Reply to:
High prevalence of ultrasound-defined enthesitis in patients with metabolic syndrome

Sirs,
We thank Falsetti et al. for their interest in our paper (1) in which we explored the prevalence of the ultrasound (US) findings indicative of enthesitis, according to the Outcome Measures in Rheumatology (OMERACT) definitions (2), in a group of 82 healthy subjects. In our paper, we found a relatively high prevalence of the US findings indicative of “active” inflammation (34.1% of the subjects, in 8.4% of the scanned entheseis) at the entheseis of the lower limb in a group of healthy subjects. Our results raise the need for a more specific definition of “active” enthesitis. This should include a combination of grey-scale (GS) abnormalities and power Doppler (PD) signal (i.e., PD signal ≥1 + entheseal thickening and/or hypoechochogenicity), as well as considering as pathological only PD grades higher than 1.

The paper by Falsetti et al. (3) shows an even higher prevalence of US findings indicative of enthesitis, according to the OMERACT criteria, in a group of patients with metabolic syndrome. Healthy subjects with a known history of metabolic syndrome were excluded from our study as the entheseis, as well as the tendons, are anatomical areas which are frequently affected in these conditions (4, 5).

Similar to our study, the authors found a very low prevalence of PD signal at the enthesis (1% of the entheseis examined), suggesting that PD signal might represent a reliable US biomarker of “active” inflammation. Interestingly, the authors found a high prevalence of US findings indicative of “structural damage”, such as bone erosions, calcifications and enthesophytes.

In our paper, we found a frequent association between the US findings of “active” inflammation, especially entheseal thickening and hypoechoic areas, and “structural damage”, suggesting that subjects showing hypoecho-