MATTERS ARISING

What's in a name?

Bertsias, and colleagues have provided an extensive report of the European League Against Rheumatism (EULAR) recommendations for systemic lupus erythaematosus (SLE).[1] While clearly a minor point in an excellent, well balanced clinical manifesto for doctors managing individuals with SLE, in the section on pregnancy outcomes atrioventricular (AV) block is referred to as "foetal heart block", qualified in parenthesis as "formerly congenital heart block". The issue of a universally accepted definition of "congenital" heart block may be somewhat controversial.[2] It is readily acknowledged that the initial term applied to the clinical condition of atrioventricular block, "complete congenital heart block (CCHB)", was too restrictive. Increased awareness of this disease and improved in utero echocardiographic techniques revealed that less advanced degrees of block were also associated with maternal anti-SSA/Ro-SSB/La antibodies and that the degree of block could progress and regress.[3 4] As greater numbers of cases were identified, it also became evident that the heart block in the absence of serious structural abnormalities was identified most often between 18–24 weeks of gestation.[3] Heart block detected after birth is generally not associated with maternal autoantibodies.[2 5] Furthermore, cardiologists often define "congenital" blocks as detected after birth.[6]

That said, the adjective "congenital" seems appropriate since it literally describes a condition as "*existing* at or *dating from* birth... *acquired during development in the uterus*..."[7] while foetal connotes "pertaining to an unborn foetus". The descriptor should emphasise the time of identification or onset of a condition rather than ascribing to the age status during which the condition is diagnosed, which makes sense as noted by the following example. A teenager carries the diagnosis of a heart block identified during gestation but which has persisted throughout his life. He is no longer a foetus, and thus does not have foetal heart block, but rather a condition diagnosed at or before birth, hence congenital heart block. Perhaps an appropriate compromise, acceptable for several specialists involved in the field, based on timing of diagnosis might be to define it as "congenital if an AV block is diagnosed in utero, at birth, or within the neonatal period (0–27 days after birth)".[2] In the case of a foetal diagnosis of incomplete AV block that resolves by birth, this could be referred to as "resolved" congenital heart block. Surely it is the condition *itself* we need to fix and not its name, which—as it stood—was technically correct.

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Authors' reply

We thank Drs Buyon, Brucato, and Friedman for their interest in our recent work and their scholarly comments about the correct use of the term "congenital". Indeed, the terminology to best describe heart block in offspring in the context of pregnancy of a mother with autoimmune diseases or autoantibodies either as "congenital" or "foetal" has been a matter of debate, with some people using the term congenital and others the term foetal.

Buyon and colleagues, consider the adjective "congenital" as more appropriate in order to emphasise the onset/identification of the disorder as "existing at or dating from birth...". However, this definition excludes those cases of foetuses with first or second degree atrioventricular block diagnosed in utero that fully respond to fluorinated corticosteroids and, as a result, their neonatal (and subsequent) echocardiograms (ECGs) are normal. In view of this, we elected to use the term "foetal". This was not intended to replace the term congenital, which for some cases is the more appropriate.

In any case, as a compromise we have elected to use the term "foetal/congenital", and the definition proposed by Buyon and colleagues in their letter of "an atrioventricular block diagnosed in utero, at birth, or within the neonatal period (0–27 days after birth)".

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CORRECTIONS

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There was an error in the figure legends in an article published in the March issue of the journal (Krueger K, Lino L, Dore R, Radominski S, Zhang Y, Kaur A, *et al*. Gastrointestinal tolerability of etoricoxib in rheumatoid arthritis patients: results of the etoricoxib vs diclofenac sodium gastrointestinal tolerability and effectiveness trial (EDGE-II). *Ann Rheum Dis* 2008;**67:**315–22.) The legends of figures 4 and 5 were transposed. The correct legend for fig 4 should be as follows: "Difference in incidences of select gastrointestinal and renovascular end points of clinical importance within 14 days of discontinuing therapy in the study. GI, gastrointestinal." The legend for fig 5 should be: "Kaplan–Meier plot of the cumulative incidence of confirmed cardiovascular events with etoricoxib compared with diclofenac within 14 days of discontinuing therapy in the study (number of patients on treatment decreases with time moving from left to right)."

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An accidental duplicate publication has occurred on the website. The following article has been retracted: González LA, McGwin Jr G, Durán S, Pons-Estel GJ, Apte M, Vilá LM, *et al*. Predictors of premature gonadal failure in patients with systemic lupus erythematosus. Results from LUMINA, a Multiethnic US cohort. *Ann Rheum Dis* Published Online First: 13 February 2008. doi:10.1136/ard.2007.083576. The correct citation for this article is as follows: González LA, McGwin Jr G, Durán S, Pons-Estel GJ, Apte M, Vilá LM, *et al*. Predictors of premature gonadal failure in patients with systemic lupus erythematosus. Results from LUMINA, a multiethnic US cohort (LUMINA LVIII). *Ann Rheum Dis* Published Online First: 28 February 2008. doi:10.1136/ard.2007.083436