MATTERS ARISING

Commented glossary for rheumatic spinal diseases

The glossary on rheumatic spinal diseases by a study group of the Committee of Pathology of EULAR[1] has certainly helped clarify many terms. This comment on spondylarthropathy is intended likewise to help with the terminology. The terms spondarthritis and spondylarthropathy, as we understand it, are now both used to describe a partly heterogenous group of diseases that have a number of features in common: familial aggregation, association with HLA B27 and probably other genetic factors, and several, partly overlapping, characteristic clinical symptoms.

The authors recommend use of the term 'spondarthritis' originally proposed by Moll and Wright in 1974,[2] their main argument being that the term spondarthritis (i) is original and historical, and (ii) emphasises the inflammation feature by including arthritis, while (iii) the term 'spondylarthropathy' can refer to any degenerative disease of the spine.

We believe that neither the term spondarthritis nor spondylarthropathy can perfectly reflect the clinical and pathological background of this overlapping disease spectrum, and we prefer the term spondylarthropathy, for the following reasons:

(1) The historical dimension and originality of the term spondarthritis is unimpressive, as the authors have to correct the original definitions introduced by Wright *et al*[3 4] by excluding Whipple's disease and Behçet's disease.[1] We agree that these two diseases should be excluded from the spectrum because they lack HLA B27 association and have a distinctive clinical picture and pathogenesis.

(2) In addition, the spectrum of clinical symptoms included in this conflation of **spond**ylitis and peripheral **arthritis**, which had been listed by the 'Leeds group' in 1987,[3] has changed since the introduction of the criteria introduced by the European Spondylarthropathy Study Group (ESSG).[4] Features such as erythema nodosum and thrombophlebitis[3] are no longer considered essential to the spondylarthropathies.

(3) These classification criteria have been developed and evaluated by leading European rheumatologists who agreed on the term spondylarthropathy.[4] Many other rheumatologists in Europe and the United States have approved these criteria, which have now gained wide international acceptance.[5–8]

(4) An advantage of the term spondylarthropathy in clinical use is that it is applicable to a group of patients suffering spondylarthropathy that is now frequently reported as 'undifferentiated spondylarthropathy'.[8 9] When established criteria for more closely defined subcategories of spondylarthropathies such as ankylosing spondylitis are used,[10] these patients often received no proper diagnosis.

(5) Arthritis need not be included in the general term, as not all patients with spondylarthropathy suffer arthritis (patients with inflammatory back pain, enthesopathy, uveitis). Of the 403 spondylarthropathy patients evaluated using the ESSG criteria, only 35·3% had synovitis of the lower limbs, while 56·4% had enthesopathy (at any site).

(6) Arthritis need not be included in the general term to exclude the so called degenerative diseases of the spine, as there has always been an argument as to whether these diseases should be primarily labelled as non-inflammatory, the problem is reflected in the differing terminology 'osteoarthritis' and 'osteoarthrosis'. From this point of view there is no clear advantage in using the term spondarthritis.

(7) Use of the term spondylarthropathy for the spectrum of HLA B27 associated diseases discussed here excludes, by definition, degenerative diseases of the spine such as spondylarthrosis and spondylosis.[4] This is justified because spondylarthropathy has not been used for all arthropathies affecting the spine previously and there is no real need for a common term to describe these heterogenous diseases.

(8) Other terms used to group rheumatological disease categories such as 'connective tissue diseases', which have been used for decades, are also far from being perfect.

In summary, no term is perfect, but agreement is needed. 'Spondylarthropathy' seems to us preferable because classification criteria using this term have been evaluated, the term is now frequently used, and it has a better chance of being accepted internationally.

Finally, we agree that the German term Bechterew's disease, having once been popular for describing patients with very severe ankylosing spondylitis and a bad disease course, should be avoided, especially in early disease, because young patients should not be burdened with an unnecessarily pessimistic prognosis.

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1 Francois R J, Eulderink F, Bywaters E G L. Commented glossary for rheumatic spinal diseases, based on pathology. *Ann Rheum Dis* 1995; **54:** 615–25.
2 Moll J M H, Haslock I, MacRae I, Wright V. Associations between ankylosing spondylitis, psoriatic arthritis, Reiter's disease, the intestinal arthropathies, and Behçet's syndrome. *Medicine* 1974; **53:** 343–64.
3 Helliwell P, Wright V. Seronegative spondarthritides. *Baillière's Clin Rheumatol* 1987; **1:** 491–523.
4 Dougados M, van der Linden S, Juhlin R, *et al*. The European spondylarthropathy study group preliminary criteria for the classification of spondylarthropathy. *Arthritis Rheum* 1991; **34:** 1218–27.
5 Boyer G S, Templin D W, Goring W P. Evaluation of the European spondylarthropathy study group preliminary classification criteria in Alaskan Eskimos. *Arthritis Rheum* 1993; **36:** 534–8.
6 Amor B, Dougados M, Mijiyawa M. Critères de classification des spondylarthropathies. *Rev Rhum* 1990; **57:** 85–9.
7 Khan M A, ed. An overview of clinical spectrum and heterogeneity of spondyloarthropathies. In: *Spondyloarthropathies. Rheum Dis Clin North Am* 1992; **18:** 1–10.
8 Braun J, Bollow M, Eggens U, König H, Distler A, Sieper J. Use of dynamic magnetic resonance imaging with fast imaging in the detection of early and advanced sacroiliitis in spondylarthropathy patients. *Arthritis Rheum* 1994; **37:** 1039–45.
9 Zeidler H, Mau W, Khan M A. Undifferentiated spondyloarthropathies. *Rheum Dis Clin North Am* 1992; **18:** 187–202.
10 van der Linden S M, Valkenburg H A, Cats A. Evaluation of diagnostic criteria for ankylosing spondylitis. A proposal for modification of the New York criteria. *Arthritis Rheum* 1984; **27:** 361–8.

Any attempt to establish a glossary for rheumatological disease description is of interest, especially when conducted in a manner that transcends national borders.[1] Deciding to accept or reject a current usage, and suggesting new terms, such as the neologism 'spondylarthritis', represents an ambitious and stimulating approach. It did seem a little unusual not to find the osteoarthrosis-osteoarthritis terminology debate considered (although perhaps the authors feel it is resolved), while attempt was made to establish the category 'spinal rheumatoid arthritis.' If it is desired to establish such a term, it seems reasonable to characterise this term further, to ensure ability to distinguish rheumatoid arthritis and spondyloarthropathy/spondylarthritis.

Spondyloarthropathy/spondylarthritis is universally recognised on the basis of sacroiliac joint erosions and fusion, syndesmophytes, and zygapophyseal joint fusion,[2–7] findings which should allow at least a proportion of individuals with that category of arthritis to be readily distinguished from those with rheumatoid arthritis.[2 3 5–11] One obvious issue relates to the nature of axial disease.

In contrast with zygapophyseal joint fusion, valid identification of zyagapophyseal joint erosions has been compromised by radiological artefacts.[12] The culprit proved to be the thin nature of zygapophyseal articular cortices. Thus loss of cortex as a result of eburnation from osteoarthritis was not radiologically distinguishable from that caused by erosion.[12] The fronts of resorption and remodelling that characterise the latter are below the resolution of clinical radiography equipment. This confusion led to the misconception that zygapophyseal joint erosion was occasionally found in rheumatoid arthritis. Validated analysis revealed that true erosions are specific for spondyloarthropathy/spondylarthritis.[12]

Eric Bywaters' eloquent report and discussion of spinous process bursal involvement in rheumatoid arthritis[13] is quite different from the zygapophyseal phenomenon seen in spondyloarthropathy/spondylarthritis. John Ball's article[14] (cited in the glossary[1]) commented on zygapophyseal joint fusion and erosion in rheumatoid arthritis. However, clinical (radiological) recognition of zygapophyseal joint erosion is fraught with artefact, precluding clinical reliability (as documented above)—and diagnosis must be questioned for those instances where fusion is reported.

The last issue pertains to diagnosis of rheumatoid arthritis and the lumper-splitter controversy.[15] The challenge relates to lack of axial joint involvement in 40–60% of the population with spondyloarthropathy/spondylarthritis.[2 3 5–7 16] Many of this group are now distinguished from those with rheumatoid arthritis on the basis of normal periarticular bone density and presence of reactive new bone. It is unclear, however, if this perspective had developed by the 60s and 70s, when cited articles on rheumatoid spine disease[1] were published. Among any population with spondyloarthropathy/spondylarthritis there are a few individuals with polyarticular disease. The presence of axial joint disease in at least some of those individuals facilitates diagnosis.[17 18]

If 'spinal rheumatoid arthritis' is to be considered a 'definition,' it seems premature to utilise the term until further characterisation ensures the ability to distinguish it from the changes of spondyloarthropathy/