

Back to Basics: Clinical versus Radiologic Recognition of Spondyloarthropathy

To the Editor:

The report by Christiansen, *et al*<sup>1</sup> again emphasizes one of the limitations to clinical application of our diagnostic paradigms. Sacroiliac joints (SIJ) have highly irregular contours with 3-D topography<sup>2</sup>. Imaging artifacts related to the limited resolution of computed tomography (related to the subchondral bone thickness of SIJ) compromises its reliability in identifying or excluding not only erosions, but also bridging or fusion<sup>3,4</sup>. Standard radiographs also have limited resolution, but no averaging artifact. One would anticipate that they would provide clarity, and they generally do for most joints. SIJ are an exception<sup>1,3</sup>. The irregular characteristic of the joint and its positioning outside of visualization on standard anterior-posterior and lateral views are thought responsible for erroneous perspectives of the “health” of the joint<sup>5</sup>. However, experimentation with alternative views (Table 1) failed to provide a solution<sup>3</sup>.

The category of disease inclusive of ankylosing spondylitis (AS) and spondyloarthropathy (SpA) in general is a construct. Clinical, laboratory, and radiologic findings have been used to facilitate its recognition. However, it is perhaps useful to examine the clinical purpose of categorization. Is it not to define a clinical population that would be anticipated to respond to a specific course of treatment?

Back pain that is worse with immobility, improved with activity, and associated with significant morning stiffness is highly characteristic, although arguably not definitive for the diagnosis of AS or at least the axial presentation of SpA<sup>6</sup>. If radiologic findings are not always reliable<sup>1,3</sup>, the value of HLA-B27 positivity is limited by its high presence in healthy

individuals<sup>7</sup>, and acute-phase reactants are variable<sup>8</sup>, is therapeutic response an alternative diagnostic consideration? If the patient’s pain complaints respond to an extension exercise program (with avoidance of flexion activities), the diagnosis of SpA is highly likely<sup>9</sup>. After all, we are clinicians and from a clinical perspective, the patient’s problem has been resolved.

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*J Rheumatol* 2017;44:6; doi:10.3899/jrheum.170164

Table 1. Radiologic views for sacroiliac joint visualization<sup>3</sup>.

Anterior-posterior (AP)
30° cephalad-angulated AP
15° cephalad-angulated AP
30° caudally angulated posterior-anterior
Obliques
Stereoscopic
Tomograms
CT scans
Fluoroscopy

CT: computed tomography.