

# Utility of Magnetic Resonance Imaging in Diagnosis and Monitoring Enthesitis in Patients with Spondyloarthritis: An OMERACT Systematic Literature Review

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**ABSTRACT. Objective.** A systematic literature review was performed to document published magnetic resonance imaging (MRI) lesion definitions and scoring systems for enthesitis in spondyloarthritis (SpA).

**Methods.** PubMed, Embase, and Cochrane Library databases were searched for original publications involving adult patients with SpA undergoing MRI of axial/peripheral joints. Selected articles were assessed for quality using a standardized assessment tool and metric indices.

**Results.** Considering the heterogeneous design, quality, and outcome measures of studies, statistical data pooling was considered inappropriate. A qualitative narrative of results was undertaken based on study designs.

**Conclusion.** Lack of a comprehensive, validated score warrants additional research to develop an MRI enthesitis scoring system. PROSPERO registration number: CRD42018090537. (First Release March 1 2019; J Rheumatol 2019;46:1207–14; doi:10.3899/jrheum.181083)

## Key Indexing Terms:

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Enthesitis, inflammation at the insertion site of tendon, ligament, or joint capsule into bone, is considered a key pathological feature in spondyloarthritis (SpA) and psoriatic arthritis (PsA)<sup>1</sup>. Compared to conventional assessment of enthesitis using clinical scores, magnetic resonance imaging (MRI) detects both soft tissue and intraosseous abnormalities in active enthesitis, potentially aiding early diagnosis and outcome measurement in SpA and PsA<sup>2</sup>. With the advent of the treat-to-target concept and novel therapies, objective and sensitive monitoring of response of enthesitis to therapy is desirable, and a validated MRI scoring system would be a useful adjunct to clinical practice as well as providing additional information as an outcome measure in clinical trials.

The Outcome Measures in Rheumatology (OMERACT) MRI in Inflammatory Arthritis Working Group undertook a systematic literature review to describe the MRI variables, definitions, and scoring systems used to diagnose and monitor enthesitis in SpA. We assessed the quality and reported psychometric qualities, including validity, reliability, and responsiveness of original publications, to understand whether there was a need for a novel MRI scoring system for enthesitis in SpA<sup>3,4</sup>.

## MATERIALS AND METHODS

**Selection criteria and search strategies.** We searched Medline, Embase, and Cochrane Library databases from their inception until February 2018 for original publications involving adult patients (> 18 yrs) with SpA in whom

MRI of axial or peripheral joints had been performed using a high-field magnet ( $\geq 1.5T$ ) to assess enthesitis. Exclusion criteria included studies on enthesitis related to other conditions, such as degenerative, trauma-related, and inflammatory diseases other than SpA. The search strategy was designed to select cross-sectional, case control, randomized controlled, and nonrandomized studies in the English language containing at least 1 term from each of the following search blocks: (1) spondyloarthritis, spondylarthritis, psoriatic arthritis, or ankylosing spondylitis; (2) enthesopathy, enthesitis or enthesion; and (3) magnetic resonance imaging or MRI. The selected studies were evaluated for definitions of MRI enthesitis lesions, quality of studies using a standardized assessment tool, and for their metric qualities.

**Selection of studies and data extraction.** Two reviewers (AJM and SK) independently selected the studies and systematically screened the titles and abstracts, applying inclusion and exclusion criteria. Selected articles were retrieved in full, and the same reviewers assessed each article for its eligibility. Disagreements between the reviewers on article selection were resolved by discussion. Data were extracted to a standardized form. Any discordance in opinion was resolved by consensus and involvement of a third reviewer (MØ). The data extraction sheet contained the following information: author, year of publication, study design, study population, number of participants, intervention, comparator, MRI field strength, sequences used, MRI sites used for evaluating enthesitis, definitions of MRI inflammatory and structural enthesitis, and scoring system used (Table 1).

**Quality assessment of selected studies.** A standardized tool (Supplementary Table 1, available with the online version of this article) for quality assessment of the analyzed studies based on a set of 12 predefined criteria addressing the following components was developed and assessed in a binary mode (yes/no): study population, enthesitis imaging feature, outcome of interest, study design and analysis, and data presentation. Concepts from review of quality assessment tools in systematic reviews of observational studies were adapted for developing these criteria<sup>5</sup>. Quality was reported on a scale of 0–12, with higher scores indicating better quality. Included studies that scored  $< 3$  on the scale were excluded from the final analysis.

**Psychometric properties of included studies.** Each selected article was analyzed and assessed to determine whether it satisfied certain aspects of validity. The following metric qualities were evaluated: face and content validity, construct validity, criterion validity, and discriminant validity (reliability and responsiveness; Table 2).

**Statistical analysis.** Details of the studies were reported with descriptive statistics such as frequencies and percentages for categorical data and mean and SD for continuous data. Because of variability in studies, metaanalysis could not be performed. PROSPERO registration number: CRD42018090537.

## RESULTS

**Literature search.** The study selection process is depicted in a PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) flow diagram (Figure 1).

**Study characteristics.** Attributes of the included studies are summarized in Table 1<sup>2,6–43</sup>. The majority of included studies were of cross-sectional design (20; 51%)<sup>2,6–17,19–24,28</sup>. Eight case-control<sup>18,25–27,29–32</sup>, 6 cohort<sup>33,34,35,36,37,38</sup>, 3 randomized controlled trials<sup>39,40,41</sup>, and 2 other longitudinal studies<sup>42,43</sup> were included. Study populations involved SpA in 22, ankylosing spondylitis in 7, and PsA in 9 studies, and chronic low back pain in 1 study. In total, 1534 individuals (range 8–127) in different groups were evaluated for MRI enthesitis in all the studies together. Peripheral enthesitis were evaluated in 24 (62%) studies<sup>7,10,11,15–29,31,32,34,36,38,39</sup>, axial enthesitis in 8 studies<sup>6,8,12,15,14,36,42,43</sup>, and enthesitis at both sites using whole-body MRI in 7 studies<sup>2,9,30,33,37,40,41</sup>. Both

T1-weighted (T1w) and T2w fat-suppressed or its comparable sequences were included in all the studies. Comparison with other methods of evaluating enthesitis [ultrasonography (US) and clinical assessment] was described in 10 studies<sup>7,9,10,11,18,30,31,32,35,36</sup>, while 5 studies compared different MRI sequences to assess enthesitis<sup>6,13,14,25,42</sup>. Only 4 studies compared efficacy of MRI against a gold standard<sup>11,13,35,42</sup>.

Qualitative assessment of enthesitis at different regions was used in 82% of studies. Only 8 studies mentioned a semiquantitative or quantitative MRI scoring system<sup>2,14,16,17,19,25,39,40</sup>. No studies described a validated, comprehensive MRI scoring system measuring all the aspects of enthesitis in any region. The majority of studies defined inflammatory enthesitis as enhancement of ligaments, increased signal intensity, perientheseal increased signal intensity, adjacent bone marrow edema (BME), soft tissue signal around ligaments or tendons, thickening of ligaments, capsulitis in sacroiliac joints, extracapsular soft tissue enhancement, Achilles tendon diameter of BME, perientheseal fluid and/or tendinitis in T1w post-gadolinium, or short-tau inversion recovery sequences. Enteseal structural damage defined by few studies includes bone erosions, enthesophytes, focal signal intensity changes, and calcaneal spur in T1w sequences<sup>2,7,16,25,27,28,29,32</sup>.

**Quality assessment of included studies.** Quality scores assessed using a standardized tool are provided in Table 2. With 1 exception, all 38 studies met the minimal quality requirement score of 4. High quality scores (10–12) were present in only 2 studies<sup>2,40</sup>, while the remaining 36 studies had moderate quality scores (5–9).

**Assessment of psychometric properties.** Table 2 describes psychometric properties of the selected studies. Face validity was assessed in 33 (87%) studies, content validity in 19 (50%) studies, and construct validity of MRI as related to ultrasound (US) and clinical examination in 5 (13%) and 6 (16%) studies, respectively. Five studies reported construct validity of different MRI sequences in relation to each other<sup>6,13,14,25,42</sup>. Criterion validity of MRI in relation to histology was described only by Tan, *et al*<sup>22</sup>. Reliability of MRI in detecting enthesitis using various scoring methods was reported by 26 (68%) studies in which images were evaluated by 2 independent readers who were blinded to clinical outcomes. Responsiveness of various MRI enthesitis scores was reported in 6 (18%) studies, of which 3 showed statistically significant changes ( $p < 0.05$ )<sup>37,40,41</sup>.

## DISCUSSION

Axial and peripheral enthesitis constitutes a core feature of SpA and PsA. The OMERACT PsA core domain set includes enthesitis, which makes it mandatory to be assessed in all clinical trials and observational studies<sup>44</sup>. MRI allows sensitive assessment of enthesitis in clinical trials. We have critically evaluated the published literature for available

Table 1. Characteristics of included studies.

Study	Study Population	No. Participants	Intervention	Comparator	MRI Field Strength	Sequences	MRI Sites	Scoring Systems
Cross-sectional studies								
Fournié, <i>et al</i> <sup>12</sup>	AS fulfilling Amor criteria and PsA based on seronegative joint disease with psoriasis	8 (5; 3)	MRI	NA	NA	T1W Gd	Anterior chest wall	Qualitative
McGonagle, <i>et al</i> <sup>16</sup>	SpA with plantar fasciitis; mechanically induced plantar fasciitis	28 (17; 11)	MRI	NA	0.5; 1.5	T1W; SPIR	Plantar fascia	Semiquantitative
Olivieri, <i>et al</i> <sup>19</sup> Tan, <i>et al</i> <sup>24</sup>	SpA with dactylitis DIP joint PsA; DIP joint OA; healthy subjects	6 30 (10; 10; 10)	MRI MRI	NA NA	1.5 1.5	T1W; T2W FS; GRE-T2W T1W; T2W FS; PD; 3DGE; T1W FS Gd	Finger tendon insertions DIP joints	Semiquantitative Qualitative
McQueen, <i>et al</i> <sup>17</sup> Tan, <i>et al</i> <sup>22</sup>	PsA DIP joint PsA; DIP joint OA; healthy subjects	10 30 (10; 10; 10)	MRI MRI	NA NA	0.6 1.5	T1W; T1W Gd; STIR T1W; T2W FS; PD; 3DGE; T1W FS Gd	2nd–5th finger DIP joints	Semiquantitative Qualitative
Marzo-Ortega, <i>et al</i> <sup>15</sup> Maksymowicz, <i>et al</i> <sup>14</sup>	SpA; RA SpA or suspected SpA	20 (10; 10) 35	MRI MRI T1W FS Gd	NA MRI T2W FS	1.5 1.5	T1W; DCE-MRI; SPIR FS Gd T1W; T1W FS; T2W FS; T1W FS Gd	MCP joints Enthesitis of SIJ ligaments	Qualitative Semiquantitative
Feydy, <i>et al</i> <sup>28</sup>	SpA; controls hospitalized low-back pain	75 (51; 24)	MRI	NA	1.5	T1W; STIR	Heel enthesitis	Qualitative
Althoff, <i>et al</i> <sup>9</sup> Aydim, <i>et al</i> <sup>10</sup> Braun, <i>et al</i> <sup>11</sup>	SpA SpA with swollen knee Suspected inflammatory joint disease	75 21 69	MRI MRI MRI	NA US Clinical	1.5 1.5 1.5	T1W; STIR T1W; T2 SPIR; T1 SPIR; T1 SPIR Gd T1W; T1W FS Gd; STIR	Whole-body Knee entheses Collateral ligaments of finger joints	Qualitative Qualitative Qualitative
Paramarta, <i>et al</i> <sup>20</sup>	Knee or ankle arthritis; SpA; RA; crystal arthritis	41 (13; 20; 8)	MRI	NA	1.5	T1W; T2W FS; STIR; T1W FS Gd	Knee and ankle entheses	Qualitative
Ramirez, <i>et al</i> <sup>21</sup>	Greater trochanter pain:	40	MRI	NA	1.5	T1W; T2W FS	Greater femoral trochanter	Qualitative
Poggenborg, <i>et al</i> <sup>2</sup> Tan, <i>et al</i> <sup>23</sup>	SpA/RA no inflammatory disease SpA; SpA; healthy subjects PsA with dactylitis; healthy subjects	48 (18; 18; 12) 22 (12; 10)	MRI MRI	NA NA	3 1.5	T1W; STIR T2W FS; T1W; TSE; T1W FS Gd	Whole-body Fingers/toes	Semiquantitative Qualitative
Agten, <i>et al</i> <sup>6</sup>	Suspected SpA	68	MRI T1W Gd	MRI STIR	1.5; 3.0	T1W FS Gd; STIR	T12-S1 interspinous and supraspinous ligaments SIJ anterior and posterior ligaments	Qualitative
Giraudo, <i>et al</i> <sup>13</sup>	Suspected SpA	106	MRI T2W; MRI PD	T1W Gd	3	T2W; PD; T1W; T1W FS Gd	SIJ anterior and posterior ligaments	Qualitative
Aivazoglou, <i>et al</i> <sup>8</sup> Maldonado, <i>et al</i> <sup>7</sup>	SpA SpA	16 40	MRI MRI	NA US; CR	1.5 1.5	T1W FS; T1W FS Gd; STIR T1W; T1W FS Gd; T2W FS or STIR	Enthesitis of SIJ ligaments Achilles tendon insertion; plantar fascia	Qualitative Qualitative
Case control studies								
Olivieri, <i>et al</i> <sup>18</sup>	SpA fulfilling Amor's criteria and showing severe Achilles enthesitis	19 pathologic 9 normal tendons	MRI	US	0.5	T1W, PD, T2W	Ankle	Qualitative
Lambert, <i>et al</i> <sup>29</sup> Erdem, <i>et al</i> <sup>27</sup> Wiell, <i>et al</i> <sup>32</sup> Emad, <i>et al</i> <sup>26</sup>	AS; healthy subjects AS; healthy subjects PsA; RA; healthy subjects PsA/AS/ReA/IBD/Skin psoriasis; healthy subjects	111 (17; 94) 33 (23; 10) 25 (15; 5; 5) 76 (56; 20)	MRI MRI MRI MRI	NA NA US NA	1.5 1.5 0.6 1.5	T1W; T2W; PD; T2W FS or STIR T1W; T2W; STIR T1W; STIR; T1W Gd T1W; T1W Gd	Shoulder Heel enthesitis Fingers/toes Knee entheses	Qualitative Qualitative Qualitative Qualitative

Table 1. Continued.

Study	Study Population	No. Participants	Intervention	Comparator	MRI Field Strength	Sequences	MRI Sites	Scoring Systems
Weckbach, <i>et al</i> <sup>30</sup> Wiel, <i>et al</i> <sup>31</sup>	PsA SpA; non-SpA; healthy subjects	30 37 (12; 15; 10)	MRI MRI	Clinical US	1.5 0.6	STIR, VIBE; VIBE Gd T1W; STIR; T1W Gd	Whole-body Achilles tendon and enthesitis	Qualitative Qualitative
Chen, <i>et al</i> <sup>25</sup> Cohort studies	PsA; healthy subjects	16 (9; 7)	MRI 3D UTE Cones	MRI T1W	3	3D UTE Cones; T1W	Achilles tendon	Qualitative
Godfrin, <i>et al</i> <sup>35</sup> Eshed, <i>et al</i> <sup>34</sup>	Enthesal pain at multiple sites SpA with hindfoot pain	33 27	MRI MRI	Clinical NA	1.5 0.2; 1.5	T1W; T2W; T1W FS Gd and/or STIR T1W; STIR; T1W FS Gd; T1W GRE FS	Not described Heel enthesitis	Qualitative Qualitative
Karpitschka, <i>et al</i> <sup>37</sup> Huang, <i>et al</i> <sup>36</sup> Althoff, <i>et al</i> <sup>33</sup> Marzo-Ortega, <i>et al</i> <sup>38</sup> Tan, <i>et al</i> <sup>43</sup>	AS AS SpA SpA AS fulfilling modified New York criteria	10 58 41 10 9	MRI MRI MRI MRI MRI	NA CR; Clinical Clinical NA NA	1.5 1.5 1.5 1.5 1.5	T1W; STIR T2W; T1W; STIR; T1W FS Gd T1W; STIR T1W; T2W FS; T1W FS Gd T1, TSE, STIR	Whole-body Hip Whole-body Depending on symptoms SIJ and spine of each patient	Qualitative Qualitative Qualitative Qualitative Semi-quantitative
de Hooge, <i>et al</i> <sup>42</sup> Randomized controlled trials	Chronic back pain	127	MRI T1W FS Gd	MRI STIR	1.5	T1W; T1W FS Gd; STIR	SIJ enthesitis/capsulitis	Qualitative
Dougados, <i>et al</i> <sup>39</sup> Song, <i>et al</i> <sup>41</sup> Krabbe, <i>et al</i> <sup>40</sup>	SpA with heel enthesitis SpA SpA	24 76 49	MRI MRI MRI	NA NA NA	Not reported 1.5 3	T1W; STIR T1W; STIR T1W; STIR	Heel enthesitis Whole-body Whole-body	Qualitative Qualitative Semi-quantitative

Numbers in parentheses denote no. participants in each group of study population. AS: ankylosing spondylitis; SpA: spondyloarthritis; PsA: psoriatic arthritis; RA: rheumatoid arthritis; OA: osteoarthritis; MCP: metacarpophalangeal joint; DIP: distal interphalangeal joint; SIJ: sacroiliac joints; T1W: T1-weighted; T2W: T2-weighted; Gd: gadolinium; FS: fat suppressed; SPIR: spectral pre-saturation with inversion recovery; GRE: gradient recalled echo; PD: proton density; 3D-GE: 3D gradient echo; STIR: short-tau inversion recovery; DCE: dynamic contrast enhanced; TSE: turbo spin echo; VIBE: volumetric interpolated breath-hold sequence; UTE: quantitative ultrashort echo time; US: ultrasound; CR: conventional radiograph; ReA: reactive arthritis; IBD: inflammatory bowel disease; MRI: magnetic resonance imaging; NA: not applicable.

Table 2. Psychometric properties and quality scores of selected studies (n = 38).

Study	Face Validity*	Content Validity*	Construct Validity*	Criterion Validity*	Reliability*	Responsiveness*	Quality Scoring
Cross-sectional studies							
McGonagle, <i>et al</i> <sup>16</sup>	YES	YES	NO	NO	YES	NO	9
Olivieri, <i>et al</i> <sup>19</sup>	YES	NO	NO	NO	NO	NO	7
Tan, <i>et al</i> <sup>24</sup>	YES	NO	NO	NO	YES	NO	7
McQueen, <i>et al</i> <sup>17</sup>	YES	YES	NO	NO	YES	NO	8
Tan, <i>et al</i> <sup>22</sup>	NO	NO	NO	YES	NO	NO	5
Marzo-Ortega, <i>et al</i> <sup>15</sup>	NO	NO	NO	NO	YES	NO	7
Maksymowicz, <i>et al</i> <sup>14</sup>	NO	NO	NO	NO	NO	NO	6
Althoff, <i>et al</i> <sup>9</sup>	YES	YES	NO	NO	YES	NO	7
Aydin, <i>et al</i> <sup>10</sup>	YES	YES	YES	NO	YES	NO	8
Braum, <i>et al</i> <sup>11</sup>	YES	YES	YES	NO	NO	NO	7
Ramírez, <i>et al</i> <sup>21</sup>	YES	NO	NO	NO	NO	NO	8
Paramarta, <i>et al</i> <sup>20</sup>	YES	YES	NO	NO	YES	NO	7
Poggenborg, <i>et al</i> <sup>2</sup>	YES	YES	YES	NO	YES	NO	10
Tan, <i>et al</i> <sup>23</sup>	YES	YES	NO	NO	YES	NO	7
Giraud, <i>et al</i> <sup>13</sup>	YES	NO	NO	NO	YES	NO	7
Agten, <i>et al</i> <sup>6</sup>	NO	NO	YES	NO	YES	NO	8
Maldonado, <i>et al</i> <sup>7</sup>	YES	YES	YES	NO	YES	NO	7
Aivazoglou, <i>et al</i> <sup>8</sup>	YES	NO	YES	NO	NO	NO	7
Case control studies							
Olivieri, <i>et al</i> <sup>18</sup>	YES	YES	YES	NO	NO	NO	6
Lambert, <i>et al</i> <sup>29</sup>	YES	YES	NO	NO	YES	NO	6
Erdem, <i>et al</i> <sup>27</sup>	YES	YES	NO	NO	YES	NO	5
Wiell, <i>et al</i> <sup>32</sup>	YES	NO	NO	NO	NO	NO	8
Emad, <i>et al</i> <sup>26</sup>	YES	NO	NO	NO	YES	NO	6
Weckbach, <i>et al</i> <sup>30</sup>	YES	NO	YES	NO	YES	NO	7
Feydy, <i>et al</i> <sup>28</sup>	YES	NO	NO	NO	YES	NO	8
Wiell, <i>et al</i> <sup>31</sup>	YES	YES	YES	NO	YES	NO	9
Chen, <i>et al</i> <sup>25</sup>	YES	YES	YES	NO	NO	NO	6
Cohort studies							
Godfrin, <i>et al</i> <sup>35</sup>	YES	NO	YES	NO	YES	NO	6
Eshed, <i>et al</i> <sup>34</sup>	YES	YES	NO	NO	YES	NO	6
Huang, <i>et al</i> <sup>36</sup>	YES	NO	YES	NO	YES	NO	9
Karpitschka, <i>et al</i> <sup>37</sup>	YES	YES	YES	NO	YES	YES	9
Althoff, <i>et al</i> <sup>33</sup>	YES	YES	NO	NO	YES	NO	8
Marzo-Ortega, <i>et al</i> <sup>38</sup>	YES	YES	YES	NO	YES	YES	8
Tan, <i>et al</i> <sup>43</sup>	YES	NO	NO	NO	NO	YES	8
de Hooge, <i>et al</i> <sup>42</sup>	YES	NO	YES	NO	NO	YES	9
Randomized controlled trials							
Dougados, <i>et al</i> <sup>39</sup>	NO	NO	NO	NO	NO	NO	7
Song, <i>et al</i> <sup>41</sup>	YES	NO	NO	NO	YES	YES	9
Krabbe, <i>et al</i> <sup>40</sup>	YES	YES	NO	NO	YES	YES	11

\* Face validity was defined as expert opinion on the credibility of scoring system used in each article to measure enthesitis. Content validity estimated the reliability of the scoring system used in each study to measure the full spectrum of outcome – inflammatory and structural changes. Construct validity was achieved when MRI evaluation of enthesitis correlated with the following concepts of enthesitis: (1) clinical assessment of enthesitis using a validated enthesitis score (e.g., MASES), (2) ultrasound or radiographic assessment of enthesitis sites, and/or (3) comparison of different sequences of MRI in assessing enthesitis. Criterion validity was achieved when MRI evaluation of enthesitis correlated with a gold standard (e.g., histology). Reliability was defined in studies mentioning inter-rater reliability measures of scoring consistency between and within MRI readers, e.g., inter/intraclass correlation coefficients or  $\kappa$  statistics. Responsiveness was achieved in studies documenting statistically significant changes in relation to treatment introduction or change. MRI: magnetic resonance imaging; MASES: Maastricht Ankylosing Spondylitis Enthesitis Score.

methods of evaluating enthesitis using MRI in patients with SpA and PsA, and identified notable limitations regarding standardization of MRI enthesitis definitions across studies and validity of available semiquantitative scores as outcome measures. The findings suggest there is no currently available reliable and validated MRI scoring system for enthesitis.

Many studies have included different definitions of MRI lesions suggestive of enthesitis, hindering direct comparison of the available methods. A fifth of the selected studies described a semiquantitative scoring system, albeit without standardization and internal validity, because all were developed based on expert opinion.

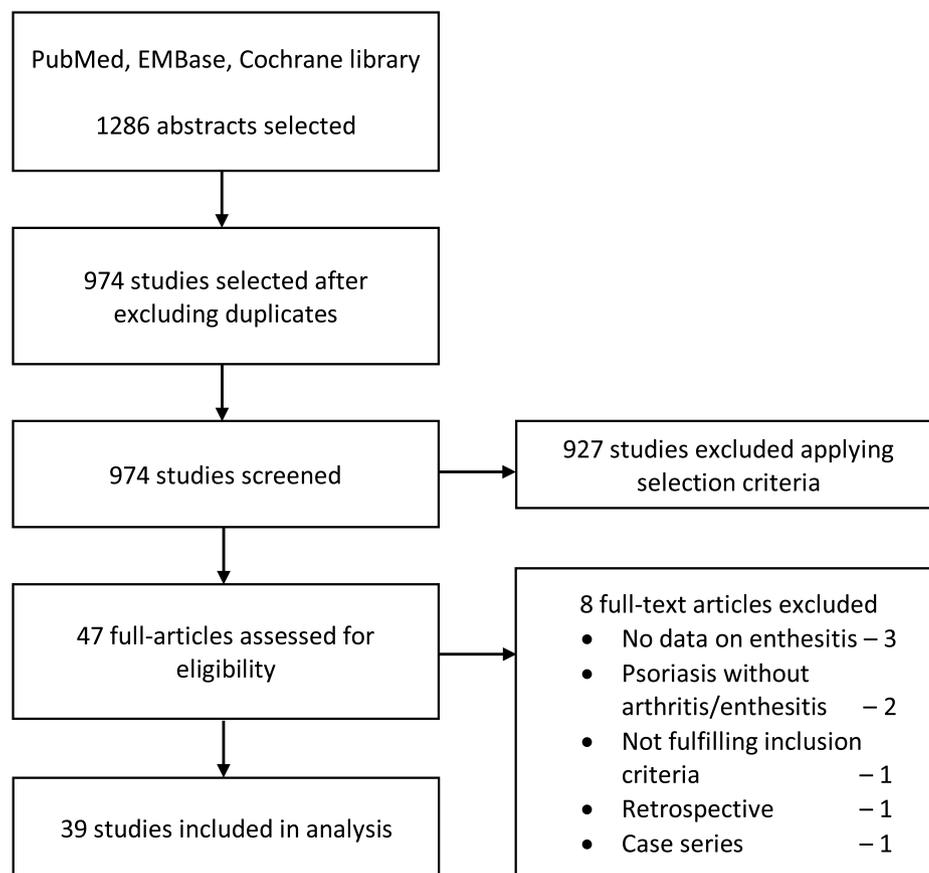


Figure 1. Flow diagram of article selection (PRISMA: Preferred Reporting Items for Systematic reviews and Meta-Analyses).

Poor content validity of reported scoring methods was another limitation of the literature. Most studies have focused on assessing inflammatory aspects of enthesitis and not the structural variables, which denote chronic, irreversible changes. MRI inflammatory lesions are amenable to change and responsive to therapy. Wide variation in the enthesal sites to be assessed adds to the challenge in standardization. Lack of a standardized definition to define the borders of enthesitis makes it difficult to differentiate it from other inflammatory variables, such as synovitis and tenosynovitis, thus increasing the variability of scores in each study.

Construct validity was evaluated in relation to US and clinical examination. Most of the studies showed poor correlation between MRI and US. This again emphasizes the lack of standardized definitions of MRI enthesitis lesions. Limited information exists regarding criterion validity because only 1 study compared MRI with histology. Lack of significant responsiveness of available qualitative and semiquantitative MRI enthesitis scores suggests limited utility as outcome measures in clinical trials.

The above-mentioned limitations and the lack of validated, generally accepted MRI enthesitis assessment systems warrant the development of a reliable and feasible

MRI enthesitis scoring system to increase the utility of MRI as an outcome measure in SpA and PsA clinical trials.

#### ONLINE SUPPLEMENT

Supplementary material accompanies the online version of this article.

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