

**PP1. REPEATED 18-FLUORODEOXYGLUCOSE POSITRON EMISSION TOMOGRAPHY IN ISOLATED POLYMYALGIA RHEUMATICA: A PROSPECTIVE STUDY IN 35 PATIENTS**

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**Objective:** To study fluorodeoxyglucose (FDG)-deposition in different vascular beds and in the large joints of patients with isolated polymyalgia rheumatica (PMR) and to investigate whether there is a relation between FDG-positron emission tomography (PET) results and risk of relapse.

**Methods:** All consecutive patients with isolated PMR underwent a FDG-PET scan before treatment with steroids was started and – if logistics allowed – at 3 and 6 months. PET-scans were scored at 7 different vascular areas and a total vascular score (TVS) was calculated, ranging from 0 to 21. FDG uptake in the shoulders, the hips and the processi spinosi of the vertebrae was scored as 0 (no uptake), 1 (moderate uptake) or 2 (intense uptake).

**Results:** Thirty-five patients entered the study. At diagnosis, vascular FDG-uptake was noted in 11 patients (31%), predominantly at the subclavian arteries. Mean TVS was low. FDG-uptake in the shoulders was noted in 94% of patients, in the hips in 89% and in the processi spinosi of the vertebrae in 51%. The intensity of FDG-uptake in the large vessels or in the shoulders, hips or processi spinosi did not correlate with the risk of relapse.

**Conclusions:** Only 1 in 3 patients has a (moderately) increased vascular FDG-uptake, especially in the subclavian arteries. The vast majority has inflammation of shoulders and hips and half of them have increased FDG-uptake at the processi spinosi. Results of FDG-PET scans in patients with PMR do not correlate with their risk of relapse.

**PP2. LONG-TERM FOLLOW-UP OF POLYMYALGIA RHEUMATICA PATIENTS TREATED WITH METHOTREXATE AND STEROIDS**

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**Introduction:** We have recently demonstrated that combination therapy with prednisone and methotrexate (MTX) is effective as steroid-sparing treatment for patients with newly diagnosed polymyalgia rheumatica (PMR) [1]. This schedule reduces the incidence of flare-ups and the amount of prednisone required to maintain remission. However, no substantial reduction was found in the incidence of steroid-related side effects in the MTX-treated patients, despite the lower cumulative dose of prednisone they received. Possible explanations are the narrow difference in the cumulative dose of prednisone between groups, and the low incidence of side effects in this relatively “healthy” group of PMR patients, a common problem of controlled trials. Another possibility is the short follow-up. To test this last hypothesis, we decided to review the charts of the participating patients and to visit them again after a mean period of 5 years after completion of the original study.

**Patients and methods:** Four of the original five rheumatologic tertiary referral centres, covering 61 of the original 72 (84.7%) patients, agreed to participate in the study. Patients were contacted by phone and asked to visit the clinic. If the patient was dead, a close relative was interviewed and information was collected on his/her previous health conditions and cause of death through a standardized questionnaire.

**Results:** Data were obtained from 47/61 (77%) of the original patients. Five patients (10.6%) had died because of cerebrovascular accident, myocardial infarction, congestive heart failure (2 patients), or unknown cause. Two of the 23 MTX-treated patients (8.7%) had died in comparison with 3/24 (12.5%) controls. Exacerbations and relapses of PMR were seen in 4/23 (17.4%) MTX-treated patients in comparison with 10/24 (41.7%) controls (p = 0.11 by Fisher’s exact test). Five out of 23 (21.7%) MTX-treated patients were still on steroids 5 years after completion of the study in comparison with 11/24 (45.8%) controls (p = 0.12). Girdle pain and stiffness, as well as results of the HAQ were not different in the two subgroups. Pain intensity, general health and physician’s opinion on the patient’s conditions by visual analogue scale tended to be better in MTX-treated patients than in controls, although not significantly so (20.2 ± 21.1 mm vs. 17.2 ± 22.7 mm, 17.3 ± 19.7 mm vs. 13.7 ± 21.1 mm, and 13.2 ± 18.8 mm vs. 6.9 ± 8.6 mm, respectively). ESR (15.5 mm/h vs. 25.4 mm/h, p = 0.013) and CRP (2.7 mg/L vs. 11.3 mg/L, p = 0.009) were lower in MTX-treated patients.

Potential side effects of steroid treatment were relatively rare. No differences were observed in their incidence, with a mean of 1.9 side effects for MTX-treated patients and 2.6 for controls. The analysis of single steroid-related side effects gave similar results.

**Conclusions:** In this long-term evaluation of the effect of MTX supplementation for PMR patients, there was a tendency toward less residual disease activity over 5 years in MTX-treated patients. However, complications of steroid treatment were rare in both groups without a significant difference between them. To assess whether MTX-supplementation therapy could spare some side-effects of steroids, a prospective evaluation of unslected patients is probably more appropriate.


**PP3. ERDHEIM-CHESTER DISEASE: YET ANOTHER MIMIC OF POLYMYALGIA RHEUMATICA AND GIANT CELL ARTERITIS?**

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**Background:** Erdheim-Chester Disease is a rare non-langerhans cell histiocytosis. First described in the 10th Century, there are only 60 cases in the literature. It can present with bone pain, visual field loss, pituitary failure and lower limb claudication. Prognosis is approximately two years from diagnosis.

We present the case of a 67 year old man whose symptoms were considered classical of polymyalgia rheumatica. He responded to steroid therapy initially but re-presented with eye symptoms thought to be caused by giant cell arteritis.