Dr. Troppmann and Dr. Karsh reply

To the Editor:

We do not dispute the principle that increasing the likelihood of a response to a treatment is desirable whether one uses expensive or inexpensive therapy. The Canadian Rheumatology Association/Spondyloarthritis Research Consortium of Canada (CRA/SPARCC) guidelines replace the expert's opinion in the ASsessments in Ankylosing Spondylitis guidelines with an objective measure of inflammation, either an elevated acute-phase reactant or magnetic resonance imaging (MRI). This is quite reasonable.

Our goal was to ascertain the proportion of patients with seronegative spondyloarthritis who might require an MRI according to the CRA/SPARCC guidelines. We did not include an opinion on the need for a tumor necrosis factor (TNF) inhibitor as an inclusion criterion because it is not part of the CRA/SPARCC guidelines. We clearly state that one of the limitations of our study[2] is the small sample size. Thus the figure of 41% is not a gross exaggeration but simply a number, an estimate based on the sample size; the confidence interval is 26%–60%.

We suspect that most rheumatologists in Canada and elsewhere include their opinion (and the patient's opinion) on the need for an anti-TNF drug whether part of the guidelines or not. This form of self-restraint is probably one of the unspoken limits to the use of expensive medications. However, agencies paying for drugs generally do not deal well with gestalt. Currently in the province of Ontario there are no published provincial formulary guidelines for the use of an anti-TNF. When applying, we follow features common to several guidelines and provide a BASDAI $\geq$ 4 and as much other evidence in support of the diagnosis and increased disease activity such as radiographs, a Bath Ankylosing Spondylitis Functional Index, and blood tests (HLA-B27 and erythrocyte sedimentation rate/C-reactive protein). We do not know which piece of information is critical to a positive response but suspect it is the BASDAI. In Ontario, at this date, the provincial formulary approves the use of etanercept and infliximab in AS but for unexplained reasons not adalimumab.

We see the value of an MRI in providing objective evidence of inflammation. It could justify the use of an anti-TNF in a stoic patient with a BASDAI $\leq$ 4 who, in the doctor's opinion, could benefit even if the patient might feel that they are in a patient-acceptable symptom state. However, the Ottawa region has the worst healthcare wait times in the province of Ontario, with a wait time of 12 months for an outpatient MRI being common[1]. Should our provincial formulary adopt the need for an MRI as eloquently described in the CRA/SPARCC guidelines, access to care in the Ottawa region would be delayed. We hope that the conclusion of our report[2] is not that there are no advantages of an MRI, but rather that more means and resources are required for the timely diagnosis and treatment of the arthritic diseases.

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