criteria, including serum level of IgG4 above 1.35 g/l and abundant IgG4+ plasma cell infiltration in the affected tissue.

A retrospective analysis of the clinical and pathological features of 85 patients in Japan with Mikulicz's disease and related disorders identified 64 cases of IgG4+MOLPS. In comparison with 31 patients who met the diagnostic criteria for SS, those with IgG4+MOLPS had a significantly lower incidence of symptoms typical of SS, such as xerostomia, xerophthalmia and arthralgia, as well as of immunological markers, such as rheumatoid factor and antibodies against Ro/SSA and La/SSB. Furthermore, although the distribution of organ involvement in the two disorders is similar, the substantial plasmacytic infiltration in the tissue of patients with IgG4+MOLPS was characterized by an IgG4+/IgG ratio >50%. The authors also highlighted that IgG4+MOLPS occurs with a far higher frequency in men than does SS, and, crucially, IgG4+MOLPS usually responds well to treatment with glucocorticoids.

The implications for appropriate treatment highlight the potential importance of distinguishing IgG4+MOLPS from SS, but the observations of this study will first need to be confirmed in a larger group of patients.

Original article Masaki Y *et al.* (2008) Proposal for a new clinical entity, IgG4-positive multi-organ lymphoproliferative syndrome: analysis of 64 cases of IgG4-related disorders. *Ann Rheum Dis* [doi:10.1136/ard. 2008.089169]

Novel anti-CD20 monoclonal antibody shows promise as therapy for RA

The results from the first human trial of ocrelizumab, a humanized anti-CD20 monoclonal antibody, in the treatment of rheumatoid arthritis (RA) have recently been presented. Genovese *et al.* investigated the safety and efficacy of ocrelizumab in 237 patients with active, moderate to severe RA who had shown an inadequate response to therapy with ≤6 DMARDs. Patients were receiving concomitant methotrexate, and were randomly allocated to receive two infusions of 10, 50, 200, 500 or 1,000 mg ocrelizumab or placebo.

A robust clinical response was seen across all dosages, with greater benefits in those receiving doses ≥200 mg. Rapid B-cell depletion was observed after the first infusion across all treatment groups, with a trend towards earlier B-cell recovery in those receiving 10 or 50 mg ocrelizumab. Reductions in C-reactive protein levels were greatest in the high-dose groups. Doses of 200 mg or higher had very low immunogenicity compared with the lower doses. Serious adverse events occurred in 17.9% of ocrelizumab-treated patients and 14.6% of the placebo group. Rates of serious infection were similar in both groups (2.0% versus 4.9%). Rates of infusion were similar across all treatment groups, and were higher than the rates in the placebo group (51% versus 17%).

These results suggest that ocrelizumab, at doses of 200 mg and over, combined with methotrexate could be an effective therapeutic strategy for patients with treatment-refractory RA.

Original article Genovese MC *et al.* (2008) Ocrelizumab, a humanized anti-CD20 monoclonal antibody, in the treatment of patients with rheumatoid arthritis. A phase I/II randomized, blinded, placebo-controlled, dose-ranging study. *Arthritis Rheum* **58:** 2652–2661

Ten-second RAPID3 tool categorizes RA disease severity similarly to standard indices

The Routine Assessment of Patient Index Data 3 (RAPID3) self-report questionnaire aims to provide an informative, quantitative index of disease activity in patients with rheumatoid arthritis (RA) without necessitating a time-consuming, formal joint count on the part of the physician. A recently published study by Pincus and colleagues showed that the categorization of disease severity as high, moderate, low or near-remission by RAPID3 scores was similar to that by standard indices.

In the study, 285 patients from three clinics completed the multi-dimensional health assessment questionnaire of pain, function and patient global estimate before undergoing evaluation for erythrocyte sedimentation rate, 28-joint count and physician global estimate. RAPID3 correlated significantly with both CDAI (Clinical Disease Activity Index; $\rho = 0.74$, $P < 0.001$) and DAS28 (Disease Activity Score 28; $\rho = 0.66$, $P < 0.001$). Adding additional measures to the calculation of RAPID3 scores, such as joint count or physician global assessment, increased this correlation, but not enough to justify the additional examination time required.