Commentary on rheumatic spinal diseases

The commentary begins with a historical overview, mentioning the work of EULAR and its glossary project, which has contributed significantly to the field of rheumatology. The authors discuss the evolution of terminology related to spondylarthropathies, highlighting the challenges in defining and categorizing these conditions.

The commentary emphasizes the need for a more unified approach to classification, noting the importance of recognizing the heterogeneity within the group of diseases known as spondylarthropathies.

The commentary also touches upon the use of imaging techniques in the diagnosis of these conditions, underscoring the role of MRI and ultrasound in identifying early changes in the spine and joints.

The commentary concludes with a call for continued research and collaboration to improve the diagnostic and therapeutic strategies for patients with spondylarthropathies, encouraging the development of more specific and effective treatments.
spondylarthritides. I look forward to the authors' continued effort.

BRUCE M ROTHSCILD
Northeastern Ohio Universities College of Medicine,
The Arthritis Center of Northeast Ohio,
Youngstown, Ohio 44512, USA


Reading the article by François, Eulderink and Bywaters reminded us of a Latin sentence we learned as students: Tres facient collegium sed non universitatem litterarum—in this context: as least three students have to attend to make it a lecture, but three professors, teachers or experts, etc cannot expect their opinion to be shared all over the world. Thus the commented glossary by François is not a consensus article, but merely a recommendation of experts asking for discussion.

We would like to make our contribution. Basically there are three pathological bony spurs that can mislead the spine: the spondylophyte in degenerative disc disease, the synovemosphyte in ankylosing spondylitis, and the parasyndemosphyte in psoriatic spondylarthritides. We have in an in depth investigation of Reiter's syndrome.

The authors mentioned the para-synovemosphyte; however, there is missing any reference to the two diseases mentioned above of which parasyndemosphytodes are indicative. They do mention paravertebral ossification, but no mention is made that this is an inaccurate synonym of para-synovemosphyte. Paravertebral ossifications sensu lato are also seen with fibrosclerosis ossificans progressiva and with tetra- and paraplegia.

François and colleagues prefer the acronym SAPHO syndrome. In 1987, Chamot et al described 'Le syndrome acné pseudotulose hyperostose ostéite' and used the acronym SAPHO—that is, this acronym reflects the first letters of this rather long denomination. In print, an acronym is used as a secondary term and artificial word, but this seems to be the case with SAPHO. In 1988, Benhamou et al (including Chamot) defined the acronym SAPHO in a different way, to adopt it for English literature: synovitis-acne-pustulose hyperostosis-osteomyelitis syndrome. This may speak in favour of the authors' inventive abilities, but from a scientific point of view the term 'SAPHO' remains questionable and seems confusing.

Use of the well substantiated and established denomination 'acquired hyperostosis syndrome', instead of SAPHO syndrome,趴lstromic arthro-ostitis or more than 40 other synonyms of the same syndrome, is rejected by François and colleagues, on the grounds that 'this term might be confused with diffuse idiopathic hyperostosis'; this sentence requires the addition of the phrase 'if used by amateurs' to complete it.

W DIHMANN
Department of Radiology, Hollemken 17, D-22339 Hamburg, Germany

J. HERING
Roentgengewinn, General Hospital Barmbek, Ruehemkamp 145, D-22291 Hamburg, Germany

Correspondence to: J. Hering.


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 spondylarthritides nor spondyloarthropathy are really adequate terms for the group of diseases to be covered, especially if not all patients exhibit spinal disease or peripheral arthritis. B27 positive diseases might be better, but is not 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 'arthropathy' has a different meaning—is 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 spondylarthropathy study group (ESSG); we just regret that the ESSG adhered to a term that we reject.

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 '–', which is already very much used in the USA.2,3 In spondyloarthropathy, the connective ‘–’ before the word indicates the association between two or more arthritis. Eventually, 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 exposed to secondary osteoarthrosis and to mechanical factors, but surely nowadays nobody believes it useful to go back to Beneke1 who called degenerative spine conditions ‘spondylitis’, and to Marie and Lérès2 who considered ankylosing spondylitis (AS) to be a form of 'spondylode'.

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

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 granulomata in the discal11 and zygapophysial12 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 zygapophysial fusion is insufficient to change their diagnosis to one of spondyloarthritides; therefore it is in several ways to reach ankylosis. RA and AS spinal changes are not characterised by a single pathognomonic lesion, but by a typical constellation of partly shared findings.

RA spinal changes also differ from degenerative changes. Eulderink et al have published a macroscopic study of 44 rheumatoid cervical spines compared with 44 control cervical spines matched for age and gender.12 They did report significant