

**Reply to the editorial:
Can we currently and confidently
assess the true burden of illness
due to non-radiographic axial
spondyloarthritis?**

by *S. van der Linden and M.A. Khan*

Sirs,

In our manuscript published in the current issue of this journal we analysed the characteristics of patients with non-radiographic axial spondyloarthritis (nr-axSpA) diagnosed by the local rheumatologist from 5 major European countries (1). We also report which older and newer classification criteria were fulfilled in these patients using the rheumatologist's diagnosis as the gold standard. Not surprisingly, there was a wide variation in the patients' characteristics (including fulfilling classification criteria), clearly indicating that more training of rheumatologists is wanted and needed for this relatively new concept of axSpA. In the accompanying editorial by van der Linden and Khan in this issue (2) these authors argue that the ASAS classification criteria for axial SpA, which includes also nr-axSpA patients, lack specificity and therefore patients without nr-axSpA might be overtreated with biologics.

We and others have argued before that classification criteria should not be used for diagnosis (3, 4). For the diagnosis, an expert rheumatologist should make a diagnosis based on the full evaluation of all clinical, laboratory and imaging information available, and – importantly – should also exclude actively other diagnoses. Only formally fulfilling classification criteria is not sufficient. This point is also stressed explicitly in the recent update of the ASAS/EULAR recommendations for the manage-

ment of axial SpA (manuscript in preparation). Indeed, the discrepancy between classification and diagnosis is characteristic for all diseases which lack single parameters with a high specificity and is also true, for example, for the ACR classification criteria for vasculitis (4) or the ACR/EULAR criteria for early rheumatoid arthritis (5). Furthermore, early diagnosis nearly always implies that not all patients identified will not move on to develop structural damage of the bone visible on x-rays in case of axSpA or rheumatoid arthritis, or structural damage elsewhere, for example, in the case of Crohn's disease (6).

Thus, in summary for a correct diagnosis of early axSpA a continuous education of rheumatologists worldwide is crucial and the axSpA classification criteria should not be used (alone) for diagnosis and treatment indication, but this is not different from other rheumatic diseases. Keeping this in mind, the development of the ASAS classification (7) has been a relevant step forward in the understanding and management of this disease, and has performed well when tested in independent cohorts (8, 9).

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