TABLE 1. Clinico-serological features in three SSc patients before and after 1 yr of leflunomide treatment

Patient no.	Age, sex	Disease duration (yr)	SSc skin subsets	Autoantibodies	Joint involvement	Ritchie index		VAS (0–100 mm)		ESR (reference range <5 mm/1st h)		CRP (reference range 0–5 mg/l)	
						Before treatment	After treatment	Before treatment	After treatment	Before treatment	After treatment	Before treatment	After treatment
1	56, F	1.5	Limited	ACA	MCP, PIP	6	0	80	10	13	15	3	3
2	49, F	16	Limited	SI70	MCP, PIP, knees, wrists, shoulders	12	2	90	10	100	22	30	3.7
3	44, F	3	Diffuse	SI70	Wrists, right ankle	6	2	100	40	47	26	27	6

VAS, visual analogue scale; ESR, erythrocyte sedimentation rate; CRP, C-reactive protein; ACA: anticentromere antibody; SI70, antitopoisomerase antibody; MCP, metacarpophalangeal; PIP, proximal interphalangeal.

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BSR guidelines for TNF blockers in ankylosing spondylitis—how useful are they?

SIR, We are writing in response to the British Society of Rheumatology (BSR) guidelines for prescribing tumour necrosis factor (TNF) blockers in adults with ankylosing spondylitis (AS) [1]. There are several points that we would like to make.

The first issue relates to the ongoing reliance on the modified New York criteria [2] for the diagnosis of AS and eligibility for treatment. They have largely been the criteria employed in trials

of anti-TNF therapy in AS to date, but appear increasingly outdated. The attitude to this disease has greatly changed with the role of imaging modalities such as magnetic resonance imaging in early diagnosis and recognition of the potential for early treatment. Recently published data [3] show that a shorter disease duration is one of the main predictors of a major clinical Bath Ankylosing Spondylitis Disease Activity Index (BASDAI 50) response to anti-TNF.

Looking at the clinical part of the criteria, relevance and applicability must be put in question, as they call for subjective assessments of 'limited' range of motion of lumbar spine and chest expansion compared to 'normal' values for sex and age. We have not encountered these values in everyday practice. When first drawn up, they were evaluated in people with established disease and may perform well in this group, but studies have shown that they are not sensitive when applied to those with shorter symptom duration [4, 5]. It has also been shown that the specificity of 'restriction of spinal mobility' can vary as much as 37–75%.

Using the modified New York criteria, the radiological criterion of grade 2 sacroiliitis bilaterally or grades 3 or 4 unilaterally infers ongoing disease, on average, of 9 yrs, according to one series [6]. Surely a set of guidelines that aims to be relevant to clinical practice should be recommending treatment before they reach such an advanced stage; these criteria are not sensitive enough in diagnosis of 'pre-radiographic' AS. There is also the issue of the specificity of diagnosing radiographic sacroiliitis, especially differentiating between grade 1 and 2, which constitutes the difference between 'no disease' and 'disease'.

There is no stipulation in the guidelines as to the use of MRI for early diagnosis instead of applying the New York criteria.

Perhaps, the working group, when they review the guidelines next year, should consider an alternative set of criteria for diagnosis, such as the one proposed by Rudwaleit *et al.* [7]. They propose a model for early diagnosis of axial spondyloarthopathy, in patients with inflammatory back pain but normal X-rays, using clinical features, laboratory findings and skeletal imaging.

Regarding the criteria for withdrawal of therapy, the recommendation laid down is to withdraw treatment if proven to be 'ineffective' after 3 months as judged by lack of reduction in scores such as the BASDAI and visual analogue scores (VSA). There is no firm recommendation for using an alternative biological agent or shortening the interval between treatment if using infliximab. A recent study from Spain [8] showed that there may be benefit to patients with persistent disease in reducing the dosage interval from 8 to 6 weeks for those on infliximab 5 mg/kg.

Finally, with regard to periodic review of the need for continued treatment and possible dose reduction, the guidelines are not very clear. This really reflects the lack of adequate evidence on this issue. Baraliakos *et al.* [9] have, however, recently published data on a group of patients with established AS who had received 3 yrs of continuous infliximab treatment, which was then stopped to see if remission was sustainable. Of 42 patients, 41 were restarted on therapy within a year because of relapse.

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BSR guidelines for TNF blockers in ankylosing spondylitis: reply

Sir, We are pleased to receive comment on the BSR guidelines for treating ankylosing spondylitis (AS) with tumour necrosis factor-α (TNF-α) blocking drugs [1]. We entirely accept that the guidelines are to some extent simplistic and we included in the report a comment to the effect that they may need subsequent updating in the light of new data and experience. They are, however, based on the best evidence from clinical studies and we did not extrapolate from that evidence to make recommendations not supported by a firm evidence base. Nor did we inject our own clinical opinions.

To take the points raised in turn:

We agree that the modified New York criteria may well not meet the needs of the clinicians who need to diagnose and treat AS early. Nonetheless, these are the only criteria that have underpinned almost all clinical trials in this area and thus the data on which the guidance is based. Moreover, we agree that there is an urgent need to develop stringent criteria for 'early AS', which takes into account the role of magnetic resonance imaging scanning. Such information is emerging, but it will take time before the necessary consensus, essential as the basis of a national guideline, develops. We agree that the logic of treating early disease is undeniable; however, it is clearly important to build up data before advocating treatment of early disease without evidence on which sound clinical decisions, balancing efficacy, risk and cost, can be based.

The group did not find a sufficient evidence base for recommendations about dose or treatment intervals other than those used in the majority of clinical trials and in manufacturers' recommendations. Similarly, we did not find any evidence on which to base the guidance with respect to dose changes or drug switching.