

A Multicenter Reliability Study of Extremity-Magnetic Resonance Imaging in the Longitudinal Evaluation of Rheumatoid Arthritis

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ABSTRACT. There are limited data on the reliability of extremity magnetic resonance imaging (E-MRI) in the longitudinal evaluation of rheumatoid arthritis (RA). Our aim was to assess the interreader reliability of the OMERACT RA MRI score in the assessment of change in disease activity and bone erosion scores using 0.2 T E-MRI hand and wrist images from 2 timepoints, evaluated by 3 readers at different international centers. The intraclass correlation coefficients and smallest detectable difference results for the change scores were generally good for erosions and synovitis, but were not acceptable for bone edema. Overall, E-MRI demonstrated ability to detect change comparable to that reported for high-field MRI for erosion and synovitis. (*J Rheumatol* 2007;34:857–8)

Key Indexing Terms:

EXTREMITY MAGNETIC RESONANCE IMAGING
EROSIONS SYNOVITIS

RHEUMATOID ARTHRITIS
BONE EDEMA RELIABILITY

While high-field magnetic resonance imaging (MRI) is an established tool for proof-of-concept studies in rheumatoid arthritis (RA), limited data exist on the reliability of low-field extremity MRI (E-MRI) in assessing longitudinal change in

RA. Only one study has attempted this, using a single reader and evaluating 35 patients with RA and 9 healthy controls and using a 0.2 T E-MRI unit¹. This study demonstrated that the unilateral wrist and MCP joint evaluation was superior to radiography of bilateral hands and feet in the detection of erosion progression. Our aim, therefore, was to assess the interreader reliability of the OMERACT RA MRI score (RAMRIS)² in a longitudinal RA cohort using low-field E-MR images and readers from multiple international centers.

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MATERIALS AND METHODS

MR images of 15 patients with RA, obtained at 2 timepoints, were selected from a Danish followup study¹. The median age and disease duration of the patients were 60 years (range 35–75) and 5 years (range 1–27), respectively. Median clinical and biochemical values for measures of disease activity and functional status at baseline were: number of swollen joints 5 (0–9) and number of tender joints 7 (0–25), serum C-reactive protein 9 mg/dl (\leq 8–103), Disease Activity Score-28 of 4.8 (1.8–7.1), and Health Assessment Questionnaire score 0.75 (0.0–2.0). Sixty-five percent of the patients had IgM rheumatoid factor. Images from 2 timepoints 12 months apart were selected for the exercise. MRI of unilateral wrists and 2nd-5th MCP joints was performed using a low-field (0.2 Tesla) dedicated E-MRI unit (Artoscan, Esaote Biomedica, Genova, Italy), equipped with a dual phased-array wrist coil. MRI sequences included coronal T1-weighted 3-D gradient-echo sequence with subsequent multiplanar reconstruction, obtained before and after intravenous contrast injection, and a coronal STIR sequence (see Ejbjerg, *et al*¹ for details). All MR images were read, paired for known chronology, using a commercial software package (Merge eFilmTM) and assessed for RAMRIS features by 3 experienced readers from different international centers.

Statistical analysis. Single-measure and average-measure intraclass correlation coefficients (ICC) and smallest detectable differences (SDD) were calculated on the change scores. The SDD³ is derived from the limits of agreement method⁴ and here is expressed in the same units of measurement as calculated for all aggregated scores. The SDD is also expressed as a percentage of the highest actual score to permit comparison of the reliability across different MRI methods or scores.

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RESULTS

For the purposes of this exercise, scores for the wrist and MCP sites were combined to provide total scores for each of erosions, synovitis, and bone edema. The ICC for the change scores for the 3 readers, and for paired readers, are presented in Table 1. Overall, the erosion and synovitis ICC were very good and close to those for high-field technology, whereas the results for bone edema were poor. The findings for erosion and synovitis were comparable with the average-measure ICC from another study using 3 experienced readers evaluating longitudinal 1.5 T images (where the ICC for erosion, synovitis, and bone edema were 0.97, 0.95, and 0.96, respectively)⁵. Table 2 shows the SDD data, and importantly, the SDD presented as a percentage of the actual maximal score achieved. These percentage SDD data demonstrate acceptable measurement error compared to both previous MRI and radiographic scoring data⁶. Again, the bone edema results demonstrated the highest SDD.

DISCUSSION

This multireader, multicenter low-field MRI scoring exercise has demonstrated high agreement for change scores of damage and synovitis, with agreement comparable to that from previous high-field MRI studies. This was despite no calibration of the 3 readers involved, although all 3 were conversant with the European League Against Rheumatism-OMERACT scoring atlas. There was, however, poor agreement on the

Table 1. Intraclass correlation coefficient (ICC) results for the 3 readers. Values are single measure ICC.

	Bone Erosion	Synovitis	Bone Edema
ICC*	0.91	0.89	0.24
ICC — readers 1,2,3	0.78	0.72	0.09
ICC — readers 1,2	0.85	0.72	0.04
ICC — readers 1,3	0.70	0.60	0.09
ICC — readers 2,3	0.76	0.80	0.32

* Average measure ICC.

Table 2. Smallest detectable difference (SDD) results for change scores for the 3 readers.

	Readers	Average Difference	SDD	% SDD of Actual Max
Bone erosion	1,2	1.2	5.4	5
	1,3	1.9	6.3	6
	2,3	0.4	7.0	7
Synovitis	1,2	-2.1	5.3	27
	1,3	-1.2	6.9	34
	2,3	0.5	4.4	23
Bone edema	1,2	-1.4	14.3	48
	1,3	-1.2	16.1	54
	2,3	0.2	6.3	21

% SDD of actual max, SDD as a percentage of the actual maximum score obtained.

change scores for bone marrow edema. It is worth noting that caution must be applied in generalizing this information to all E-MRI machines, which differ substantially in their image quality and in their ability to perform adequate STIR sequences that are required to identify bone edema. Our findings support the use of low-field MRI for use in clinical trials with erosion and synovitis as endpoints.

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