

Response to: 'Comment on: 'Idiopathic inflammatory myopathies and antisynthetase syndrome: contribution of antisynthetase antibodies to improve current classification criteria' by Greco *et al*' by Knitza *et al*

We have with great interest read the letter entitled 'Response to: 'Idiopathic inflammatory myopathies and antisynthetase syndrome: contribution of antisynthetase antibodies to improve current classification criteria' by Greco *et al*' by Knitza *et al*, to be published in the *Annals of the Rheumatic Diseases*.¹

We appreciate the thoughtful comments made by the authors and agree on the importance of aminoacyl transfer RNA synthetase (ARS) autoantibodies, as well as other autoantibodies for correct classification of the associated diseases. The discussion stems from the European League Against Rheumatism (EULAR)/American College of Rheumatology (ACR) classification of idiopathic inflammatory myopathies (IIM) where anti-Jo-1 autoantibody positivity is included.² The authors emphasise the importance of careful interpretation of assays used to detect anti-ARS autoantibodies. In the centre of the authors, they found a low specificity for positive anti-ARS autoantibodies in relation to clinical manifestations of anti-synthetase syndrome (ASSD) where only 17% of their cases with positive anti-ARS antibodies had one of the clinical manifestations including arthritis, myositis or interstitial lung disease (ILD). We completely agree with the concern of the authors. This concern applies to the use of tests for myositis-specific autoantibodies in general, and not only for the anti-ARS autoantibodies, in clinical settings as a tool for diagnosis and classification. We agree with the authors that validation of commercially available immune blot techniques is important. We also want to emphasise that the positive predictive value depends on the context in which the anti-ARS antibodies are tested. In a recent study from our group, we found a high agreement between anti-Jo-1 positivity by a line blot assay and clinical manifestation of ASSD with ILD present in 15/18 (83%) anti-Jo-1+ patients with IIM. This was similar to the presence of ILD in 11/12 anti-Jo-1+ patients by immunoprecipitation.³ The results presented by Knitza *et al* emphasise the importance to limit the testing of anti-ARS antibodies to patient populations with a high suspicion of ASSD or IIM. As anti-Jo-1 autoantibodies are one of the variables in the 2017 EULAR/ACR classification criteria for IIM, we want to underline careful interpretation of commercially available assays and welcome more validation studies that support the value of different assays.

Within the Euromyositis register collaboration, our continued efforts to standardise and harmonise methods for systematic

collection and handling of samples, as well as analysing and interpreting autoantibody data have been implemented.⁴ These data will provide a basis for future revision of classification criteria and evaluation of other autoantibodies in this context.⁵

We appreciate and commend all initiatives and comments aimed at improving the accuracy of the EULAR/ACR classification criteria for IIM and encourage the use of the criteria to evaluate their precision as well as clinical relevance.

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