## Could this be the pioneering case of short-blanket syndrome?

**Comment on:**
**Development of ultrasound enthesitis score to identify patients with enthesitis having spondyloarthritis: prospective, double-blinded, controlled study.**
MILUTINOVIC *et al*. *Clin Exp Rheumatol* 2015

Sirs,
We have read the paper recently published in your journal by Dr. Milutinovic *et al*. entitled "Development of ultrasound enthesitis score to identify patients with enthesitis having spondyloarthritis: prospective, double-blinded, controlled study" (1) with great interest.
This is a well written and very interesting paper in our opinion as it is the first study carried out using the new OMERACT definition for ultrasound (US) enthesitis (2). According to this new definition, bursitis and tendonitis are no longer included in the elementary lesions indicative of SpA enthesitis and the power Doppler signal is only considered significant when it is close to the bone profile (<2 mm). The authors have compared their results with the study carried out by De Miguel *et al*. in 2009 (3), which included all elementary lesions for defining enthesitis and considered a PD signal as positive even when further than 2mm from the bone profile. In that study, the MASEI US score demonstrated sensitivity and specificity values of both 83% in identifying patients with SpA *versus* a sensitivity of 47% (for PsA) and 59% (for SA) and specificity of 92% (for both PsA and SA) of the BUSES scoring system.
The authors have explained this discrepancy by focusing on the different recruitment processes of the patients - in their study it was SpA against RA and mechanical enthesitis while in the second study it was SpA against healthy subjects - and on the longer duration of the disease in the study by De Miguel.
In our opinion, the different assessment of enthesitis by US could further explain this discrepancy. The new OMERACT definition probably favours a high specificity rather than a high sensitivity and this could partially explain the differing results of the two studies.
It would be very interesting, if the authors still have the archived images of the study, to assess enthesitis also according to the old criteria (including tendonitis and bursitis and considering a positive PD signal even if further than 2mm from the bone cortex) and to re-verify the sensitivity and specificity values in their cohort of patients. This could in fact be a really interesting step towards a better understanding of the impact of these elementary lesions in real life and their influence on sensitivity and specificity values of US for discriminating SpA patients.
In conclusion as this is the first cohort study on US in SpA using the new enthesitis definition, a comment from the authors on the possible impact of the new enthesitis definition on the sensitivity and specificity of US in discriminating SpA patients could be really valuable. Could the new definition be responsible for the drop in sensitivity ahead of a slight gain in specificity? If yes, is it worth it?
Thank you very much for this really interesting study.

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*Competing interests: none declared.*

### References

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