further studies of CPN10 in patients with RA are warranted.

Original article Vanags D *et al.* (2006) Therapeutic efficacy and safety of chaperonin 10 in patients with rheumatoid arthritis: a double-blind randomised trial. *Lancet* **368:** 855–863

Long-term results of rituximab therapy in patients with SLE and vasculitis

Current treatments for systemic lupus erythematosus (SLE) and antineutrophil cytoplasmic antibody (ANCA)-associated vasculitis include toxic immunosuppressive agents such as cyclophosphamide, and less-toxic treatments would be beneficial. A UK trial has now shown that B-cell depletion with rituximab is a safe and effective long-term treatment for both these conditions.

The study included 11 patients with SLE and 11 patients with ANCA-associated vasculitis. All patients had active disease refractory to conventional therapy. Participants received four weekly infusions of rituximab 375 mg/m^2, plus one infusion of cyclophosphamide 500 mg at the same time as the first infusion of rituximab. Patients who experienced relapse received two infusions of 1 g rituximab, 2 weeks apart, without cyclophosphamide. Patients who were receiving mycophenolate mofetil or azathioprine at enrollment continued this treatment at the same dose until 6 months, when a dose reduction was allowed. The median follow-up was 24 months.

Rituximab resulted in B-cell depletion in all patients and clinical response to treatment in 21 patients. Relapses occurred in all patients with SLE after a median of 12 months, and in 6 patients with ANCA-associated vasculitis after a median of 16.5 months; all episodes of relapse were associated with B-cell regeneration, except in one patient who had undetectable B cells at treatment initiation. Re-treatment with rituximab was successful in all patients who relapsed. The most common adverse events were mild infusion reactions. Four patients had severe infections; it is not known if rituximab contributed to them.

Original article Smith KGC *et al.* (2006) Long-term comparison of rituximab treatment for refractory systemic lupus erythematosus and vasculitis. *Arthritis Rheum* **54:** 2970–2982

Long-term glucocorticoid use linked with high mortality in patients with RA

Patients with rheumatoid arthritis (RA) have increased mortality compared with the general population. The excess mortality of these patients has been attributed to several factors; however, the contribution of glucocorticoid use remains poorly defined.

In their population-based study, Sihvonen and colleagues reviewed the medical records of 604 patients with RA. Data on these patients' general state of health, comorbidities, severity of RA, and RA treatments including oral glucocorticoid therapy were collected between 1988 and 1999. No information was obtained on intra-articular glucocorticoid therapy. Patients were assigned to groups according to their oral glucocorticoid use: minimal users ($n = 209$) had never taken glucocorticoids or had used them for >1 month, medium-term users ($n = 276$) had taken glucocorticoids for between 1 month and 10 years, and long-term users ($n = 119$) had taken glucocorticoids for >10 years.

In total, 160 patients had died by 1999: 48 (23%) minimal users; 57 (21%) medium-term users; and 53 (45%) long-term users. The main cause of death was cardiovascular disease in all groups. Infections and intestinal perforations due to amyloidosis were more frequent in long-term glucocorticoid users than in patients from the other groups, and lymphomas were most common in medium-term and long-term glucocorticoid users.

The authors conclude that patients with RA who take oral glucocorticoids for >10 years have an increased risk of mortality compared with those who take glucocorticoids for <10 years or have never taken glucocorticoids.

Original article Sihvonen S *et al.* (2006) Mortality in patients with rheumatoid arthritis treated with low-dose oral glucocorticoids. A population-based cohort study. *J Rheumatol* **33:** 1740–1746

Extremity MRI shows promise for prediction of early joint damage in RA

Conventionally, the progression of rheumatoid arthritis (RA) is monitored by radiography, but this technique only detects late stages of joint damage. MRI is more sensitive than