Differences in understanding and application of 1987 ACR criteria for rheumatoid arthritis and 1991 ESSG criteria for spondylarthropathy. A pilot survey

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ABSTRACT

Objectives

To determine areas of agreement and disagreement among experts in the interpretation of the published criteria for RA (ACR) and spondylarthropathies (ESSG).

Methods

Thirty-two experts (16 from France and 16 from 10 other countries) replied anonymously to a mailed questionnaire.

Results

Tenosynovitis and 'sausage-like' painless swelling of the toes were considered as criteria for RA by 18 and 14 experts, respectively. The definition of symmetry differed widely among experts (symmetry of only one group of joints was sufficient for 13). Twenty-five experts considered erosions of other joints than the wrists and fingers as a criterion for RA, 17 thought that fulfilment of criteria could be achieved cumulatively, and 19 would appreciate clarifications of the current criteria. Among possible clarifications for RA, it was frequently recommended that morning stiffness and nodules be eliminated and that new marker antibodies, X-rays of the feet, and exclusion criteria be added. Twenty-three of the 29 experts who gave an opinion (79%) agreed with the notion of SP in the absence of axial signs and sacroiliitis, 26/31 (84%) indicated that a patient can have both RA and SP, and 19/30 (63%) thought that RA and SP could be regarded as syndromes more than diseases. Only 5/32 experts relied more on the criteria than on their clinical judgement in diagnosing RA.

Conclusions

There would seem to be a need for the optimisation of RA and ESSG criteria, particularly within the context of early arthritis.

Key words

Criteria, rheumatoid arthritis, spondylarthropathy, early arthritis.

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Introduction

The definition of classification criteria for rheumatoid arthritis (RA) and spondylarthropathy (SP) may be regarded as an important development (1, 2). Some physicians have tended to use these criteria for clinical diagnosis (even in early RA or early SP) rather than relying on their own discernment, although it was considered by the creators of these criteria that they should not be used as diagnostic criteria. The first reports concerning the efficiency of the 1987 RA criteria in the context of early arthritis were optimistic (3, 4), but subsequent works (5-9),including a recent large population-based study (8, 9), concluded that the 1987 American College of Rheumatology (ACR) criteria for RA were less efficient, at least within the context of early arthritis. Tree or list formats indicated that the percentages of patients classified as RA ranged from 38% to 67% at baseline and from 25% to 82% after three years of follow-up (9).

In this context, 16 international experts and 16 French experts were requested to reply to a questionnaire on the ACR criteria for RA (1) and the European Spondylarthropathy Study Group (ESSG) criteria for SP (2). The major objective of this pilot survey was to check for discrepancies among the selected experts (even within a single country such as France) concerning the interpretation and application of the ACR criteria for RA and ESSG criteria for SP. Minor objectives were: (i) to consider the experts'suggestions for improving the efficiency or reproducibility of RA and ESSG criteria, especially within the context of early arthritis; (ii) to ascertain whether the concept of SP was accepted by most experts, even in the absence of axial signs or sacroiliitis, and whether they agreed on the possibility of overlaps between RA and SP; and (iii) to determine to what extent the experts relied on their clinical judgement in diagnosing patients as RA and/or SP rather than on fulfilment of current criteria for these 2 conditions.

Methods

Choice of experts

International experts were randomly selected on the basis of their previous publications concerning the diagnosis of early arthritis (either RA or SP). Two were chosen mainly for geographical considerations, and none should necessarily be considered as representative of the rheumatologists in his or her country. The authors did not consult any of the experts before the study began and were unaware of their opinions concerning the criteria. The same questionnaire was sent to each expert, and 16/20 agreed to reply. These 16 experts were from the U.S.A. (n = 4), the United Kingdom (n = 3), Greece (n = 1), Italy (n = 1), Japan (n = 1), Singapore (n = 1), Denmark (n = 1), Finland (n = 1), Germany (n = 1), The Netherlands (n = 1) and Brazil (n = 1).

Eleven French experts with a special interest in RA and SP also agreed to reply anonymously to the questionnaire, together with 5 other French experts in early arthritis. The authors were also unaware of the opinions of these French experts on ACR and ESSG criteria. The inclusion of as many French as international experts provided a basis for studying possible cross-cultural differences as well as the homogeneity of opinions within a single country.

Questionnaire

Experts were requested to reply to the same questionnaire (see appendix) sent by mail.

Results

Replies concerning 1987 ACR criteria for RA

The results regarding discrepancies among experts in interpretation of ACR criteria for RA appear in Table I.

Suggestions for improving the efficiency of ACR criteria, especially within the context of early arthritis, were solicited and the results may be summarized as follows. Nineteen out of 31 (61%) experts suggested various changes to improve the definition of current criteria, mainly for symmetry and typical radiological signs. A need for clarification concerning how the criteria should be cumulated (or not) was also expressed by 15/31 (48%) experts. Modification of the binary classification of

patients as RA or not-RA was recommended by 13/30 (43%) experts, including 8/16 (50%) French experts who are still in favour of the use of several confidence steps to distinguish definite RA from probable RA. The removal of one or more criteria was suggested by 14/31 (45%) experts. This concerned mainly morning stiffness (7 citations), nodules (5 citations), and erosions (considered as illogical for the diagnosis of early RA by 4 experts). Conversely, the addition of a new radiological criterion was suggested by 19/30 (63%) experts (15/16 French): inclusion of X-rays of the feet (16 citations) and demonstration of early erosions by magnetic resonance imaging (5 citations). The addition of a new biological test as a criterion was proposed by 16/29 (55%) experts (14/16 French) (Table I), mainly for anti-citrulline antibodies (10) (so-called anti-keratin antibodies and anti-perinuclear factor) (10 suggestions). Twenty out of 29 (69%) experts (13/20 French) were in favour of a list of exclusion criteria, although their suggestions differed considerably.

The experts' confidence in the 1987 criteria for RA when (wrongly) applied as diagnostic rather than classification criteria was analyzed. Only 5/32 (16%) experts rely more on criteria than on their clinical judgement in diagnosing the RA patient. Although 2 out of 32 (6%) were as confident in the criteria as in their clinical judgement, the large majority of experts (24/30; 80%) rely more on clinical judgement. The confidence levels (on a 0-100 scale) were 78 ± 14 for clinical judgement and 51 ± 21 and 39 ± 23 for the ACR criteria (for long-lasting RA and early RA, respectively).

Replies concerning ESSG criteria

Most experts agree with the concept of SP: the mean range of agreement (expressed on a 0 to 100 analogue scale) was 85 ± 16, and only 2/32 (6%) rated their agreement below 50. This was true even for patients without axial or sacroiliac involvement, although the mean agreement was then slightly lower (72 ± 30), as was the number of experts rating their agreement above 50 [n = 23/29 (79%), including 15/16 French experts; 3 experts did not reply]. Twenty out of 30 (67%) declared that they had already used ESSG criteria in their previous publications, and 16/31 (52%) indicated that they used these criteria as a diagnostic tool.

Experts often disagreed about the interpretation and use of the ESSG criteria for SP (Table I).

Finally, 26 out of 31 (84%) experts agreed that RA and SP can overlap, and 19/30 (63%) consider that RA and SP are syndromes more than diseases.

Table I. Replies to questions about 1987 ACR criteria for RA and the 1991 ESSG criteria for SP.

	International	French	Total
1987 ACR criteria for RA			
Used the tree format in publications	5/16	5/16	10/32
Use the tree format in routine practice	2/16	4/16	6/32
Use the list format in routine practice	12/16	9/16	21/32
Criteria must be fulfilled at final examination	4/16	1/16	5/32
Criteria must have been present simultaneously	4/16	6/16	10/32
Criteria can be validated cumulatively	8/16	9/16	17/32
Duration of morning stiffness: until no more stiffness	2/16	4/16	6/32
Duration of morning stiffness: until maximal improvement	14/16	12/16	26/32
Tenosynovitis applies for soft tissue swelling	7/16	11/16	18/32
Bursitis applies for soft tissue swelling	0/16	3/16	3/32
Sausage-like swelling of toes applies for soft tissue swelling	7/16	7/16	14/32
Symmetrical involvement of one group of joints is sufficient	8/15	5/16	13/31
Symmetrical involvement of two groups of joints is required	7/15	4/16	11/31
Symmetrical involvement of three groups of joints is required	0/15	3/16	3/31
Symmetrical involvement of all groups of joints	0/15	4/16	4/31
Chondrolysis of wrist or fingers is considered as a criterion	3/16	10/16	13/32
Deviation of wrists or fingers is considered as a criterion	0/16	1/16	1/32
Erosion of other joints is considered as a criterion	12/16	13/16	25/32
Need for more precise definition of criteria	9/15	10/16	19/31
Need for precise recommendation for addition of criteria	6/15	9/16	15/31
Need for more subtle classification than RA or 'not-RA'	5/14	8/16	13/30
Need for removal of some criteria	5/15	9/16	14/31
Need for addition of new biological criteria	2/13	14/16	16/29
Need for new radiological criteria	4/14	15/16	19/30
Need for exclusion criteria	7/13	13/16	20/29
1991 ESSG criteria for SP			
Used ESSG criteria in publications	5/14	15/16	20/30
Use ESSG criteria as a diagnostic tool	5/15	11/16	16/31
Criteria must be fulfilled at final examination	1/11	1/16	2/27
Criteria must have been present simultaneously	4/11	4/11	8/22
Criteria can be applied cumulatively	6/11	11/16	17/27
Asymmetrical involvement of one group of joints is sufficient	2/12	3/15	5/27
Asymmetrical involvement of two groups of joints is required	3/12	1/15	4/27
Asymmetrical involvement of three groups of joints is required	7/12	11/15	18/27
Asymmetrical involvement of all groups of joints is required	2/12	0/15	2/27
Cervical inflammatory pain is a major criterion (if under 45)	2/15	3/15	5/30
Arthritis predominantly in lower limbs, if more extensive	13/15	13/15	26/30
Arthritis predominantly in lower limbs, if more severe	5/14	4/15	9/29
Arthritis predominantly in lower limbs (patient's opinion)	5/14	3/15	8/29

Discussion

As this pilot study was based on a relatively small number of opinions, due caution is required in comparing the proportion of experts replying to any given question. Nonetheless, this survey strongly suggests that discrepancies are quite frequent among experts

concerning the interpretation and application of the ACR criteria for RA (Table I). These discrepancies are mainly concerned with the way the ACR criteria for RA should be added to the format list (cumulatively for 17/32 experts); the grouping of tenosynovitis (18/32 experts) or 'sausage-like swelling of toes' (14/32 experts) with 'soft tissue swelling' of joint(s); the fulfilment of 'radiographic changes' for patients with erosions of other joints than the wrists and fingers (25/32 experts) or for patients with chondrolysis of the wrist and/or fingers without erosions (13/32 experts); and the definition of symmetrical involvement. The last point is important, as the application of this criterion can lead to the classification of patients as either RA or SP, whereas many patients may have symmetrical arthritis in some joints and asymmetrical involvement in others (11).

The second conclusion is that most experts feel that improvement is needed in the definition of current criteria. This recommendation applied mainly to symmetry and 'the typical radiological signs for RA'. Another request was to clarify how the criteria should be cumulated. The removal of morning stiffness and nodules, and the addition of new serological markers of RA such as anti-citrulline antibodies (10) and X-rays of the feet were other frequent suggestions. In this respect, it is noteworthy that 10/16 French experts recommended the inclusion of anti-citrulline antibodies as a new criterion for RA as compared to only 1/16 non-French experts, and that 15/16 French experts recommended the inclusion of a new radiologic criterion as compared to 4/14 non-French experts. This suggests that some cross-cultural differences exist in the nosology of RA and tends to confirm the results of a previous survey showing that French experts were less reluctant to classify early arthritis patients as SP (12). The binary classification of patients as RA or not-RA was criticised by 13/30 experts, and it was suggested that setting upper and lower limits for the fulfilment of criteria could be a solution.

These suggestions for alternative criteria need to be considered with due caution, especially as criteria sets tend to be limited rather than comprehensive. The inclusion of any new item should be based on the results of large prospective studies indicating that it really helps discriminate between early RA, early SP and other disorders.

Although 19/30 experts considered that RA and SP are syndromes more than diseases, and 26/31 that RA and SP can overlap (at least at the nosological level), the most frequent source of disagreement among rheumatologists on the classification of some patients was peripheral inflammation in SP (6). One possible solution for improving the specificity of the ACR criteria would be to question the validity of the SP concept and classify as RA those patients with SP features who satisfy the ACR criteria for RA. However, the third conclusion of the present survey is that peripheral SP appears to be an accepted concept [23/29 (79%) experts], even in the absence of axial signs or sacroiliitis. Moreover, some experts strongly disagree with the classification of SP-like psoriatic arthropathies as RA simply because the RA criteria are fulfilled. Hence, there could also be room for improvement of the ESSG criteria for SP (2).

As in the case of the ACR criteria for RA, clarification of the way SP criteria can be cumulated would be welcome. Similarly, a more precise definition of 'asymmetrical' involvement and 'arthritis predominantly in the lower limbs' could improve the efficiency of the ESSG criteria (2). Finally, inflammatory cervical pain beginning before the age of 45 and lasting for more than 3 months (which is common in early RA) could be excluded from the definition of the first major criterion. In fact, the American criteria for RA and the European criteria for SP should ideally be replaced by international criteria acceptable for both. This would be a welcome development until the concepts of early RA and early SP can be replaced by new classifications based on a listing of the predisposing factors present (13) and the target tissues involved (synovium and/or enthesis).

In the present survey 26/32 (81%) experts felt more confident in the clinical diagnosis than in the fulfilment of the 1987 ACR criteria for the classification of RA, especially in early RA. Accordingly, several authors have recently suggested the need for more suitable sets of criteria for the context of early arthritis (9, 14). This might be an impossible task, as RA should be considered a chronic disease. However, for research purposes at least, it might be worth determining whether MRI and other tests are helpful in predicting RA more accurately and if they could be added to current classification criteria for patients with early arthritis.

Thus, prospective studies are needed both for long-lasting and early RA to generate data-driven modifications of the RA and SP criteria. However, these criteria do not really perform so poorly (15) and are used in routine practice by 21/32 experts. The experts' opinion that improvement is desirable should only be considered as a suggestion and prerequisite for change.

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Appendix. Questionnaire completed by the experts.

Questions about the 1987 ARA criteria for RA:

1. In your previous publications, did you ever use the classification tree to classify patients as RA? (Yes or No).
2. How do you add criteria to reach (or not) the threshold of 4, when using the list format? (please tick just one of three): patients must still satisfy the criteria on the day of assessment; patients who do not satisfy the criteria on the day of assessment must have satisfied them simultaneously before; patients must just have satisfied 4 criteria cumulatively (not necessarily at the same time).
3. When you ask patients about how long their morning stiffness lasts (criterion No. 1), do you indicate (please tick just one of two): until there is no more stiffness? until maximal improvement of stiffness is reached?
4. Do you consider that the following situations apply for 'soft tissue swelling'of joint areas (criterion No. 2) (tick as many as you wish): tenosynovitis (*e.g.* flexor tendons of the wrists) (*i.e.* without signs of radio-carpal or radio-ulnar arthritis), bursitis (*e.g.* olecranon bursitis), sausage-like painless swelling of toes.
5. In considering that (poly)arthritis is symmetrical, do you require (please tick just one reply): symmetrical involvement of at least one group of joints (MCP and PIP being considered as a single joint); symmetrical involvement of at least two groups of joints (MCP and PIP being considered as a single joint); symmetrical involvement of at least three groups of joints (MCP and PIP being considered as a single joint); symmetrical involvement of all groups of joints (MCP and PIP being considered as a single joint)?
6. Do you consider the 'radiographic changes'criterion fulfilled for a patient with chondrolysis of wrist-fingers without erosions or decalcification? (Yes or No), desaxation/subluxation of wrist or fingers without erosions? (Yes or No), erosions from other joints than wrists and fingers? (feet, shoulders, *etc.*) (Yes or No).
7. In your routine clinical practice, do you use the classification tree to ensure better diagnosis of RA (and/or for medico-legal reasons)? (Yes or No).
8. In your routine clinical practice, do you use the list format to ensure better diagnosis of RA (and/or for medico-legal reasons)? (Yes or No).
9. Finally, in diagnosing a patient as RA, do you rely more on: your clinical judgement [analogue scale from 0 (not at all) to 100 (absolutely)]; or validation of the 1987 ARA criteria [analogue scale from 0 (not at all) to 100 (absolutely)].
10. In your experience, do the 1987 ACR criteria for RA perform well in early-onset arthritis (*i.e.* do they allow a reliable early distinction between RA and other diagnosis?) [analogue scale from 0 (not at all) to 100 (absolutely)].

If a new set of criteria more suitable for the classification of patients with early-onset arthritis as beginning RA were adapted from current 1987 ARA criteria, what modifications would you suggest?

A: modifications/further information about: the definition of some current (1987) criteria? (*e.g.* 'symmetrical', presence of RF on several tests, *etc.*) (Yes or No); the way criteria should be cumulated (or not) (Yes or No); binary classification of patients as early RA or 'not-RA' (instead of a more graduated scale: probable, *etc.*).

B: removal of one or more clinical criteria (*e.g.* nodulosis, morning stiffness) (Yes or No).

C: addition of new biological tests? (anti-Sa, anti-citrulline antibodies, *etc.*) (Yes or No); new radiological criteria? (Yes or No) (*e.g.* X-rays of the feet, ultrasonography or MRI); or exclusion criteria? (Yes or No).

Questions about the 1991 ESSG criteria for spondylarthropathy:

11. Do you agree with the concept of 'spondylarthropathy' [analogue scale from 0 (not at all) to 100 (absolutely)].
12. Do you agree to classify a patient as 'spondylarthropathy' when there is no spinal or sacroiliac involvement? [analogue scale from 0 (not at all) to 100 (absolutely)].
13. In your previous publications, did you ever refer to ESSG criteria for diagnosis of spondylarthropathy?
14. In your routine practice, do you use ESSG criteria as a diagnostic tool?
15. Do you consider that ESSG criteria are 'pertinent' for diagnosis of (early) spondylarthropathy [analogue scale from 0 (not at all) to 100 (absolutely)].
16. If you use these criteria (at least one of the two major criteria and one of the 7 minor criteria), how do you combine the major and minor criteria to classify patients as spondylarthropathy? (please tick just one reply): patients must satisfy the criteria on the day of assessment; patients who do not satisfy them on the day of assessment must have satisfied them simultaneously before; patients must just have satisfied 4 criteria cumulatively (*i.e*. not necessarily at the same time).
17. In considering that (poly)arthritis is asymmetrical, do you require (please tick just one reply): asymmetrical involvement of at least one group of joints (MCP and PIP being considered as a single joint); asymmetrical involvement of at least three groups of joints (MCP and PIP being considered as a single joint); asymmetrical involvement of the majority of the group of joints; asymmetrical involvement of all groups of joints (MCP and PIP being considered as a single joint)?
18. Do you consider that isolated inflammatory cervical pain of more than 3 months' duration and of insidious onset before the age of 45 is sufficient to consider that the criterion 'inflammatory spinal pain' is fulfilled? (Yes or No).
19. In your opinion, what should be considered as arthritis predominantly in the lower limbs: more arthritis in the lower than upper limbs; more severe arthritis of the lower limbs including the hip; the patient's own interpretation?
20. Do you consider that: a patient can be classified as both RA and spondylarthropathy? RA and spondylarthropathy can overlap? RA and spondylarthropathy are syndromes more than diseases?