal impairment). The table shows the median number of BVAS items and systems scored for the vasculitis and non vasculitis groups. There was a statistically significant difference in the number of BVAS items scored by the vasculitis patients (8) compared with the non vasculitis patients (5); p=0.008. There was no difference in the number of BVAS systems scored between the two groups.

<table>
<thead>
<tr>
<th>BVAS items and systems scored for vasculitis and non vasculitis patients</th>
<th>Median No. of BVAS items scored (range)</th>
<th>Median No. of BVAS systems scored (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vasculitis</td>
<td>8 (5-14)</td>
<td>3 (2-4)</td>
</tr>
<tr>
<td>Non vasculitis</td>
<td>5 (2-12)</td>
<td>3 (1-6)</td>
</tr>
<tr>
<td>p Value</td>
<td>p = 0.008</td>
<td>p = not significant</td>
</tr>
</tbody>
</table>

Conclusions: This pilot study suggests that there may be a role for using a simple checklist of symptoms and signs in patients presenting with multi-system disease in order to detect those most likely to have systemic vasculitis who may need urgent treatment. We found a statistically significant difference between the vasculitis and non vasculitis groups in terms of the number of BVAS items scored. Recording of > 5 BVAS items at presentation had a positive predictive value of 70% for the diagnosis of vasculitis among patients presenting with acute pulmonary and/or renal disease, with a sensitivity of 86% and specificity of 63% [data not shown].

269. WEGENER’S GRANULOMATOSIS: COMPARISON OF OUTCOME IN PATIENTS TREATED WITH LOW DOSE IV CYCLOPHOSPHAMIDE, ORAL CYCLOPHOSPHAMIDE OR OTHER CYTOTOXIC AGENTS
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Background: Wegener’s Granulomatosis (WG) is a necrotizing granuloma- tosis affecting small to medium-sized vessels. Cytoxic agents and glucocorticoids are the mainstay of treatment.

Objective: To assess outcome of WG patients treated with low dose intravenous (iv) Cyclophosphamide (CYC) compared to other induction regimens.

Methods: We retrospectively studied outcome in WG patients treated with 3 different types of induction therapy: low dose iv CYC, oral (po) CYC or other cytotoxic drugs. Case notes were reviewed for the following: age, race, sex, duration of disease, antineutophil cytoplasmic antibodies (ANCA), treatment, Vasculitis Damage Index (VDI) (Scale 0-64, none-severe damage) and the ILAR classifcation reapplied. The case notes of each child were reviewed and patients classified according to the ACR 1990 criteria with low dose iv CYC, oral CYC and other cytotoxic therapies respectively. The common regimen in the iv group was 500mg fortnightly for 6 doses. The total mean CYC dose per patient was 10g and 88g in the iv and po groups respectively. Methotrexate (MTX)(18%), azathioprine (AZA)(47%) or a combination of cytotoxic drugs (35%), were used for maintenance therapy. In the other cytotoxic groups, induction and maintenance therapy with AZA(27%), MTX(27%) or both drugs sequentially (27%) were used. Corticosteroids were used in 98% of patients for a mean of 90% of disease duration. 67% of patients were on co-trimazole. The mean total VDI, at diagnosis and on current assessment, current SF36 and the occurrence of significant side effects were recorded and compared.

<table>
<thead>
<tr>
<th>Induction treatment</th>
<th>Mean total VDI</th>
<th>Mean current VDI</th>
<th>Mean change VDI</th>
<th>Occurrence of side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV CYC</td>
<td>3.3</td>
<td>4.6</td>
<td>1.3g-0.04g</td>
<td>72</td>
</tr>
<tr>
<td>PO CYC</td>
<td>3.9</td>
<td>5.9</td>
<td>1.9g-0.01g</td>
<td>58</td>
</tr>
<tr>
<td>Other Cytostics</td>
<td>1.7</td>
<td>2.8</td>
<td>1.1g-0.04g</td>
<td>52</td>
</tr>
</tbody>
</table>

* Wilcoxon signed rank test Vs baseline VDI

Paediatric rheumatology

271. SUBGROUP CLASSIFICATION OF CHILDREN WITH JIA USING THE ILAR SCHEME DOES NOT CHANGE OVER 12 MONTHS OF OBSERVATION
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Background: Juvenile idiopathic arthritis (JIA) is a heterogeneous disorder and affected children are sub-divided into clinically defined homogeneous subsets to allow comparability in study. The ILAR classification scheme (1997), which is weighted heavily on disease characteristic at first presentation, was introduced as an easily applied system, to provide mutually exclusive categories, robust on follow-up. There are few data from prospective studies, however, on the reliability of this system. We have used the opportunity afforded from the pilot phase of the UK multicentre Childhood Arthritis Prospective Study (CAPS) to investigate (1) whether the subgroup allocation is stable over the first year and (2) the face validity of the allocation compared to clinician opinion.

Methods: CAPS recruits consecutive children attending the participant centres with any joint inflammation, lasting at least two weeks not due to trauma or sepsis. At first visit, all are assessed by a paediatric rheumatologist and allocated to an ILAR group. The children are seen again at 6 and 12 months and the ILAR classification reapplied. The case notes of each child were examined independently and the criteria reapplied at each stage reviewed against the stated rules.

Results: To date 124 children have been recruited, of whom 71 have been followed for 6 months, and 45 for 12 months. At baseline 13 (10.5%) could not be classified into any category due to the short duration of inflammation - ILAR requiring a minimum of 6 weeks. In all 63 (51%) were classified as having oligoarthritis, 7 (6%) extended oligoarthritides, 11 (9%) rheumatoid factor (RF) negative, and 4 (3%) RF positive, polyarthritis, and 10 (8%) systemic rheumatoid arthritis.