Letters to the Editor

Aristea Papageorgiou1, Athanasios G. Tzioufas1 and Michael Voulgarelis1
1Department of Pathophysiology, Medical School, National University of Athens, Greece.
Accepted 17 January 2012
Correspondence to: Michael Voulgarelis, Department of Pathophysiology, Medical School, National University of Athens, 75 Mikras Asias Street, 11527 Athens, Greece.
E-mail: mvoulgar@med.uoa.gr

SIR, The lack of specificity of the new American College of Rheumatism/European League Against Rheumatism (ACR/EULAR) criteria for classification of RA [1] may have suffered its first casualty [2]. Periarticular osteopenia has characteristics indistinguishable from other individuals diagnosed with SpA [6]. Fifty per cent of the split-off and SpA groups do not manifest periarticular osteopenia and may actually have new bone formation (increased density).

All four possibilities should be considered. If possibilities (ii) and (iii) explain the findings, then DEXA would appear to have no role in addressing the question of periarticular osteopenia. If the first possibility explained the observations by Alves et al. [2], there may have been no reason to even perform the study. However, the most likely explanation may be the lack of specificity of entry criteria. The ACR/EULAR certainly are most helpful for making the diagnosis of RA that many insurance companies (at least in the USA) require for prescription of biologic agents. This solves the physician’s patient care dilemma, as uSpA has not been one of the insurance company criteria for allowing such therapy. However, lumping disparate diseases may be compromising our ability to understand their nature.

Disclosure statement: The author has declared no conflicts of interest.

Bruce Rothschild1,2
1Northeast Ohio Medical University, Rootstown, OH and 2Biodiversity Institute, University of Kansas, Lawrence, KS, USA.
Accepted 3 February 2012
Correspondence to: Bruce Rothschild, Biodiversity Institute, University of Kansas, Lawrence, KS 66045, USA.
E-mail: bmr@ku.edu

References
1 Alettaha D, Neogi T, Silman AJ et al. 2010 rheumatoid arthritis classification criteria: an American College...
between healthy controls, early arthritis and RA wereistics of RA [4]. However, BMD values in our study
were not used in this article, and therefore we cannot draw
ACR criteria to define established RA [3]. The new criteria
In the methods, it is clearly stated that we used the 1987
ging technique useful to further improve early diagnosis [2].
measured by DXA using our technique could be an ima-
first casualty, as we merely stated in the introduction that
against Rheumatism (EULAR) criteria have suffered their
would not say that the new ACR/European League
He offers a different view on our article. However, we
study using dual-energy X-ray absorptiometry: Reply
Sir, We read the letter by Rothschild with great interest [1].
He offers a different view on our article. However, we
would not say that the new ACR/European League
Against Rheumatism (EULAR) criteria have suffered their
first casualty, as we merely stated in the introduction that
we set out to see whether periarticular osteoporosis as
measured by DXA using our technique could be an imaging
technique useful to further improve early diagnosis [2].
In the methods, it is clearly stated that we used the 1987
ACR criteria to define established RA [3]. The new criteria
were not used in this article, and therefore we cannot draw
conclusions towards the specificity or lack thereof of the
new ACR/EULAR criteria.
We do agree that osteoporosis is one of the characteristics of RA [4]. However, BMD values in our study
between healthy controls, early arthritis and RA were
overlapping. This means in diagnostic test terms that
DXA does not discriminate between patients and healthy
controls, as we explained in figure 2 of our paper.
The second point refers to our entry criteria and the pos-
sibility of unaffected joints averaging the afflicted joints.
As described in our introduction, we were well aware of
this difficulty. A previous study showed that including
smaller regions of interest (ROIs) caused large coefficients
of variation (CVs) [5]. We therefore first aimed to size the
ROI as small as possible, but not too small to keep low
CVs, enabling us to detect small differences in BMD.
Another related point is that patients were not selected
based on joint involvement. The aim of our study was
to develop a diagnostic tool that could be applied to
all patients at risk for RA, and not only to those with
MCP involvement. If one would like to study the aetiology
of RA and its consequences on bone loss in individual
joints, Dr Rothschild is absolutely right about the relation-
ship between affected joints and BMD loss.

Disclosure statement: The authors have declared no conflicts of interest.

Celina Alves1, Jolanda J. Luime1 and Edgar
M. Colín1,2
1Department of Rheumatology, Erasmus MC, University
Medical Center Rotterdam, Rotterdam and 2Department
of Rheumatology, Ziekenhuis Groep Twente, Almelo,
The Netherlands. Accepted 8 March 2012
Correspondence to: Celina Alves, Department of
Rheumatology, Erasmus MC, University Medical Center
Rotterdam, PO Box 2040, 3000 CA Rotterdam,
The Netherlands. E-mail: c.alves@erasmusmc.nl

References