spondylarthritis. I look forward to the authors' continued effort.

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Reading the article by François, Eulderink and Bywaters[1] reminded us of a Latin sentence we learned as students: *Tres faciunt collegium sed non universitatem litterarum*—in this context: at 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 and colleagues 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 to be found on the spine:[2] the spondylophyte in degenerative disc disease, the syndesmophyte in ankylosing spondylitis, and the parasyndesmophyte in psoriatic spondylitis and in spinal involvement of Reiter's syndrome.

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

François and colleagues prefer the acronym SAPHO syndrome. In 1987, Chamot *et al*[3] described 'Le syndrome acné pustulose hyperostose ostéite' and used the acronym SAPHO—that is, this acronym reflects the first letters of this rather long denomination of this syndrome. In principle, an acronym is used as a secondary term and artificial word, but this seems to be not the case with SAPHO. In 1988, Benhamou *et al* (including Chamot)[4] 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 conversion remains questionable and seems confusing.

Use of the well substantiated and established denomination 'acquired hyperostosis syndrome',[5 6] instead of SAPHO syndrome, pustulotic arthro-osteitis or more than 40 other synonyms[7] 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.

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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 spondarthritis 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-related-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 its etymological 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[1] 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 spondyl-arthropathy study group (ESSG); we just regret that the ESSG adhered to a term that we consider inappropriate.

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

The first is the inclusion of a connective –o–, which is already very much used in the USA.[2–4] In spondyloarthropathy, the connective –o– before the vowel indicates the association between spinal and another arthritis. Incidentally, the ESSG criteria, but not always the term spondylarthropathy, 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 inflammatory diseases are exposed to secondary osteoarthrosis and to mechanical factors, but surely nowadays nobody believes it useful to go back to Beneke[5] who called degenerative spinal conditions 'spondylitis', and to Marie and Léri[6] who considered ankylosing spondylitis (AS) to be a form of 'spondylose'?

To Dr Rothschild, we want 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 discal[7–11] and zygapophyseal[10] 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 zygapophyseal fusion is insufficient to change their diagnosis to one of spondyloarthritis; there are indeed 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

differences, even if some changes were present in both groups.

We agree that conventional radiograph pictures of zygapophyseal joints are difficult to read. Histological analysis of several or many samples at different stages of disease evolution is needed to reconstruct the 'natural' history of chronic diseases with unknown aetiology.

Professor Dihlmann and Dr Hering are quite correct when they state that three experts cannot expect their opinion to be shared all over the world. We did not aim to elevate ourselves to the rank of judges, deciding which ideas are correct and which people should be condemned for theirs. Instead we tried to alleviate part of the confusion that has arisen from improper coining or use of terms. Many people do not understand the real meaning of some words of everyday medical jargon. We first established a methodology in order to avoid arbitrary selection of terms that we would like or dislike. Five rules were adopted and the first one was to respect the etymological sense of the terms.

Many acquired conditions are characterised by hyperostosis: for example vertebral ankylosing hyperostosis, fluorosis, and Paget's disease, to name but three. Therefore, the term 'acquired hyperostosis syndrome' applies stricto sensu to a wide variety of conditions and is not the best one to replace the 40 that exist to name sternocostoclavicular hyperostosis, recurrent focal osteomyelitis, etc. SAPHO as an acronym just means that the authors, in common with Dihlmann, wanted to group several conditions. Are we yet certain that the pathological basis of acne related locomotor changes is the same as that of the other hyperostoses of the group? There is also the lumpers-splitters controversy: we support that similar diseases be grouped in the same section of a textbook, but should they be named by one term?

Acronyms are often no more than a society game or a good mnemotechnic device. The game, however, should be fair. DISH contains a pleonasm (skeletal hyperostosis); the original and the English spelling of the Lesbos poetess is Sappho; in French dictionaries, Sappho is the main entry, but Sapho is accepted too.

Concerning parasyndesmophytes, we defined them according to their morphological character. We could have added a comment that they are more frequent in psoriasis and Reiter's syndrome; they do occur in uncomplicated ankylosing spondylitis.[13-14] The psoriatic paravertebral ossifications[15] differ from parasyndesmophytes in that they are unconnected to the vertebral bodies. Of course, that term applies as well to other paravertebral bone formations. This is why in the glossary it is followed by the qualification '(in psoriasis)'.

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Destructive large joint arthritis

I was interested to read the article on destructive large joint arthritis by Regan and colleagues.[1] In the differential diagnosis they have not included the destructive arthropathy sometimes seen in chondrocalcinosis articularis[2 3] as a result of calcium pyrophosphate crystal deposition. The two patients described by Regan and colleagues had neuropathic joint destruction, but no mention is made as to whether crystals were sought in the biopsy specimen of patient 1 or if the shoulder effusion of patient 2 was aspirated and examined for crystals.

Calcium pyrophosphate deposition in large joints may be found without radiological chondrocalcinosis, particularly when joint destruction has taken place, and calcium pyrophosphate crystal deposition has also been described in neuropathic joints, albeit in four patients with late latent syphilis.[4]

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AUTHORS' REPLY: We thank Dr Richard for his comments. We agree that the destructive arthropathy seen in chondrocalcinosis should be included in the differential diagnosis of a rapidly destructive large joint arthritis.

Crystals were not sought in the synovial biopsy specimen or synovial fluid from either patient described.

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