Clinical prediction guide

Preliminary clinical criteria had moderate sensitivity but low specificity for detecting osteoporosis in rheumatoid arthritis


QUESTION: In patients with rheumatoid arthritis (RA), what is the accuracy of 3 item criteria based on age, disease activity, and functional status for identifying patients at increased risk of osteoporosis?

Design
Clinical decision criteria proposed in a previous study were evaluated using data from a population based cohort of patients (followed for 2 y) with RA recruited from the Oslo RA Register.

Setting
Oslo, Norway.

Patients
287 patients (mean age 58 y, 82% women) with RA who had a complete data set for hip and spine bone mineral density measurements, Health Assessment Questionnaire (HAQ) (score range 0–3, higher scores indicate worse disability), and C reactive protein (CRP) or erythrocyte sedimentation rate (ESR) at 2 years.

Description of prediction guide
Patients with RA who were at high risk of osteoporosis were identified according to inflammation, age, and immobility. To meet the criteria, 2 of the following 3 preliminary clinical criteria had to be present: (1) high disease activity defined as mean CRP > 20 mg/l or mean ESR > 20 mm per first hour or both; (2) older age defined for women as ≥ 50 years and men as ≥ 60 years; and (3) immobility, defined as HAQ ≥ 1.25. Classification using the clinical decision rule was compared with standardised bone mineral density measurements (T and Z scores) for diagnosis of osteoporosis.

Main outcome measures
Sensitivity, specificity, and positive and negative likelihood ratios.

Main results
62 patients (22%) had osteoporosis at the femoral neck or spine (T score ≤ −2.5; WHO definition of osteoporosis). The sensitivity, specificity, and positive and negative likelihood ratios for the clinical decision criteria are in the table.

Conclusion
In patients with rheumatoid arthritis, preliminary clinical criteria based on age, inflammation, and immobility had moderate sensitivity and low specificity for identifying patients at high risk of osteoporosis.

COMMENTARY
The study by Haugeberg et al assessed the accuracy of 3 risk factors (age, inflammatory disease activity, and functional class) for identifying patients with RA who are at risk of osteoporosis. These items had reasonable sensitivity but only fair specificity.

Several questions arise from this investigation. Although all 3 variables tested have been shown to be associated with low bone mass, there are other known risk factors. Both antiresorptive agents and corticosteroid use could have influenced bone mass in this cohort. Patients receiving antiresorptive agents may have had higher bone mass; whereas those receiving corticosteroids may have had an increased risk of osteoporosis (sensitivity was lower and specificity higher in patients who had never used corticosteroids than in the whole cohort). Corticosteroid use has been found to be a relatively sensitive measure of osteoporosis in patients with RA. Also, other known risk factors for hip fractures, such as a previous low impact fracture, were not included in the study.

An interesting aspect of this study was the use of CRP to measure disease activity. CRP production is influenced by interleukin 1 and 6, which increase the maturation and activity of osteoclasts. Systemic inflammation in RA measured by CRP serum levels may influence bone mass in RA. Additional studies need to be done with adjustment for these potentially confounding variables.

The results of this trial suggest that the 3 clinical risk factors studied are not strong predictors of osteoporosis in patients with RA. In postmenopausal women, it is not clinical risk factors but bone mineral density measurement that best predicts osteoporosis.

Nancy Lane, MD
University of California at San Francisco
San Francisco, California, USA