MATTERS ARISING

Commentary for rheumatic spinal diseases

The commentary for rheumatic spinal diseases by a study group of the Committee of Pathology of the European League Against Rheumatism (EULAR) has certainly helped clarify many terms. This commentary on spondylarthropathy is intended to help with terminology. The terms spondarthritis 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 with HLA B27 and probably other genetic factors, and several, partly overlapping, characteristic clinical symptoms.

The authors recommend use of the term 'spondyloarthropathy' originally proposed by Moll and Wright in 1974, their main argument being that the term spondarthriti (i) is original and historical, and (ii) emphasizes the inflammatory feature by including arthritis, while (iii) the term 'spondylarthritis' has not been used for any arthropathies affecting the spine previously and there is no real need for a common term to describe these heterogenous diseases.

(6) Arthritis need not be included in the general term to exclude the so called degenerative diseases of the spine, as there has always been an argument as to whether these diseases should be primarily labelled as non-inflammatory, the problem is reflected in the differing terminology 'osteoarthritis' and 'osteoarthrosis'. From this point of view there is no clear advantage in using the term spondarthriti.

(7) Use of the term spondylarthropathy for the spectrum of HLA B27 associated diseases discussed here excludes, by definition, degenerative diseases of the spine such as spondylitis and spondylosis. This is justified because spondylarthropathy has not been used for all arthropathies affecting the spine previously and there is no real need for a common term to describe these heterogenous diseases.

(8) Other terms used to group rheumatological disease categories such as 'connective tissue diseases', which have been used for decades, are also far from being perfect.

In summary, no term is perfect, but agreement in the nomenclature seems to us preferable because classification criteria using this term have been evaluated, the term is now frequently used, and it has a better chance of being accepted internationally.

Finally, we agree that the German term 'Bebchew's disease', having once been popular for describing patients with very severe ankylosing spondylitis and a bad disease course, should be avoided, especially in early disease, because young patients should not be burdened with an unnecessary pessimistic prognosis.

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10. van der Linden S M, Valkenburg H A, Cats A. Evaluation and classification criteria for ankylosing spondylitis. A proposal for modification of the New York criteria. Arthritis Rheum 1984; 27: 561–8. Any attempt to establish a glossary for rheumatological disease description is of interest, especially when conducted in a manner that transcends national borders. Deciding to accept or reject a current usage, and suggesting new terms, such as the neologism 'spondylarthriosis', represents an ambitious and stimulating approach. It also adds to the ongoing debate on the rheumatoid arthritis (RA)/spondylarthropathy terminology. 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/spondylarthritis.

Spondyloarthropathy/spondylarthropathy is universally recognised on the basis of sacroiliac joint erosions and fusion, syndesmophytes, and zygapophyseal joint fusion, 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 7 8 One obvious issue relates to the nature of axial disease. The term 'axial' in the context of spondylarthropathy, valid identification of zygapophyseal joint erosions has been compromised by radiological artefacts. 5 The culprit proved to be the thin nature of zygapophyseal articulation. It has seemed to us as a result of this confusion that spondylarthropathy/spondylarthritis is occasionally found in rheumatoid arthritis. Validated analysis released in true erosions are specific for spondylarthropathy/spondylarthropathy. 13

Eric Bywaters' eloquent report and discussion of spinal process bursal involvement in rheumatoid arthritis 9 is quite different from 'spinal spondylarthropathy' in spondylarthropathy/spondylarthropathy. John Ball's article 10 (cited in the glossary) commented on zygapophyseal joint fusion and unusual features in rheumatoid arthritis. 11 However, clinical recognition of zygapophyseal joint erosion is fraught with artefact, precluding clinical reliability (as documented above)—and diagnosis must be questioned for those instances where fusion is reported.

The last issue pertains to diagnosis of rheumatoid arthritis and the lumper-splitter controversy. 13 The challenge relates to lack of axial joint involvement in 40–60% of the population with spondylarthropathy/spondylarthropathy. 2 5 7 8 Many of this group are now distinguished from those with rheumatoid arthritis on the basis of normal peripheral bone density and presence of reactive new bone. It is unclear, however, if this perspective had developed by the 60s and 70s, when cited arthritis on rheumatoid arthritis, for any population with spondylarthropathy/spondylarthropathy there are a few individuals with polyarthritis. The presence of axial joint disease in at least some of those individuals facilitates diagnosis. 13

If 'spinal rheumatoid arthritis' is to be considered a 'definition', it seems premature to utilise the term until further characterisation ensures the ability to distinguish it from the 'original spondylarthropathy/spondylarthropathy'.
spondylarthritides. I look forward to the authors' continued effort.

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AUTHORS’ REPLY. We have been very interested by the comments made by several readers on the paper 'Commented glossary for rheumatic spinal diseases, based on pathology'.

We agree with Drs Braun and Sieper that neither spondarthropathy nor spondylarthropathy are really adequate terms for the group of diseases to be covered, especially if not all patients exhibit spinal disease or peripheral arthritis. B27 and spondylarthropathy might be better, but not is perfect either, because B27 has only a statistical link to the disease and is not present in every patient.

Our working group did not support 'spondylarthropathy' because it had a mean connotation of 'any vertebral or spinal disease'. We are aware that people use it in a more restricted sense, but why call a hospital a 'building' instead of a hospital? It is the responsibility of people who propose new terms to elaborate them according to existing rules and to avoid using any term for any disease without taking account of the significance of the word proposed.

We do not deny the value of the criteria elaborated by the European spondyloarthropathy study group (ESSG); we just regret that the ESSG adhered to a term that would not be too different from spondylarthropathy.

Taking account of the weight of common practice—our fifth methodological rule—we proposed a term that would not be too different from spondylarthropathy.

The first is the inclusion of a connective -o-, which is already very much used in the USA. In spondyloarthropathy, the connective -o- before the vowel indicates the association between the bone and another arthritis. However, the ESSG criteria, but not always the term spondyloarthropathy, gained international recognition: Khan, quoted by Braun and Sieper, uses spondyloarthropathy.

The second alteration consists in replacing arthropathy by arthritis, which is more accurate.

We all agree that degenerative conditions may exhibit some low grade inflammation and that chronic inflammation is characteristic of other arthritis. People are exposed to secondary osteoarthritis and to mechanical factors, but surely nowadays nobody believes it useful to go back to Beneke who called degenerative spinal conditions 'spondylitis', and to Marie and Lérit who considered ankylosing spondylitis (AS) to be a form of 'spondylosis'.

To Dr Rothschild, we want to emphasise that our neologism is not 'spondylarthritis', which means 'spinal arthritis', but 'spondyloarthropathy'.

Dr Rothschild casts doubt on the existence of rheumatoid lesions in the spine. His observations are based on defleshed bones. Study of fresh cadavers seems much more pertinent to the description of evolving and early changes.

Histopathologists have actually observed synovitis, pannus, and rheumatoid granuloma in the discal and zygapophyseal joints of rheumatoid arthritis patients. Their observations, however, were mainly anecdotal. To our knowledge, a true systematic and comparative study of the spinal changes associated with AS and rheumatoid arthritis (RA) is still lacking. The fact that a minority of RA patients develop zygapophysseal fusion is insufficient to change their diagnosis to one of spondyloarthropathy, therefore it is indeed several ways to reach ankylosis. RA and AS spinal changes are not characterised by a single pathognomonic lesion, but by a particular constellation of partly shared findings.

RA spinal changes also differ from degenerative changes. Eulierink et al have published a macroscopic study of 44 rheumatoid cervical spines compared with 44 control cervical spines matched for age and gender. They did report significant

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