The target population of the ASAS criteria is patients who have chronic back pain for >3 months, with onset before age 45 years. The characteristics of our cohort were very similar to those of the Spondyloarthritis Caught Early (SPACE) cohort (4), particularly in the clinical arms; the SPACE cohort is a prospective cohort that enrolls patients from the same target population.

In conclusion, we are confident in our case ascertainment, and in the conclusion that only a minority of patients in a population-based cohort with nonradiographic SpA progressed to having AS after 15 years of follow-up. Consistent with our finding, Bakland et al reported that in a population-based cohort, 4 of 20 patients with nonradiographic SpA progressed to having AS after 8 years of follow-up (5). More recently, Dougados and colleagues also reported a low rate of progression (6), using data from the Devenir des Spondyloarthropathies Indifférérenciées Récentes (DESIR) cohort, a prospective study of patients with early inflammatory back pain. A prospective population-based study would be the ideal design with which to assess the evolution of nonradiographic axial SpA. Given the slow progression of SpA, such a study would likely require 10 or more years of follow-up. However, potential modification of the classification criteria for nonradiographic SpA during this time may make the results of such a study obsolete.

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Missing information about disease controls: comment on the article by Mangnus et al

To the Editor:

In the recently published article by Mangnus et al (Mangnus L, van Steenbergen HW, Reijnierse M, van der Helm-van Mil AH. Magnetic resonance imaging–detected features of inflammation and erosions in symptom-free persons from the general population. Arthritis Rheumatol 2016;68:2593–602), the finding of magnetic resonance imaging features of articular disease in the hands and feet of a sizeable proportion of symptom-free individuals in the general population is of great interest, and admittedly is something the rheumatology community should have investigated decades ago. However, one issue remains. The authors did not provide the parallel information on the 99 patients with early arthritis or with clinical suspicion of arthralgia (arthralgia without clinical synovitis) who were included as controls. We believe that information would further enrich this important work.

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Reply

To the Editor:

We thank Dr. Esatoglu and colleagues for their interest in our study. Prior to the scoring of magnetic resonance images (MRIs) in that investigation, the scans from the symptom-free volunteers were intermingled with scans from patients with clinical suspicion of arthralgia or with early arthritis (n = 99 in total). This was done to prevent observer bias that could have been introduced had the reader been aware that he/she was evaluating scans from individuals without symptoms. After scoring and unblinding, the highest MRI inflammation scores were, as expected, observed in patients with early arthritis, with a median score of 17 (interquartile range [IQR] 9.5–29.0). Among patients with clinical suspicion of arthralgia, the median score was 8.0 (IQR 2.0–18.0) in those whose condition progressed over time to clinical arthritis and 2.5 (IQR 1.3–6.0) in those who did not develop clinical arthritis over time. For comparison, the median inflammation score in the symptom-free volunteers was 2.0 (IQR 0.5–4.5).

Of note, we have observed that age importantly influences the MRI inflammation score (1), and the patient groups mentioned above were not age-matched with the population controls in our study. In addition, the number of patients included in the study (30 with early arthritis, 69 with clinical suspicion of arthralgia) was relatively small. In other recent studies by our group, scans from many more patients were scored and evaluated in relation to the data on symptom-free controls. Specifically, we have investigated the differences in MRI inflammation scores between rheumatoid arthritis patients and controls as well as the effect of age (1), and have