

Letter

ASAS Health Index as an Addition to Routine Clinical Practice

To the Editor:

We have read with great interest the recent editorial published in *The Journal* by Dr. Kiltz, *et al*, referring to the possibility of using the Spondyloarthritis international Society Health Index (ASAS HI) as an all-in-one in the assessment of axial spondyloarthritis (axSpA)¹. AxSpA has been evaluated over the years with different tools that have tried to determine the degree of activity [Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)/Ankylosing Spondylitis Disease Activity Score (ASDAS)], functional limitations (Bath Ankylosing Spondylitis Functional Index), mobility restrictions (Bath Ankylosing Spondylitis Metrology Index), structural damage accumulated over time (Bath Ankylosing Spondylitis Radiology Index/modified Stoke Ankylosing Spondylitis Spinal Score), or quality of life (Ankylosing Spondylitis Quality of Life scale) of these patients. Most of these instruments constitute the pillar on which both the results of clinical trials, as well as most clinical and therapeutic decisions taken in clinical routine in this disease, are based on².

However, as Kiltz, *et al* point out in their editorial, the concept of health is somehow broader and encompasses, among other aspects, the impairments, limitations, and restrictions that a person with a certain disease faces in their day-to-day life in a specific sociocultural environment¹. In this way, most of the aforementioned tools, by their own design, do not have the ability to capture these aspects, which are closely linked to the disease and the sociocultural environment in which the patient lives. This, precisely, has been the guiding principle for the development and validation of the ASAS HI³.

One of the main challenges faced by many rheumatologists in their clinical routine is the management of numerous health metrics designed to evaluate the different aspects of the different diseases treated in rheumatology clinics, of which SpA are only a small part. In very busy clinics, it can be materially impossible to use all these tools due to obvious time constraints. However, in large academic rheumatology departments, where rheumatologists with a preferential and vocational dedication to one or a few diseases usually coexist, it is possible and advisable to use all available metrology to globally address a certain entity. However, this is not the reality for many clinicians who must attend to a large number of patients with rheumatic diseases of a very diverse nature. In this last situation, it is desirable to have a few metrics that provide information with added value for decision making. The ASAS HI could fulfill part of these needs in the evaluation of axial and peripheral SpA. This, in no way, means that some tools should or can replace others that have been designed for a different purpose. As Kiltz, *et al* point out, ASAS HI has the mission of addressing the whole range of functioning, disability, and health represented by the comprehensive International Classification of Functioning, Disability and Health core set for SpA^{1,3}. With its multidimensional structure, the ASAS HI has the ability to identify not only aspects clearly related to the disease (e.g., pain) but also other more patient-dependent aspects (e.g., feelings of frustration). It is logical to expect some concordance between the ASAS HI and other more standard assessment measures of SpA (construct validity), as we and others have verified^{4,5,6,7,8}, but this does not point, in any way, to interchangeability between these measures. In the Kiltz, *et al* editorial, the authors state that in our study, we argued in favor of the use of ASAS HI to evaluate disease activity, thus replacing more conventional tools such as ASDAS or BASDAI in this task^{1,4}. It is true that in a paragraph of the discussion of our work, the possibility of ASAS HI is mentioned as the sole metric in overly busy

clinics⁴. When we argue that it could be used as a “single measure,” we are not saying that it should replace what all doctors do in their day-to-day practice (anamnesis, physical examination, use of complementary diagnostic tests) but rather that it could be incorporated together with this daily clinical routine, with the objective of obtaining a more comprehensive view of what happens to these patients in their everyday lives. Further, the conclusion of the abstract states that ASAS HI could be used as an “additional” instrument to evaluate SpA⁴. Finally, in the discussion, we state that “ASAS HI is a simple instrument that could be used as a single measure for the evaluation of these patients in busy practices. Regardless, we must keep in mind that the ASAS HI and the BASDAI/ASDAS are instruments that were designed for different tasks; therefore, these measures are not interchangeable, and both should be incorporated into the routine evaluation of these patients”⁴.

We sincerely appreciate the interest shown by Kiltz and colleagues in our work, and we express our congratulations for her magnificent editorial, with which we agree in its entirety, with the aforementioned exceptions.

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