Dr. Mader replies

To the Editor:

I thank Dr. Verdone for his valuable comments. I agree that diffuse idiopathic skeletal hyperostosis (DISH) is under diagnosed, and the clinical manifestations were not investigated properly. It is true that the number of published articles on this topic did not grow significantly, but there is certainly more awareness of the sometimes dreadful complications it might inflict[1,2]. Although DISH and osteoarthritis (OA) can coexist, it is not surprising that, despite several distinguishing features, patients with DISH are often discussed in conjunction with OA patients[3]. At present, the definition of DISH is based mainly on the characteristic radiological findings involving, in particular, the thoracic spine. The notion that the condition is not limited to the spine led researchers to use the widely accepted term DISH, introduced by Resnick, *et al*[4]. The extraspinal manifestations of DISH are numerous and have been recently reviewed[5]. At present, entheseal new bone formation, either spinal or peripheral, can be detected by imaging techniques and therefore, too late in their evolution. In contrast to ankylosing spondylitis (AS), DISH is considered at present to be a noninflammatory condition. Nevertheless, AS and DISH may, infrequently, co-exist, and occasionally DISH may present with a clinical picture that closely resembles AS. A recent paper addressed the distinguishing features of these 2 entities[6]. The association of DISH with metabolic syndrome, diabetes mellitus, and an increased cardiovascular risk has been recently reiterated[7,8]. With the increasing prevalence of these disorders in Western societies, an increase in the prevalence of DISH might be expected. It is therefore not surprising that in a hospital setting, up to one-third of elderly patients were affected by DISH[9]. It is therefore imperative to redefine the clinical characteristics, to investigate tools for early detection, and better understand the pathogenetic mechanisms of this condition in order to allow better preventive and therapeutic measures. Your letter and this response further emphasize why it is "time for a change[10]."

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REFERENCES

1. Mader R. Clinical manifestations of diffuse idiopathic skeletal hyperostosis of the cervical spine. Semin Arthritis Rheum 2002;32:130-5.
2. Westerveld LA, Verlaan JJ, Oner FC. Spinal fractures in patients with ankylosing spinal disorders: a systematic review of the literature on treatment, neurological status and complications. Rheumatology 2009;48:1133-6.
3. Mader R. Diffuse idiopathic skeletal hyperostosis: a distinct clinical entity. IMAJ 2003;5:506-8.
4. Resnick D, Shaul SR, Robins SM. Diffuse idiopathic skeletal hyperostosis (DISH): Forestier's disease with extraspinal manifestations. Radiology 1975;115:513-24.
5. Mader R, Sarzi-Puttini P, Atzeni F, Olivieri I, Pappone N, Verlaan JJ, Buskila D. Extraspinal manifestations of diffuse idiopathic skeletal hyperostosis. Rheumatology 2009;48:1478-81.
6. Olivieri I, D'Angelo S, Palazzi C, Padula A, Mader R, Khan MA. Diffuse idiopathic skeletal hyperostosis: differentiation from ankylosing spondylitis. Curr Rheumatol Rep 2009;11:321-8.
7. Mader R, Novofestovski I, Adawi M, Lavi I. Metabolic syndrome and cardiovascular risk in patients with diffuse idiopathic skeletal hyperostosis. Semin Arthritis Rheum 2008;38:361-5.
8. Mader R, Lavi I. Diabetes mellitus and hypertension as risk factors for early diffuse idiopathic skeletal hyperostosis (DISH). Osteoarthritis Cartilage 2009;17:825-8.
9. Weinfeld RM, Olson PN, Maki DD, Griffiths HJ. The prevalence of diffuse idiopathic skeletal hyperostosis (DISH) in two large American Midwest metropolitan hospital populations. Skeletal Radiol 1997;26:222-5.
10. Mader R. Diffuse idiopathic skeletal hyperostosis: Time for a change. J Rheumatol 2008;35:377-9.