Drs. Neogi and Felson reply

To the Editor:

We thank Dr. Kirwan for his insightful comments regarding potential concerns about relying on a physician global assessment for rheumatoid arthritis (RA) disease activity assessment. We agree that “which physician” is providing his/her global assessment is an important determinant of the validity and reliability of such an outcome.

While we advocated the use of composite indices of disease activity over individual core set measures, we did argue that the physician global assessment may be considered a type of composite index in the setting of a clinical trial. In such a setting, the physician global assessment is informed by the systematic collection of data regarding tender and swollen joint counts, patient-reported pain and function, and laboratory measures. Indeed, in the clinical trial setting, the physician global assessment has been found consistently to be among the core set measures with the highest sensitivity to change¹⁻³. However, this may not necessarily be the case in a clinic setting, where, in contrast to a clinical trial, a physician global assessment may not be informed by such comprehensive data. Differences in levels of experience and expertise as well as cognitive heuristics can contribute to variability in such assessments in the clinic.

We agree that a clinic-based measure of disease activity would provide rheumatologists with a systematic tool to monitor RA disease activity in clinical practice and could inform treatment decisions. The Disease Activity Score (DAS)⁴ is certainly a valid and reliable instrument for this purpose. However, one caveat regarding the use of DAS in the clinic is that swollen and tender joint counts used in the calculation of the DAS remain assessor-dependent and this assessment carries variability similar to that of

the physician global assessment. Work is needed to examine whether implementing such quality of care measures in the clinic setting (outside a trial) has an influence on patient outcomes.

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