MATTERS ARISING

Outcome of patients with early rheumatoid arthritis over a two year period

We have been interested in the publication by Möttönen and colleagues concerning the outcome of patients with early rheumatoid arthritis (RA) who have been treated actively by disease suppressing drugs using a "sawtooth" strategy[1][2] and have assessed the outcomes in our patients with early RA who have been treated using a similar strategy. Our study is prospective for five years and started in 1996. Up to now 50 patients have been recruited and followed up for two years. All patients fulfilled the American Rheumatism Association criteria for RA. Patients were treated actively with conventional doses of standard disease suppressing drugs. Disease activity was recorded using the disease activity score (DAS) (this included erythrocyte sedimentation rate, tender joint score, swollen joint score, and a global assessment score (VAS).

At two years 14 patients were in remission, nine patients showed partial improvement but were not in remission, 21 subjects have not shown an over all clinical improvement. (In 13 of these subjects the disease suppressing drugs have been stopped because of side effects, and in eight subjects the drug regimen has been tolerated but has not been effective so far). There were five drop outs and one non-drug related death. There were no significant clinical differences in the baseline measurements of disease severity or activity between those patients who subsequently developed remission with drug treatment and those who did not improve.

In conclusion, the most common cause for failing to respond to a regimen of treatment of early RA patients within two years is lack of tolerance to the disease suppressing drug regimen. The 28% remission rate noted in our patients at two years is very similar to the 27% noted by Möttönen and colleagues after two year of treatment suggesting that this figure could be used as a standard for those auditing the outcome of the management of early RA by different rheumatology centres.

1 Möttönen T, Paimela L, Leirisalo-Repo M, Kautiainen H, Ilonen J, Hannonen P. Only high disease activity and postive rheumatoid factor indicate poor prognosis in patients with early rheumatoid arthritis treated with "sawtooth" strategy. Ann Rheum Dis 1998;57:533–40.
2 Möttönen T, Paimela L, Ahonen J, Helve T, Hannonen P, Leirisalo-Repo M, *et al.* Arthritis Rheum 1996;39:996–1005. Outcome of patients with early rheumatoid arthritis treated according to the "sawtooth" strategy.

J TEIR
J GRAY
A PENDLEBURY
D M GRENNAN
Department of Rheumatology, Wrightington Hospital for Joint Disease, Hall Lane, Appley Bridge, Wigan, Lancashire WN6 9EP

Correspondence to: Dr Grennan.

Author's reply

We wish to thank Dr Teir and colleagues for the comments and their data concerning the outcome of patients with early rheumatoid arthritis (RA). We all agree now that the treatment of RA should aim at clinical remission. The frequency of the patients with achieved remission at two years after the institution of slow acting anti-rheumatic drugs (SAARDS) was quite similar in their cohort compared with our results (28% *v* 27%). However, it is notable that the figures concern patients treated actively with SAARDs in their early phase of disease. Therefore, in our opinion it is of crucial importance to describe accurately the treatment stragegy used in studies investigating the outcome and predictive factors of RA. Despite the observed seemingly high remission rates it is clear that the results obtained with these treatment modalities do not satisfy all the RA patients, especially those with most severe disease and we have to develop more effective strategies to treat RA patients.

TIMO MÖTTÖNEN
LEENA PAIMELA
MARJATTA LEIRISALO-REPO
HANNU KAUTIAINEN
J ILONEN
PEKKA HANNONEN
The Division of Rheumatology of the Department of Medicine, Turku University Central Hospital, Paimio Hospital, FIN-21540 Paimio, Finland

Correspondence to: Dr Möttönen.

Musculoskeletal disorders in the community

We noted with interest the recent findings of Urwin *et al.*[1] We have previously reported higher HAQ scores (poorer function) in rheumatoid arthritis (RA) patients from more deprived areas.[2] We subsequently wished to determine whether this difference in func tional ability was a true difference or one of patient perception. A cross sectional study of 37 female RA patients was conducted in an outpatient rheumatology clinic. Patients were asked to complete a HAQ (self reported HAQ) and thereafter observed performing the tasks delineated in the HAQ excluding bathing, toileting, and outdoor activities (observed HAQ). Observed HAQ scores were completed by the same observer in a room equipped for the assessment. The observer was blinded to the self reported HAQ and no discussion took place between observer and patient. Self reported and observed scores were calculated as described by Fries *et al.*[3] Observed scores had maximum score of 21 (seven categories). Social deprivation was determined using the Carstairs Index, which is derived from the patients' postcode and is based on overcrowding, social class, male unemployment, car ownership.[4] Deprivation category 1—most affluent; deprivation category 7—most deprived. Discordance in HAQ was calculated by subtracting self reported HAQ from observed HAQ. Table 1 lists the results. Because of the small sample size previous differences observed in HAQ between deprivation categories were not found.

Thus self reported HAQ correlated well with observed HAQ in each group. Self reported HAQ was accurate and equally valid regardless of level of social deprivation. The important influence of social deprivation on functional ability is not one of patient perception and requires further investigation.

H A CAPELL
A MCENTEGART
Centre for Rheumatic Diseases, Royal Infirmary, 84 Castle Street, Glasgow G4 0SF

Correspondence to: Dr McEntegart.

1 Urwin M, Symmons D, Allison T, Brammah T, Busby H, Roxby M, *et al.* Estimating the burden of musculoskeletal disorders in the community: the comparative prevalence of symptoms at different anatomical sites, and the relation to social deprivation. Ann Rheum Dis 1998;57:649–55.
2 McEntegart A, Morrison E, Capell HA, Duncan M, Porter D, Madhok R, *et al.* Effect of social deprivation on disease severity and outcome in patients with rheumatoid arthritis. Ann Rheum Dis 1997;56:410–13.
3 Fries JF, Spitz PW, Kraines RG, Holman HR. Measurement of patient outcome in arthritis. Arthritis Rheum 1980;23:137–45.
4 Carstairs V, Morris R. *Deprivation and health in Scotland.* Aberdeen: Aberdeen University Press, 1991.

Table 1   Observed and self reported HAQ scores in 37 RA patients

Deprivation category	1 and 2	3, 4, and 5	6 and 7
Patients (n)	7	16	14
*Self reported HAQ	1.86 (1.43–2.28)	1.71 (0–2.43)	1.64 (0.43–2.28)
*Observed HAQ	2.14 (0.1–2.43)	1.64 (0.43–2.43)	1.71 (0.43–2.71)
*Discordance in HAQ	−0.14 (−0.57–0.71)	0 (−0.29–0.71)	0.07 (−0.15–0.86)

*Median (range). Mann-Whitney analysis: no significant difference between self reported and observed HAQ in any group.