The Journal of Rheumatology 2023;50:461–2
doi:10.3899/jrheum.220821
First Release October 1 2022

Drs. Schneeberger and Citera reply

To the Editor:

We greatly appreciate the comments from Profs. Pincus and Schmukler.[1] We strongly agree that the Routine Assessment of Patient Index Data 3 (RAPID3) is an excellent instrument to provide quantitative data on the status of our patients with axial spondyloarthritis (axSpA), as shown by the studies cited. Our group cross-culturally adapted and validated the RAPID3 in 51 consecutive patients aged ≥ 18 years diagnosed with axSpA (according to modified New York criteria 1987 and/or Assessment of SpondyloArthritis international Society [ASAS] 2009).[2-4] RAPID3 has shown to be a questionnaire that is not only quick and simple to calculate and complete but also has very good correlation with Simplified Ankylosing Spondylitis Disease Activity Score (SASDAS; ρ 0.87), Bath Ankylosing Spondylitis Disease Activity Index (ρ 0.89), Bath Ankylosing Spondylitis Functional Index (BASFI; ρ 0.8), and Ankylosing Spondylitis Quality of Life (ASQoL; ρ 0.83), and a good correlation with Maastricht Ankylosing Spondylitis Enthesitis Score (ρ 0.58).[4] "In multiple linear regression, using total RAPID3 score as a dependent variable and adjusting for age, sex, and disease duration, a significant association was observed" with BASFI (β 0.25, $P = 0.008$), ASQoL (β 0.22, $P = 0.02$), and mainly with SASDAS (β 0.42, $P = 0.001$) and BASDAI (β 0.55, $P = 0.0001$).[4] In relation to Fibromyalgia Assessment Screening Tool 4 (FAST4), we have no experience with it; however, we believe it is important to include in clinical practice a simple tool that allows health practitioners to identify patients with fibromyalgia since it is a prevalent comorbidity in these patients.

However, the ASDAS has shown excellent performance in the evaluation of patients with axSpA[5-7]: it is part of the ASAS-Outcome Measures in Rheumatology (OMERACT) core domain set for axSpA[8] and has been chosen as a point of reference for treat-to-target strategy in axSpA.[9] This composite index includes both subjective variables related to axial involvement and an objective laboratory value such as C-reactive protein, and its cut-off points have excellent power of discrimination and allow definition of the different states of disease activity.

Finally, we consider that the SASDAS has a performance similar to that of the ASDAS but that it is simpler to calculate and does not require the weighting of its components.[10,11] However, it is the future task of our group to review the cut-off points of the SASDAS, to further improve its performance. Again, we thank Drs. Pincus and Schmukler, who certainly honor us with their letter.

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The authors declare no conflicts of interest relevant to this article.

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