Additional proposals to reduce comorbidity in patients with chronic inflammatory rheumatic diseases: comment on 'Points to consider for reporting, screening for and preventing selected comorbidities in chronic inflammatory rheumatic diseases in daily practice: a EULAR initiative' by Baillet *et al*

We have read with great interest the European League Against Rheumatism (EULAR) initiative on comorbidities in chronic inflammatory rheumatic diseases (CIRDs) that was recently published online in *ARD*.¹ This initiative focuses primarily on the most prevalent and important comorbidities in patients with CIRDs, mainly rheumatoid arthritis (RA), spondyloarthritis, connective tissue disorders and crystal arthropathies but the authors indicate that they may be also applied to cases of severe osteoarthritis.¹

Comorbidity has high impact in the prognosis and health outcome. It is applicable to patients with CIRDs. In this regard, the existence of several comorbidities increases the patient's disability in CIRDs. For example, in RA, the disability measured by the Health Assessment Questionnaire (HAQ), increases depending on the number of existing comorbidities with the same disease activity.²

Cardiovascular (CV) disease is an important cause of comorbidity in CIRDs. The presence of metabolic syndrome increases the CV risk in patients with RA, psoriatic arthritis and gout.³ Because of that, we feel that both body mass index and abdominal perimeter assessment should be routinely assessed in patients with CIRDs. In addition to some clinical characteristics of the disease such as duration or severity of disease and serological biomarkers, already included in the EULAR recommendations to determine the CV risk of patients with RA,⁴ non-invasive tools should also be used in the CV risk stratification of patients with CIRDs.⁵ It is especially true for carotid ultrasound that was found to be useful to identify patients with high CV disease risk who fulfilled the definitions of moderate CV risk when risk charts were applied.⁶

Osteoporosis is another frequent cause of comorbidity in CIRDs. Vitamin D may play a role in immunoregulation. Recently, we have demonstrated a high prevalence of vitamin D insufficiency in patients with CIRD.⁷ Therefore, the assessment of vitamin D level should be routinely performed in patients with CIRDs.

Periodontitis is another frequent cause of comorbidity that is often underestimated in the guidelines.⁸ Periodontal disease has been implicated in the pathogenesis and severity of RA and it has recently been demonstrated that some strains of periodontal pathogens in the oral cavity are associated with the severity of the disease.⁹ Therefore, evaluation of the mouth at the time of disease diagnosis and then periodically should be conducted in patients with CIRDs. Physicians and dentists should collaborate to prevent complications such as jaw osteonecrosis.⁹

An important point discussed by the authors of the EULAR initiative was related to the psychological impact of fibromyalgia or fatigue, which interferes with the assessment and monitoring of patients.¹ We strongly support the recommendation related to the identification of fibromyalgia or chronic fatigue symptoms at the time of the assessment of response to a particular treatment.

Finally, the EULAR initiative experts suggested the possible extrapolation of the proposal to patients with osteoarthritis.¹

We entirely agree on this point since the presence of comorbidity is one of the most innovative and interesting aspects of the last guidelines of the OARSi for the management of knee osteoarthritis.¹⁰

In conclusion, we support all the points considered in the EULAR initiative. However, we think that additional actions should also be conducted to improve the outcome of patients with CIRDs.

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