MATTERS ARISING

Commented glossary for rheumatic spinal diseases

The glossary on rheumatic spinal diseases by a study group of the Committee of Pathology of EULAR1 has certainly helped clarify many terms. This comment on spondylarthropathy is intended to advance some help with the terminology. The terms spondarthritus and spondylarthropathy, as we understand it, are now both used to describe a partly heterogenous group of diseases that have a number of features in common: familial aggregation, association with HLA B27 and probably other genetic factors, and several, partly overlapping, characteristic clinical symptoms.

The authors recommend use of the term 'spondarthritus' originally proposed by Moll and Wright in 1974,2 their main argument being that the term spondarthritus (i) is original and historical, and (ii) emphasises the inflammation feature by including arthritis, while (iii) the term 'spondylarthropathy' found by Wright and his co-workers can refer to any degenerative disease of the spine.

We believe that neither the term spondarthritus nor spondylarthropathy can perfectly reflect the clinical and pathological background of this overlapping disease spectrum, and we prefer the term spondylarthropathy, for the following reasons:

(1) The historical dimension and originality of the term spondarthritus is unimpressive, as the authors have to correct the original definitions introduced by Wright et al.4 by excluding Whipple's disease and Behçet's disease.5 We agree that these two diseases should be excluded from the spectrum because they lack HLA B27 association and have a distinctive clinical picture and pathogenesis.

(2) In addition, the spectrum of clinical symptoms included in this conflation of spondarthritus and peripheral arthritis by which the original term had been listed by the 'Leeds group' in 1987,5 has changed since the introduction of the criteria introduced by the European Spondylarthropathy Study Group (ESSG).6 Features such as enthesopathy, erosion and thrombophilia9 are no longer considered essential to the spondylarthropathies.

(3) These classification criteria have been developed and evaluated by leading European rheumatologists who agreed on the term spondylarthropathy.4 Many other rheumatologists in Europe and the United States have approved these criteria, which have now gained wide international acceptance.4

(4) As a synonym of the term spondylarthropathy in clinical use is that it is applicable to a group of patients suffering spondylarthropathy that is now frequently reported as 'undifferentiated spondylarthropathy'.8 9 When established criteria for more closely defined subcategories of spondylarthropathies such as ankylosing spondylitis are used,10 these patients often received no proper diagnosis.

(5) Arthritis need not be included in the general term, as not all patients with spondylarthropathy suffer arthritis (patients with inflammatory back pain, enthesopathy, uveitis). Of the 403 spondylarthropathy patients evaluated using the ESSG criteria, only 35·3% had synovitis of the lower limbs, while 56·4% had enthesopathy (at any site).

(6) Arthritis need not be included in the general term, as not all patients with spondylarthropathy suffer arthritis (patients with inflammatory back pain, enthesopathy, uveitis). Of the 403 spondylarthropathy patients evaluated using the ESSG criteria, any attempt to establish a glossary for rheumatoid arthritis description is of interest, especially when conducted in a general term that transcends national borders. Deciding to accept or reject a current usage, and suggesting new terms, such as the neologism 'spondylarthritus', represents an ambitious and stimulating approach. It is never easy to establish the true nature of the osteoarthrosis-osteitis arthritis terminology debate considered (although perhaps the authors feel it is resolved), while attempt was made to establish the term 'spondylarthritus'.5 11 12 If it is desired to establish such a term, it seems reasonable to characterise this term further, to ensure ability to distinguish rheumatoid arthritis and spondylarthropathy/spondylitis.

Spondyloarthropathy/spondylarthritus is universally recognised on the basis of sacroiliac joint erosions and fusion, syndesmophytes, and zygapophyseal joint fusion,13 findings which should allow at least a proportion of individuals with that category of arthritis to be readily distinguished from those with rheumatoid arthritis.5 11 12 One obvious issue relates to the nature of axial disease.

By contrast, in undifferentiated spondylarthropathy, valid identification of zygapophyseal joint erosions has been compromised by radiological artefacts.14 The culprit proved to be the thin nature of zygapophyseal articular cartilage. Thus, zygapophyseal joint fusion as a result of erosion from osteoarthrosis was not radiologically distinguishable from that caused by erosion.15 The fronts of resorption and remodelling that characterise the latter are not the result of osteoarthrosis equipment. This confusion led to the misconception that zygapophyseal joint erosion was occasionally found in rheumatoid arthritis. Validated analysis revealed that true erosions are specific for spondylarthropathy/spondylitis.15

Eric Bywaters' eloquent report and discussion of spinous process bursal involvement in rheumatoid arthritis16 is quite different from the zygapophyseal and interspinous joint erosion in spondyloarthropathy/spondylarthritus. John Ball's article16 (cited in the glossary) commented on zygapophyseal joint fusion. Whether this can be avoided, especially in early disease, because young patients should not be burdened with an unnecessarily pessimistic prognosis.

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3 Moll J M H, Haslack I, MacRae I, Wright A. Associations between ankylosing spondylitis, porotic bone disease and the disease, the intestinal arthropathies, and Behçet's syndrome. Ann Rheum Dis 1993; 52: 63–64.


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