The American College of Rheumatology/European League Against Rheumatism Criteria for the classification of rheumatoid arthritis: a game changer

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Over the last several years the two pre-eminent professional societies representing rheumatology, the American College of Rheumatology (ACR) and the European League Against Rheumatism (EULAR), have been discussing increasing their collaboration in areas of interest to rheumatologists worldwide. These discussions resulted in a letter of agreement in 2008 on the framework whereby the two organisations would work together to develop disease classification criteria as well as recommendations for conducting of clinical trials. To enhance communication between the two organisations, ACR representatives now sit on the EULAR Standing Committee for Clinical Affairs and the EULAR Standing Committee of Epidemiology, and EULAR representatives now sit on the ACR Criteria Subcommittee and Quality of Care Committee.

The first result of this effort was the joint publication, in *Annals of the Rheumatic Diseases and Arthritis Care & Research*, of the recommendations on reporting disease activity in clinical trials of patients with rheumatoid arthritis (RA).1,2 This document was important in that it delineated the minimal standards necessary for clinical trials evaluating new therapeutics in RA. Several collaborative projects are under way on RA, and also on gout, scleroderma, myositis and vasculitis. The positive aspects of developing a consensus between the dominant voices in world of rheumatology are self-evident.

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This article is published simultaneously in the September 2010 issue of *Arthritis & Rheumatism*
patient selection for clinical trials will be of great interest.

Change can be difficult for a generation of rheumatologists used to classifying RA with the old criteria. Concerns over the absence of erosion in the scoring system, as well as the absence of the necessity of symmetric joint involvement, will be raised. The working group does acknowledge that the presence of erosions typical of RA would justify classification of a patient as having RA, but also raises the question of what is meant by significant erosive disease and what evidence of erosions should be considered acceptable as signifying ‘typical of RA’. Symmetric joint disease was not found to provide additional independent weight to the criteria. Additional concerns exist regarding the utility of these classification criteria for the primary care physician who must determine synovitis by examination and then exclude other possible diagnoses that might explain the synovitis. The authors correctly point out that the criteria are not to be used as a tool for referral of patients with inflammatory arthritis to the rheumatologist, and there are several ongoing efforts in progress to provide primary care practitioners with the tools to recognize patients who need rapid, early referral.

It might be predicted that classic pharmaceutical studies of ‘early’ active RA will be unchanged, since the vast majority of these patients with a high disease activity score and frequent radiological erosions have an advanced phenotype. The exciting new area will be patients previously labelled as having undifferentiated arthritis, with one to two swollen joints and anticitrullinated protein antibody positivity, who may well score sufficiently to be labelled as having RA. This should encourage studies of the disease at this crucial stage of evolution. For these patients, the issue of defining synovitis and, as noted above, a ‘typical’ erosion will need to be evaluated, and the current subjective clinical diagnosis may need refinement using objective and more sensitive imaging modalities, such as MRI and ultrasound.

We applaud the efforts of all involved in the development of the new RA classification criteria. Prior to publication, the manuscript was critically reviewed not only by the journal editors and reviewers, but also by leadership of both the ACR and EULAR, including the boards of directors and committee members. That input was important in the eventual publication of this straightforward and well-written document. The acceptance of the evolving nature of RA is a step-change conceptually. We look forward to the identification of future biomarkers that will again result in another call to modify the RA classification criteria. When that occurs, improvement in the quality of life of our patients will surely follow.

Competing interests None.

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

Contributors Drs Cohen and Emery drafted and revised the article and approved the final version to be published.

Accepted 28 June 2010
doi:10.1136/ard.2010.138446

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The American College of Rheumatology/European League Against Rheumatism Criteria for the classification of rheumatoid arthritis: a game changer
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Ann Rheum Dis 2010 69: 1575-1576
doi: 10.1136/ard.2010.138446

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