Response to: 'Additional proposals to reduce comorbidity in patients with chronic inflammatory rheumatic diseases'. Screening for comorbidities: what is the remit of rheumatologists?

We thank Castañeda *et al*[1] for their interest in our paper[2] and are pleased to have the opportunity to respond to their comments in order to clarify what part of the management of comorbidities we believe to be within the remit of rheumatologists, that is, what is likely to be done by the rheumatologist and what rheumatologists are able to do in the daily practice.

The European League Against Rheumatism (EULAR) task force anticipated that the screening of a wide scope of comorbidities would make the final process too complex or too extensive to be implemented. The EULAR task force acknowledged that fibromyalgia impacts on the assessment of the disease activity and response to treatment of chronic inflammatory rheumatic diseases (CIRDs). American College of Rheumatology 1990 classification criteria for fibromyalgia[3] and recent recommendations[4] considered fibromyalgia as a diagnosis of exclusion that requires a specific visit in order to rule out other disorders that could be the cause of symptoms and to evaluate fibromyalgia severity. Therefore, we considered that the screening for fibromyalgia was beyond the scope of this initiative.

Moreover, we strived to focus on the screening or the reporting of comorbidities for which specific and pragmatic recommendations could be made. Consequently, we mainly considered the screening of risk factors that are highly predictive of significant comorbidities. We agree that surrogate marker of obesity such as waist circumference are superior to body mass index in predicting cardiovascular risk. However, substantial evidence of ethnic, sex and age variations in waist circumference,[5] hampering the collection of waist circumference by a rheumatologist in his/her daily practice. 25-hydroxyvitamin D has a dual benefit for prevention of fractures in the elderly:[6] a benefit on bone density and muscle strength. However, the correlation between 25-hydroxyvitamin D levels and risk of fractures in younger patients, such as patients with spondyloarthritis, is still unclear.[7 8] Therefore, the EULAR task force did not recommend systematically assessing serum 25-hydroxyvitamin D in every patient with CIRDs.

Finally, we anticipated that next steps would be required to facilitate the dissemination of this initiative in European countries in accordance with national guidelines. These EULAR points to consider were recently disseminated in France, using an evidence-based approach followed by expert consensus.[9] In this initiative, Gossec *et al* clearly defined what part of the management of comorbidities is potentially within the remit of French rheumatologists. Screening for asymptomatic atherosclerotic plaques by use of carotid ultrasound is likely to reclassify patients with rheumatoid arthritis as very high risk patients, as evidence of carotid plaques was reported in 65% patients at moderate total cardiovascular risk (HEART score risk 1–5%).[10] Thus, it was proposed to refer all patients with a risk >1% because the decision to perform carotid ultrasound and also the interpretation of this examination and subsequent treatment decisions should be made by a specialist. In this initiative,[9] a visit to the dentist was recommended every year, in view of both the infectious risk represented by poor dental hygiene, and potential links between some CIRDs and periodontitis, as suggested by Castañeda *et al*.[1]

In summary, the EULAR Task Force does recognise the interest of the evaluation of comorbidities in patients suffering from chronic inflammatory rheumatic diseases and is proposing a core set of domains and items to be evaluated. However, the implementation of these proposals has to consider not only the national and local recommendations in this area but also the medical problems for each individual patient.

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