EXTENDED REPORT

Predictive value of autoantibodies from anti-CCP2, anti-MCV and anti-human citrullinated fibrinogen tests, in early rheumatoid arthritis patients with rapid radiographic progression at 1 year: results from the ESPOIR cohort

Yannick Degboé,1,2 Arnaud Constantin,1,2 Delphine Nigon,1 Gabriel Tobon,3 Martin Cornillet,4,5 Thierry Schaeverbeke,6 Gilles Chiocchia,7 Pascale Nicaise-Roland,8 Leonor Nogueira,4,5 Guy Serre,4,5 Alain Cantagrel,1,2 Adeline Ruysen-Witrand1,9

ABSTRACT

Objectives: We compared the ability of antibodies against cyclic citrullinated peptides (anti-CCP2), against mutated citrullinated vimentin (anti-MCV) and against citrullinated fibrinogen (AhFibA) to predict 1 year rapid radiographic progression (RRP; total Sharp score variation ≥5 points), in early rheumatoid arthritis (RA).

Methods: We analysed 566 patients from the ESPOIR cohort with early RA fulfilling the 2010 American College of Rheumatology/European League Against Rheumatism (ACR/EULAR) criteria at year 1. We assayed the 3 anticitrullinated peptide antibodies (ACPA) tests on baseline sera. We compared the performance of these 3 ACPA tests to predict first-year RRP, by comparing areas under the receiver operating characteristic curves (ROCs). We assessed the 1 year RRP risk by ACPA titres. We used a logistic multivariate regression to analyse RRP risk in terms either of ACPA positivity or titre: high (>3 times the N cut-off) and low (1 to 3N).

Results: 145 patients displayed RRP. Areas under the ROCs were similar (0.60) for the 3 tests. High ACPA titres were associated with 1 year RRP, whatever the test was, and with similar ORs. Low+ anti-MCV titres were not associated with 1 year RPP, whereas low+ anti-CCP2 titres (p=0.0226) and low+ AhFibA titres (p=0.0332) were significantly associated. In multivariate analysis, 1 year RPP was associated with anti-CCP2 positivity (p=0.0001), AhFibA positivity (p<0.0001) and high anti-MCV titres (p<0.0001).

Conclusions: Anti-CCP2 antibodies and AhFibA were predictive of 1 year RPP in early RA whatever their titre was, whereas only high anti-MCV antibody titres were predictive, potentially making them more discriminant to predict 1 year RPP risk.

INTRODUCTION

Anticitrullinated peptide antibodies (ACPA) are the most specific autoantibodies known as markers of rheumatoid arthritis (RA). In cohorts of early RA, ACPA are associated with increased clinical disease activity and progression of structural damage.1 ACPA have high weight in the final scoring system of the 2010 American College of Rheumatology/European League Against Rheumatism (ACR/EULAR) RA classification criteria for RA.2 This weight is modulated by the ACPA
titre (negative, low and high), with increased risk of RA being associated with high titres.

Data concerning the link between the structural expression of RA and ACPA detected with various tests show discrepancies. In four works performed in early RA with various ACPA tests using different antigens, the link between ACPA and structural progression was variable.3-6 In the work of Fisher et al.,5 radiographic progression (RRP) over 2 years was greater for ACPA-positive than for ACPA-negative patients; however, anti-CEP-1 antibodies (directed to citrullinated α-enolase) did not confer additional severity. In a study by Scherer et al.,6 the structural damage progression over 5 years in ACPA-positive patients was not associated with any antibody to the six citrullinated peptides used as antigens (2 from vimentin, 2 from fibrinogen, 1 from α-enolase, 1 from myelin basic protein). The extent of the ACPA epitope directory analysed on these peptides did not modify the structural prognosis.

However, three studies considered antimutated citrullinated vimentin (anti-MCV) antibodies as an additional marker of structural severity.7-9 Montes et al.8 found that patients with antibodies to the citrullinated vimentin peptide 60–75 show a higher prevalence of erosions than patients without, independently of their positivity for anticyclic citrullinated peptide (anti-CCP2) antibodies. Harre et al.9 found that the presence of anti-MCV antibodies could increase osteoclastogenesis and bone resorption.

Our work compared ACPA assayed with three different tests. The anti-CCP2 antibodies were considered as the reference because of their wider usage. We evaluated the anti-MCV antibodies because of the supposed direct pro-erosive role of anticitrullinated vimentin antibodies.7 Lastly, we evaluated the anti-human citrullinated fibrinogen-2 antibodies (AhFibA) since citrullinated fibrin is the main ACPA autoantigen in the synovial tissue of patients with RA.10 The 3 tests have shown similar value for the diagnosis of RA in early arthritis;11 however, to date, only a few studies have assessed their performance in terms of structural outcome and, moreover, they show some discrepancies.12-17

This work aimed to compare anti-CCP2 antibodies, anti-MCV antibodies and AhFibA, all assayed at baseline in the patients of the ESPOIR cohort, and to analyse their association with rapid RRP at 1 year.

**Methods**

**Patients**

Eight hundred and thirteen patients with suspected or confirmed diagnosis of early RA, referred to 1 of 14 regional centres, were included in the French ESPOIR cohort. The inclusion criteria of ESPOIR cohort were: age 18–70 years, more than two swollen joints for >6 weeks and <6 months, suspected or confirmed diagnosis of RA and not taking any disease-modifying anti-rheumatic drugs (DMARDs) or steroids except for <2 weeks before enrolment. We analysed data from 3 ACPA tests at baseline (anti-CCP2, anti-MCV, AhFibA) and from radiographic assessment at baseline and at 1 year, for 566 patients fulfilling the 2010 ACR/EULAR criteria at year 1. Patients were excluded from analysis because of 252 missing radiographs at baseline or year 1, 109 did not fulfill ACR/EULAR criteria and 115 had missing data for ACPA (crude counts; some patients had several missing data). All patients gave their written informed consent to the prospective follow-up study before inclusion. Further details concerning patients are provided in a previous publication.18

**Clinical evaluation**

For each patient, we collected data on age, sex, smoking, symptom duration, Disease Activity Score in 28 joints, patient and physician visual analogue scale score for global assessment, functional ability by Health Assessment Questionnaire-Disability Index and disease activity by the Simple Disease Activity Index.

**Biological evaluation**

ACPA tests were assessed at baseline. Anti-CCP2 (DiaSorin) and anti-MCV antibodies (Orgentec) were assayed in Montpellier or Paris centres. AhFibA were assayed in the Toulouse centre with an in-house ELISA.11 For these ACPA tests, we used the positivity threshold (N) corresponding to the 95% diagnostic specificity: anti-CCP2 >25 U/mL, anti-MCV >20 U/mL, AhFibA >0.056 AU. ACPA tests were also assessed at the 98% diagnostic specificity threshold: 40 U/mL for anti-CCP2, 35 U/mL for anti-MCV and 0.119 AU for AhFibA. Moreover, the anti-CCP2 test was assessed at a previously validated cut-off: 50 U/mL.11 Over the cut-off sera were considered positive. Considering the weight of ACPA titres in the 2010 ACR/EULAR criteria, we assessed the antibody titres, classified as high positive if >3 times the cut-off (3N), and low positive if 1 to 3 times the cut-off.11 IgM rheumatoid factor (RF) (Menarini Diagnostics) was considered positive if >9 UI/mL. HLA-DRB1 4-digit typing and subtyping was performed in a single laboratory (Immunology laboratory, CHU Montpellier, France) using a PCR-based method. Erythrocyte sedimentation rate and C reactive protein (CRP) level were measured at baseline, then at each visit in each centre.

**Radiographic evaluation**

Radiographs of hands (anteroposterior view) and feet (anteroposterior and oblique views) were performed at inclusion and at 1 year. All radiographs were evaluated blinded by a single reader (GT, CHU Brest) by the van der Heijde-modified Sharp score. Results were expressed as total van der Heijde-modified Sharp score (mTSS). Intra-reader correlation coefficient was 0.97. The smallest detectable change was estimated at 1 point. RRP was defined as an increase in the mTSS ≥5 points per year.19 In this study, 14 patients displayed RRP.
**Statistical analysis**

The primary end point was to compare the performance of the 3 ACPA tests to predict first-year RRP by comparing areas under the receiver operating characteristic curves (AUC). Secondary end points were (1) to assess the 1 year RRP risk linked to the baseline ACPA titres, and (2) to further analyse the 1 year RRP risk by multivariate analysis including ACPA positivity and high ACPA titres if associated on univariate analysis. For descriptive analysis, continuous quantitative data with normal distribution are expressed as mean±SD and with non-normal distribution as median+IQR. One-year RRP was compared by autoantibody titres in terms of class (negative, low and high) by \( \chi^2 \) test. We modelled 1 year RRP risk by backward logistic multivariate regression, with 1 model for each test. The covariates tested included age, gender, duration of disease course before inclusion, smoking consumption, clinical centre, presence of erosions at inclusion, presence of the HLA-DRB1 shared epitope (SE) and ACPA, RF and CRP positivity. The use of steroids, or synthetic or biological DMARDs (within the first year) was included in the model. Covariates were selected if associated on univariate analysis (\( \alpha=20\% \)). Performance of the models was compared by area of the receiver operating characteristic curve analysis for each model. \( p \) Value <0.05 was considered statistically significant, with a 95% CI.

Further details concerning Methods section are provided in a previous publication.\(^1\)

**RESULTS**

**Characteristics of patients with RA**

We analysed data from 566 patients with early RA, having a complete biological and radiographic set of data. The main characteristics of patients are shown in table 1. Three hundred and thirty-three patients were positive for at least one of the three ACPA tests, 2 were anti-CCP2

| Table 1 Demographic, biological and radiographic data for the patients with early rheumatoid arthritis |
|----------------------------------|-----------------|-----------------|-----------------|
| Patients (n=566) | Patients without RRP at 1 year (n=421) | Patients with RRP at 1 year (n=145) | p Value |
| Demographic data | | | |
| Age, median (IQR) | 50.5 (40.2–57.0) | 49.9 (40.0–56.7) | 52.4 (41.7–58.6) | NS |
| Women, n (%) | 445 (78.6) | 336 (79.8) | 109 (75.2) | NS |
| Smokers, n (%) | 272 (48.1) | 204 (48.5) | 68 (46.9) | NS |
| Disease duration in months, median (IQR) | 5.0 (3.1–7.4) | 4.8 (3.0–7.1) | 5.2 (3.5–7.8) | NS |
| Biological data | | | |
| ESR, mm/1 h, median (IQR) | 22 (12–37) | 20 (12–34) | 27 (14–49) | 0.0063 |
| CRP level, mg/L, median (IQR) | 9 (0–21) | 8 (0–18) | 14 (5–36) | <0.0001 |
| ≥1 allele encoding HLA-DRB1 SE, n (%) | 292 (54.0%) | 205 (50.9) | 87 (63.0) | 0.0133 |
| RF+, n (%) | 307 (54.2) | 208 (49.4) | 99 (68.3) | <0.0001 |
| Anti-CCP2 titres, n (%) | | | |
| Negative | 295 (52.1) | 242 (57.5) | 53 (36.5) | <0.0001 |
| Low | 11 (1.9) | 6 (1.4) | 5 (3.4) | 0.0063 |
| High | 260 (45.9) | 173 (41.1) | 87 (60.0) | 0.0133 |
| Anti-MCV titres, n (%) | | | |
| Negative | 268 (47.3) | 217 (51.5) | 51 (35.2) | <0.0001 |
| Low | 51 (9.0) | 44 (10.4) | 7 (4.8) | <0.0001 |
| High | 247 (43.6) | 160 (38.0) | 87 (60.0) | 0.0133 |
| AhFibA titres, n (%) | | | |
| Negative | 272 (48.1) | 225 (53.4) | 47 (32.4) | <0.0001 |
| Low | 30 (5.3) | 20 (4.8) | 10 (6.9) | <0.0001 |
| High | 264 (46.6) | 176 (41.8) | 88 (60.7) | <0.0001 |
| Radiographic data | | | |
| Baseline mTSS, median (IQR) | 3 (0–7) | 2 (0–7) | 3 (0–8) | NS |
| mTSS at 1 year, median (IQR) | 6 (2–12) | 4 (2–8) | 13 (8–19) | <0.0001 |
| mTSS progression, median (IQR) | 2 (0–5) | 0 (0–2) | 8 (6–11) | <0.0001 |
| Baseline therapeutic data | | | |
| Steroids | 71 (12.5) | 51 (12.1) | 20 (13.8) | NS |
| Year 1 therapeutic data | | | |
| Steroids | 259 (45.8) | 190 (45.4) | 69 (47.6) | NS |
| Any DMARDs | 436 (82.4) | 315 (80.2) | 121 (89.0) | 0.020 |
| Biologics | 40 (7.1) | 30 (7.1) | 10 (6.9) | NS |

AhFibA, antihuman citrullinated fibrinogen antibodies; anti-CCP2, anticyclic citrullinated peptides generation 2 antibodies; anti-MCV, antimitated citrullinated vimentine antibodies; CRP, C reactive protein; ESR, erythrocyte sedimentation rate; mTSS, van der Heijde modified total sharp score; DMARDs, disease modifying antirheumatic drugs; RF, rheumatoid factor; RRP, rapid radiographic progression; SE, presence of at least one allele of the shared epitope of HLA-DRB1.
showed 1 year RRP as de
hundred and seven patients were positive for RF and 145
−
concerning the 98% diagnostic speci
+p+
/AhFibA+ (see online supplementary table S1). Three
hundred and seven patients were positive for RF and 145
showed 1 year RRP as defined above. Serological
data concerning the 98% diagnostic specificity thresholds and
previously validated anti-CCP2 threshold are available in
online supplementary table S2.

RRP risk at 1 year by positivity of ACPA
The AUCs for anti-CCP2, anti-MCV and AhFibA anti-
bodies were similar, and matched with modest perform-
ance: respectively, 0.601 (95% CI 0.550 to 0.651), 0.607
(95% CI 0.555 to 0.659) and 0.599 (95% CI 0.547 to
0.651). No differences were found among the tests
(p=0.87; figure 1).

Predictive values of these tests were also similar (see
online supplementary table S3).

Figure 1 Receiver operating characteristic (ROC) curves:
rapid radiographic progression prognosis by anticyclic
citrullinated peptides generation 2 antibodies (anti-CCP2),
antimutated citrullinated vimentine antibodies (anti-MCV)
and antihuman citrullinated fibrinogen antibodies (AhFibA) tests.
ROC curves built on the ability of each test (for anti-CCP2,
antimutated citrullinated vimentine antibodies (anti-MCV) and
AhFibA) to predict 1-year rapid radiographic
progression. Area under the curve values are expressed as
continuous variables.

Multivariate analysis of 1 year RRP risk
To test the independence of the association of ACPA
with 1 year RRP, we evaluated four multivariate models
by backward logistic regression. Results are shown in
table 4.

With assessment of ACPA positivity as a binary variable
(presence/absence; models 1, 2 and 3), both anti-CCP2
and AhFibA tests were significantly associated with 1-year
RRP (anti-CCP2: OR 2.15, 95% CI 1.43 to 3.21; AhFibA:
OR 2.39, 95% CI 1.57 to 3.63). In model 2, anti-MCV
positivity was not signi
cant whatever the titre. By contrast, in
high anti-MCV antibodies titres were associated with
an increase in 1 year RRP with a risk similar to that
given by high anti-CCP2 or AhFibA titres. Unlike
patients with high anti-MCV titres or those positive for
the other two tests, only 13.7% of the patients with low
anti-MCV titres showed RRP. These results remained
similar with other positivity thresholds (see online
supplementary table S4).

Correlation between anti-MCV titres and mTSS eval-
uated by the Spearman correlation test was: 0.214; p<10^{−6}
(see figure 2).

RRP risk by shared epitope carriage and ACPA status
We analysed the RRP outcome in regard to the SE status
and ACPA positivity (table 3). In the SE negative sub-
group (249 patients), ACPA-positive patients displayed a
significant higher RRP risk when compared to
ACPAs-negative patients. However, this increased RRP risk
was observed with anti-CCP2 and AhFibA tests but not
with the anti-MCV test (OR=1.86; 95% CI 0.94 to 3.64).
In the SE-positive subgroup (292 patients), ORs were
not different from 1, whichever the ACPA test was.

DISCUSSION
ACPA are among the best predictors of erosive RA. A
direct role of the RA-specific autoantibodies in produc-
tion of structural damage is highly suspected.7 20 In
modelling the RRP risk at 1 year after inclusion in the
ESPOIR cohort, we identi
died above. Serological data
concerning the 98% diagnostic specificity thresholds and
previously validated anti-CCP2 threshold are available in
online supplementary table S2.

RRP risk at 1 year by positivity of ACPA
The AUCs for anti-CCP2, anti-MCV and AhFibA anti-
bodies were similar, and matched with modest perform-
ance: respectively, 0.601 (95% CI 0.550 to 0.651), 0.607
(95% CI 0.555 to 0.659) and 0.599 (95% CI 0.547 to
0.651). No differences were found among the tests
(p=0.87; figure 1).

Predictive values of these tests were also similar (see
online supplementary table S3).

Figure 1 Receiver operating characteristic (ROC) curves:
rapid radiographic progression prognosis by anticyclic
citrullinated peptides generation 2 antibodies (anti-CCP2),
antimutated citrullinated vimentine antibodies (anti-MCV)
and antihuman citrullinated fibrinogen antibodies (AhFibA) tests.
ROC curves built on the ability of each test (for anti-CCP2,
antimutated citrullinated vimentine antibodies (anti-MCV) and
AhFibA) to predict 1-year rapid radiographic
progression. Area under the curve values are expressed as
continuous variables.
between studies may be explained by differences in inclusion criteria and treatment regimen across studies. Only few studies compared ACPA specificities in terms of radiographic outcome.

In our cohort, low anti-MCV titres were not associated with 1 year RRP, as compared with high ACPA titres. The threshold of 3N was more discriminating to predict the risk of RRP among patients with a positive anti-MCV test, which was not the case with two other tests. In multivariate analysis, the erosive burden brought by ACPA positivity was associated with high anti-MCV titre but not with the other two tests titres. Thus, the anti-MCV titre was discriminating to predict the evolution towards 1 year RRP unlike the other two tests titres.

Syversen et al\textsuperscript{21,22} were among the first to show that high anti-CCP2 and high anti-MCV (ELISA, Orgentec) titres added information to the radiographic outcome when compared to ACPA positivity. The observation concerning anti-MCV test supports our results. In these studies, high ACPA corresponded to the third tertile (>253 U/mL) for anti-MCV test and >200 U/mL for anti-CCP2 test. It seems important to consider that: high ACPA titres in these papers are higher than our cut-off (3 times the positivity threshold ie, 75 U/mL for anti-CCP2 and >60 U/mL for anti-MCV) and populations studied were not comparable.

In the current work, one weakness is the small sample size for patients with low anti-MCV positivity (51 patients). Most of the patients with rapid RRP had high ACPA titres (approximately 60%) and only a few (<10%) had low+ ACPA. We cannot exclude the fact that a lack of power could explain the absence of observed 1 year RRP risk in the low+ anti-MCV group. However, even with small sample size for patients with low anti-CCP2 positivity and low AhFibA positivity, we observed an over-risk of 1 year RRP. These results need to be confirmed on other cohorts of early RA.

Studies assessing prognostic relevance of anti-CCP levels often evaluated ‘radiographic progression’. We assessed the correlation with the ‘rapid radiographic progression’ (RRP), with a different definition from ‘radiographic progression’. The change in the radiographic outcome may influence the results.

Considering the anti-CCP2 test, we did not make the same observation as with the anti-MCV test, and the 3N threshold did not seem discriminating for identifying RRP RA. The wide antigen specificity of the anti-CCP2 test could also ‘attenuate’ the radiographic discriminating properties of some ACPA specificity titres.

Table 2  One-year RRP and baseline ACPA titres (anti-CCP2, anti-MCV, AhFibA)

| Anti-CCP2                  | Number of patients with RRP (%) | OR (95% CI)          | p Value ($\chi^2$) |
|----------------------------|---------------------------------|----------------------|--------------------|
| Negative                   | 53 (18.0)                       | 1                    | –                  |
| Low titre (≤3N)            | 5 (45.5)                        | 3.80 (1.11 to 13.10) | 0.0226             |
| High titre (>3N)           | 87 (33.5)                       | 2.30 (1.54 to 3.43)  | <0.0001            |
| p Value (OR trend)         | 2.90 $10^{-15}$                 |                      |                    |
| Anti-MCV                   | Negative                        | 51 (19.0)            | 1                  | –                  |
| Low titre (≤3N)            | 7 (13.7)                        | 0.68 (0.29 to 1.59)  | NS                 |
| High titre (>3N)           | 87 (35.2)                       | 2.31 (1.54 to 3.48)  | <0.0001            |
| p Value (OR trend)         | 2.96 $10^{-15}$                 |                      |                    |
| AhFibA                     | Negative                        | 47 (17.3)            | 1                  | –                  |
| Low titre (≤3N)            | 10 (33.3)                       | 2.39 (1.04 to 5.49)  | 0.0332             |
| High titre (>3N)           | 88 (33.3)                       | 2.39 (1.58 to 3.62)  | <0.0001            |
| p Value (OR trend)         | 2.08 $10^{-15}$                 |                      |                    |

>3N, 3 times the cut-off; ≤3N, ≤3 times the cut-off.

p Value, $\chi^2$ test, comparisons of the percentages of patients with negative, low and high titres of antibodies, with negative as the reference. p Value (OR trend) = test of trend.

ACPA, anticitrullinated peptide antibodies; AhFibA, antihuman citrullinated fibrinogen antibodies; anti-CCP2, anticyclic citrullinated peptides generation 2 antibodies; anti-MCV, antimitated citrullinated vimentine antibodies; RRP, rapid radiographic progression.

Figure 2  Spearman correlation between anticitrullinated peptide antibodies (ACPA) titres and total modified sharp score (mTSS): antimitated citrullinated vimentine antibodies (anti-MCV) test.
We analysed patients with serodiscordance between the three ACPA tests. There were only a few patients displaying serodiscordance and subgroup size was too small to draw any firm conclusion. This concordance between the three ACPA tests suggests that they detected 'similar' autoantibodies. This concordance also suggests that, to improve our knowledge of the link between autoantibodies fine specificities and radiographic outcome in RA, assessment of tests with lower concordance is needed.

Our results should be interpreted with regard to the qualitative aspect of the ACPA test used. The commercial anti-CCP2 kit uses a mix of synthetic citrullinated peptides. Thus discussion about the fine specificities of ACPA and radiographic outcome is inappropriate with this test owing to its wide specificities. This kind of report cannot be made with home-made tests such as AhFibA. Although it is justifiable to wonder about the performances of home-made tests, the AhFibA test proved it was a reliable test for RA diagnosis with similar performances to those of anti-CCP2 and anti-MCV tests when used on a large scale on the ESPOIR cohort.11

We assessed the relationship between SE carriage, ACPA positivity and radiographic outcome. ACPA positivity was associated with an increased RRP risk, but only in the SE negative subgroup. This result suggests an

| Table 3 | One-year RRP in regard to the shared epitope and ACPA status |
|---------|-------------------------------------------------------------|
|         | RRP+ (n) | RRP+ and ACPA+ (n) | RRP− (n) | RRP− and ACPA+ (n) | OR (95% CI) | p Value ($\chi^2$) |
| Anti-CCP2 |          |                      |          |                      |            |                   |
| Shared epitope + | 87  | 62  | 205  | 126  | 1.55 (0.88 to 2.80) | NS          |
| Shared epitope − | 51  | 25  | 198  | 46   | 3.18 (1.59 to 6.32) | 0.0003      |
| Anti-MCV |          |                      |          |                      |            |                   |
| Shared epitope + | 87  | 65  | 205  | 132  | 1.63 (0.91 to 3.02) | NS          |
| Shared epitope − | 51  | 24  | 198  | 64   | 1.86 (0.94 to 3.64) | 0.0496      |
| AhFibA |          |                      |          |                      |            |                   |
| Shared epitope + | 87  | 66  | 205  | 132  | 1.74 (0.96 to 3.24) | NS          |
| Shared epitope − | 51  | 27  | 198  | 56   | 2.85 (1.44 to 5.63) | 0.0009      |

ACPA, anticitrullinated peptide antibodies; AhFibA, antihuman citrullinated fibrinogen antibodies; anti-CCP2, anticyclic citrullinated peptides generation 2 antibodies; anti-MCV, antimutated citrullinated vimentine antibodies; N, number of patients; NS, not significant; p, results of $\chi^2$ test; RRP, patients with rapid radiographic progression.

| Table 4 | Multivariate analysis of variables associated with 1 year RRP |
|---------|-------------------------------------------------------------|
|          | OR             | 95% CI          | p Value |
| Model 1: assessing anti-CCP2 | AUC 0.6496 (95% CI 0.5979 to 0.7003) | Anti-CCP2 positivity 2.15 1.43 to 3.21 <0.001 |
|          |                | CRP level (>10 mg/L) 1.73 1.15 to 2.58 0.007 |
|          |                | Erosions at baseline 1.50 1.00 to 2.25 0.049 |
| Model 2: assessing anti-MCV | AUC 0.6304 (95% CI 0.5784 to 0.6825) | Anti-MCV positivity Discarded during logistic regression |
|          |                | RF positivity 2.12 1.40 to 3.20 <0.001 |
|          |                | CRP level (>10 mg/L) 1.80 1.21 to 2.67 0.004 |
| Model 3: assessing AhFibA | AUC 0.6536 (95% CI 0.6018 to 0.7055) | AhFibA positivity 2.39 1.57 to 3.63 <0.001 |
|          |                | CRP level (>10 mg/L) 1.68 1.13 to 2.51 0.011 |
|          |                | Age at RA onset 1.02 1.00 to 1.04 0.031 |
| Model 4: assessing high ACPA titre (>3N) | AUC 0.6480 (95% CI 0.5958 to 0.7003) | High anti-CCP2 or AhFibA titres Discarded during logistic regression |
|          |                | High anti-MCV titres 2.17 1.45 to 3.24 <0.001 |
|          |                | CRP level (>10 mg/L) 1.69 1.13 to 2.53 0.010 |
|          |                | Erosions at baseline 1.50 1.00 to 2.25 0.049 |

Models included baseline ACPA status, age, erosive status, CRP level and RF status.
ACPA, anticitrullinated peptide antibodies; AhFibA, antihuman citrullinated fibrinogen antibodies; anti-CCP2, anticyclic citrullinated peptides generation 2 antibodies; anti-MCV, antimutated citrullinated vimentine antibodies; AUC, area under (the receiver operating characteristic) curve; CRP, C reactive protein; RA, rheumatoid arthritis; RF, rheumatoid factor; RRP, rapid radiographic progression.
interaction between the SE and the ACPA status with a redundancy. This interaction could explain why we did not find an association between SE carriage and RRP in our multivariate analysis models including ACPA status. Similar results were reported in a paper by Scherer et al. In their study, concerning patients with RA from the Leiden Early Arthritis Clinic and EURIDISS cohorts, SE alleles were associated with RRP. This association was not observed in the ACPA-positive subgroup.

Concerning comparability on therapy, we assessed the rapid RRP in different groups of patients depending on their treatment (data not shown). Baseline steroids and 1 year steroids use did not influence the 1 year RRP status. DMARDs use at year 1 influenced the radiographic course. Biologics use during the first year did not seem to influence the rapid RRP. But it is important to take into account that the inclusions were incorporated between 2002 and 2005 and that only 40 patients used biologics during the first year. Thus we cannot draw any conclusion concerning biologics. We cannot exclude the fact that some of our results could be explained, at least in part, by the treatment or the population size. We analysed the ‘treatment with DMARD at year 1’ as a variable (data not shown). About 83% of the patients were treated with any DMARD at year 1. Although associated with protection against rapid RRP in univariate analysis, this variable was not associated in our multivariate analysis, and keeping this variable in the three ACPA tests multivariate models did not change the results observed.

Our data concerning the anti-MCV test and the recent report of better radiographic outcome for patients with anti-MCV seronegation support the point that, among ACPA tests, the anti-MCV test may predict RRP. The anti-MCV test is specific for the diagnosis of RA; we showed that anti-MCV titres may also be informative to predict 1 year RRP.

**Author affiliations**

1Rheumatology Center, Purpan University Hospital, Toulouse, France
2UMR 1043, INSERM, CPTP, Toulouse, France
3Rheumatology Department, La Cavale Blanche Hospital, Brest, France
4Laboratory of Epidermis Differentiation and Rheumatoid Autoimmunity, UMR CNRS 5165, INSERM 1056, Toulouse, France
5Laboratory of Cell Biology and Cytology, Purpan University Hospital, Toulouse, France
6Rheumatology Department, Pellegrin University Hospital, Bordeaux, France
7INSERM U1173, UFR des Sciences de la Santé, University Versailles Saint Quentin, Montigny-Le-Bretonneux, France
8UF Immunology Autoimmunity & Hypersensitivity, Bichat-Claude Bernard Hospital, APHP, Paris, France
9UMR 1027, INSERM, University Paul Sabatier Toulouse III, Toulouse, France
10. Masson-Bessiere C, Sebbag M, Gribat-Neuhauser E, et al. The authors thank Nathalie Rincheval for expert monitoring and data management; S Martin for measuring the central doses of CRP level, IgA and IgM RF, and anti-CCP antibodies; the Biological Resources Centre (Paris-Bichat, J Benessiano), which was in charge of centralising and managing biological data collection; and all the investigators who recruited and followed patients (F Berenbaum, Paris-Saint Antoine; M C Boissier, Paris-Bobigny; B Combe, Montpellier; M Dougados, Paris-Cochin; P Fardelonne and P Boumier, Amiens; B Fautrel and P Bourgeois, Paris-La Pitie; R M Filpo, Lille; Ph Goupille, Tours; F Liotte, Paris-Lariboisière; X Le Loet and O Vittecoq, Rouen; X Mariette, Paris-Bicêtre; O Meyer +, Paris Bichat; A Saraux, Brest; Th Schaeverbeke, Bordeaux; J Sibilia, Strasbourg).

**Funding** An unrestricted grant from Merck, Sharp and Dohme (MSD) was allocated for the first 5 years of the ESPORI cohort. Two additional grants from INSERM were obtained to support establishing part of the biological database. The French Society of Rheumatology, Abbvie and Wyeth also supported the ESPORI cohort study, but the industrial firms were not involved in the study design, data collection, data analysis, manuscript preparation or decision to publish.

**Competing interests** None declared.

**Ethics approval** Ethics approval was provided by Montpellier Ethics Committee.

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data sharing statement** No additional data are available.

**Open Access** This is an Open Access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/

**REFERENCES**

1. Forslind K, Ahlmen M, Eberhardt K, et al. Prediction of radiological outcome in early rheumatoid arthritis in clinical practice: role of antibodies to citrullinated peptides (anti-CCP). *Ann Rheum Dis* 2004;63:1090–5.
2. Aletaha D, Neogi T, Silman AJ, et al. 2010 Rheumatoid arthritis classification criteria: an American College of Rheumatology/European League Against Rheumatism collaborative initiative. *Ann Rheum Dis* 2010;69:1580–8.
3. Fisher BA, Plant D, Brode M, et al. Antibodies to citrullinated alpha-ensolase peptide 1 and clinical and radiological outcomes in rheumatoid arthritis. *Ann Rheum Dis* 2011;70:1095–9.
4. Innala L, Kokkonen H, Eriksson C, et al. Antibodies against mutated citrullinated vimentin are a better predictor of disease activity at 24 months in early rheumatoid arthritis than antibodies against cyclic citrullinated peptides. *J Rheumatol* 2008;35:1002–8.
5. Scherer HU, van der Woude D, Willemsz E, et al. Distinct ACPA fine specificities, formed under the influence of HLA shared epitope alleles, have no effect on radiographic joint damage in rheumatoid arthritis. *Ann Rheum Dis* 2011;70:1461–4.
6. van der Linden MP, van der Woude D, Iano-Facisinay A, et al. Value of anti-modified citrullinated vimentin and third-generation anti-cyclic citrullinated peptide compared with second-generation anti-cyclic citrullinated peptide and rheumatoid factor in predicting disease outcome in undifferentiated arthritis and rheumatoid arthritis. *Arthritis Rheum* 2009;60:2232–41.
7. Hamre U, Georgess D, Bang H, et al. Induction of osteoclastogenesis and bone loss by human autoantibodies against citrullinated vimentin. *J Clin Invest* 2012;122:1791–802.
8. Mathsson L, Mullazehi M, Wick MC, et al. Antibodies against citrullinated vimentin in rheumatoid arthritis: higher sensitivity and extended prognostic value concerning future radiographic progression as compared with antibodies against cyclic citrullinated peptides. *Arthritis Rheum* 2008;58:36–45.
9. Montes A, Perez-Pampin E, Calaza M, et al. Association of anti-citrullinated vimentin and anti-citrullinated alpha-ensolase antibodies with subsets of rheumatoid arthritis. *Arthritis Rheum* 2012;64:3102–10.
10. Masson-Bessiere C, Sebbag M, Girbal-Neuhauser E, et al. The major serovar targets of the rheumatoid arthritis-specific anti-flaggiran autoantibodies are determinated forms of the alpha- and beta-chains of fibrin. *J Immunol* 2001;166:4177–84.
11. Nicase-Roland P, Noqueira L, Demattei C, et al. Autoantibodies to citrullinated fibrinogen compared with anti-MCV and anti-CCP2 antibodies in diagnosing rheumatoid arthritis at an early stage: data from the French ESPORI cohort. *Ann Rheum Dis* 2013;72:357–62.
12. Meyer O, Nicase-Roland P, Santos MD, et al. Serial determination of cyclic citrullinated peptide autoantibodies predicted five-year radiological outcomes in a prospective cohort of patients with early rheumatoid arthritis. *Arthritis Res Ther* 2006;8:R40.
13. Nell VP, Machold KP, Stamm TA, et al. Autoantibody profiling as early diagnostic and prognostic tool for rheumatoid arthritis. *Ann Rheum Dis* 2005;64:1731–6.

14. Quinn MA, Gough AK, Green MJ, et al. Anti-CCP antibodies measured at disease onset help identify seronegative rheumatoid arthritis and predict radiological and functional outcome. *Rheumatology (Oxford)* 2006;45:478–80.

15. Reneses S, Gonzalez-Escribano MF, Fernandez-Suarez A, et al. The value of HLA-DRB1 shared epitope, -308 tumor necrosis factor-alpha gene promoter polymorphism, rheumatoid factor, anti-citrullinated peptide antibodies, and early erosions for predicting radiological outcome in recent-onset rheumatoid arthritis. *J Rheumatol* 2009;36:1143–9.

16. Saeki Y, Kudo-Tanaka E, Ohshima S, et al. Baseline anti-citrullinated peptide antibody (ACPA) titers and serum interleukin-6 (IL-6) levels possibly predict progression of bone destruction in early stages of rheumatoid arthritis (ERA). *Rheumatol Int* 2013;33:451–6.

17. Mouterde G, Lukas C, Logeart I, et al. Predictors of radiographic progression in the ESPOIR cohort: the season of first symptoms may influence the short-term outcome in early arthritis. *Ann Rheum Dis* 2011;70:1251–6.

18. Combe B, Benessiano J, Berenbaum F, et al. The ESPOIR cohort: a ten-year follow-up of early arthritis in France: methodology and baseline characteristics of the 813 included patients. *Joint Bone Spine* 2007;74:440–5.

19. Fauteil B, Granger B, Combe B, et al. Matrix to predict rapid radiographic progression of early rheumatoid arthritis patients from the community treated with methotrexate or leflunomide: results from the ESPOIR cohort. *Arthritis Res Ther* 2012;14:R249.

20. Kastbom A, Forslind K, Ernestam S, et al. Changes in the anticitrullinated peptide antibody response in relation to therapeutic outcome in early rheumatoid arthritis: results from the SWEFOT trial. *Ann Rheum Dis* 2014;63. [Published Online First: Epub Date].

21. Syversen SW, Gaarder PI, Goll GL, et al. High anti-cyclic citrullinated peptide levels and an algorithm of four variables predict radiographic progression in patients with rheumatoid arthritis: results from a 10-year longitudinal study. *Ann Rheum Dis* 2008;67:212–7.

22. Syversen SW, Goll GL, van der Heijde D, et al. Prediction of radiographic progression in rheumatoid arthritis and the role of antibodies against mutated citrullinated vimentin: results from a 10-year prospective study. *Ann Rheum Dis* 2010;69:345–51.