

Adult-onset Still's disease: still a long way to go. Comment on the article "Adult-onset Still's disease: review of 41 cases" by Riera et al.

Sirs,
 We have read with great interest the article by Riera *et al.*, describing clinical and laboratory characteristics of a large cohort of patients with adult-onset Still disease (AOSD), recently published in *Clinical and Experimental Rheumatology* (1).
 We agree that serum ferritin levels are very useful both to diagnose and to monitor patients with AOSD. Our work, previously published in *Seminars in Arthritis and Rheumatism* suggests that ferritin may be a useful prognostic factor, perhaps in combination with others (2). Interestingly, as shown in Table I, comparing serum ferritin levels in patients with chronic systemic and chronic articular disease at the time of diagnosis and 6 months later, it is possible to infer that the persistence of high ferritin levels, after adequate treatment may predict a chronic articular course.
 Our experience with anti-TNF- α agents, partially presented at the 2007 ACR meeting, is also corroborated by that of Riera *et al.* Anti-TNF- α medicines, in fact, may be helpful in controlling systemic and articular symptoms of refractory AOSD. Our data have suggested that TNF- α blockade would not be as effective in slowing down the articular damage as in improving systemic and osteo-articular symptoms. This leads to the awareness that anti-TNF- α agents should not be a conceivable first line therapy in AOSD. Owing to a more reassuring safety profile and a more targeted action, as well as more evidence-based effectiveness, we think that interleukin-1 receptor antagonist anakinra could actually be considered a first line choice in AOSD patients (3, 4).
 Although AOSD has usually been considered a benign disease, we think it is worth pointing

Table I. Serum ferritin levels at the time of the diagnosis and 6 months later for chronic systemic and for chronic articular course in a large Italian cohort.

	polycyclic (23 patients)		chronic articular (33 patients)	
	at time of diagnosis	after 6 months	at time of diagnosis	after 6 months
Ferritin mean (SD)	3645 (6204)	229 (97)	7242 (9806)	1593 (3643)

out that patients with the systemic form of the disease should be closely monitored because of the possibility of life-threatening complications, that could also represent the heralding manifestation of the disease (5-8).
 In conclusion, we think that a multi-centre study aimed at the identification and validation of a set of diagnostic criteria should be encouraged. There are currently several classification criteria for AOSD, but those of Yamaguchi are the most used (9). However, it is worth recalling that the latter are not specified in detail; in particular the exclusion criteria provide only general recommendations and there is no precise list of diagnoses or set of laboratory tests to be performed. The second important limitation is that serum ferritin and its glycosylated component are not included as is in Fautrel's proposed criteria (10). Besides, Yamaguchi's criteria give the possibility to classify AOSD patients as having no fever. As far as fever is concerned, we think that a feverish polyarthritis should be a *sine qua non* criteria for suspecting a diagnosis of AOSD. Larger, prospective studies are also needed to identify reliable prognostic factors.

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