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Title

The OMERACT MRI in Enthesitis Initiative: Definitions of Key Pathologies, Suggested MRI Sequences and Novel Heel Enthesitis Scoring System (HEMRIS)

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Conflicts of interest

None

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Running head

OMERACT heel enthesitis MRI score

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Abstract

Objectives: To develop and validate an enthesitis MRI-scoring system for spondyloarthritis/psoriatic arthritis, using the heel as model.

Methods: Consensus definitions of key pathologies and three heel enthesitis multi-reader scoring exercises were done, separated by discussion, training and calibration.

Results: Definitions for bone and soft tissue pathologies were agreed. In final exercise, median pairwise single-measures intra-class correlation coefficients (ICCs; patient-level) for enthesal inflammation status/change scores were 0.83/0.82 for all readers. For radiologists and selected rheumatologists ICCs were 0.91/0.84 and quadratic-weighted kappas (lesion-level) 0.57-0.91/0.45-0.81.

Conclusion: The proposed definitions and heel enthesitis scoring system (HEMRIS) are reliable among trained readers and promising for clinical trials.

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Introduction

Enthesitis, inflammation at insertion sites of ligaments, fasciae, tendons and joint capsules to bone, is a central feature of spondyloarthritis (SpA), including psoriatic arthritis (PsA). Sensitive and objective assessment of enthesitis is important in SpA clinical trials. Conventional clinical methods have limited reliability, validity and sensitivity¹⁻³. Magnetic resonance imaging (MRI) is a sensitive method for detecting enthesitis in peripheral SpA and the only method allowing detection of peri-enthesal osteitis⁴⁻⁶. MRI studies have demonstrated decreased enthesal inflammation after anti-tumor necrosis factor (TNF) therapy, but no validated MRI-scoring systems exist for evaluating enthesitis in clinical trials⁷. Our aim was to create consensus-based MRI-definitions of key enthesitis pathologies and through multi-reader exercises to develop and validate an MRI score for assessing enthesitis in patients with SpA, focusing on the heel region.

Methods

The OMERACT MRI in Arthritis Working Group initially performed a systematic literature review (SLR) of studies with MRI being used for assessment of enthesitis⁸. Based on this SLR, MRI-sequences for optimal visualization of enthesitis were identified, and MRI-definitions of key enthesitis pathologies were decided by consensus between group members through meetings/e-mails. The heel region (insertions of Achilles tendon and plantar fascia) was chosen for initial testing due to its frequent involvement. Three multi-reader exercises, with consensus discussion and calibration in-between were then performed. A graphical data entry schematic (Appendix-Figure 1A) was created, and subsequently a web-based interface which simultaneously displayed DICOM-images and the data entry schematic (Appendix-Figure 1B). In Exercise 1, performed to identify challenges and pitfalls, sagittal T1-weighted (T1w) and sagittal and axial T2w-fat-suppressed (T2wFS) MR-images of 10 ankles (4 inflammatory enthesitis (peripheral SpA), 4 mechanical enthesitis and 2 normal controls) were scored by 15 readers from 10 countries), with varying expertise in ankle MRI, for enthesitis at Achilles tendon and plantar fascia insertions. This was followed by a web-based calibration exercise leading to minor score sheet modifications. In Exercise 2, 16 ankle MRIs (8 inflammatory enthesitis (peripheral SpA), 3 mechanical enthesitis and 5 normal controls; MRI-sequences as above) were scored by 16 readers. In Exercise 3, ankle MRIs (sagittal T2wFS only) of 21 SpA patients from a clinical trial, obtained before and after anti-TNF therapy, were scored for inflammatory pathologies by 10 readers, blinded to chronological order. For assessing the reliability scores among the more experienced readers, agreement between the participating radiologists and the 3 rheumatologists with best overall ICCs for inflammatory pathologies in exercise 2 were analyzed separately.

Statistical analysis

Exercise 1 was mainly used for qualitative training and understanding principles and pitfalls, while for Exercises 2-3 reliability statistics (pairwise single measures and average measures intraclass correlation coefficients by absolute agreement (smICC and amICC) for sum scores (patient level) and squared weights Cohen's kappa for individual component scores (lesion level) were calculated. In Exercise 3, the standardized response mean (SRM) was calculated.

Results

Definitions of key pathologies

Key enthesal pathologies were selected and their definitions agreed upon by consensus within the OMERACT MRI in inflammatory arthritis working group (Table 1), based on knowledge from an SLR⁸, and published OMERACT MRI definitions for comparable conditions⁹⁻¹¹. The selected pathologies were intra-tendon hypersignal (enthesal tendonitis), peri-tendon hypersignal (enthesal peritendinitis), bone marrow edema (enthesal osteitis), bursitis, tendon thickening, enthesophyte, enthesal bone erosion and intra-tendon hypersignal on T1w sequence.

MRI sequences and planes

For evaluating inflammatory pathologies, it was agreed to include a fluid-sensitive sequence (short-tau inversion recovery(STIR) or T2wFS), and/or a fat-suppressed T1w-sequence following intravenous gadolinium (Gd) injection (*see appendix*). A T1w-sequence prior to contrast injection (T1-pre-Gd) was considered helpful in determining the exact localization of inflammatory pathologies, due to its high anatomical resolution, and is essential for assessment of structural pathologies.

Scoring system

It was decided to score all assessed pathologies on a semiquantitative scale of 0-3 (none/mild/moderate/severe), following the principles from the RAMRIS and PsAMRIS systems⁹⁻¹¹, and to create a total enthesal inflammation score by summation of scores of all inflammatory parameters (intra-tendon hypersignal on T2w/STIR sequences, peri-tendon hypersignal, bone marrow edema and bursitis). Similarly, a total enthesal structural damage score by summation of structural scores (enthesophyte, bone erosion, tendon thickening) was evolved. Intra-tendon hypersignal on T1w sequences was not included in sum scores. In exercises described in the present paper, scoring of entheses of the heel region was chosen, i.e. at calcaneal insertions of the Achilles tendon and plantar fascia, respectively.

Exercise 1

Exercises 1 and 2 included single-point images of the heel region, which were scored for the selected pre-defined pathologies. Exercise 1 was used for initial learning, calibration and identification of pitfalls. Mean pairwise inter-reader single-measure ICCs for inflammatory and structural variables, done without calibration, were 0.40 and 0.41, respectively.

Exercise 2

In Exercise 2, agreement between reader pairs varied from poor-very good for various lesion types and their sum scores (Table 2). When limiting the analyses to three participating musculoskeletal radiologists and three rheumatologists with best ICCs for inflammatory pathologies in exercise 2, reliability improved to moderate-very good. For this subset of readers, median single-measures ICCs for total inflammation scores were 0.85, while for total structural damage scores 0.68. Median kappas for different inflammatory pathologies varied from 0.60-0.89, and for individual structural pathologies from 0.41-0.78. Average-measure ICCs based on two readers among the pre-selected 6 readers (median 0.92 for total inflammatory score, 0.81 for total damage scores) were better than the above-mentioned single-measure ICCs.

Exercise 3

This exercise included two-time point images, in which inflammatory pathologies were scored. Mean pairwise inter-reader ICCs and lesion-wise kappa agreement demonstrated moderate to good reliability when all readers were considered (Table 3). The subset of readers (3 rheumatologists with best agreement for inflammatory parameters in exercise 2 and the participating radiologist in exercise 3) demonstrated good to very good reliability, both for baseline scores and for change in scores (Table 2); the median baseline single-measures ICCs for total inflammation was 0.91, while 0.84 for change in score. Median average-measure ICCs based on two readers (status: 0.95(range 0.95-0.97); change: 0.92(0.89-0.96)) were higher than single-measure ICCs. Using three readers demonstrated numerically higher average-measure ICCs (status: median 0.97(0.97-0.97); change 0.94(0.94-0.95)).

HEMRIS showed moderate responsiveness, with SRM of 0.70(95%CI 0.38-1.05) for all readers in exercise 3.

Discussion

This study is the first international consensus effort towards development of a comprehensive MRI-scoring system, combined with MRI definitions and reader rules, for enthesitis in patients with spondyloarthritides. The work was informed by a SLR⁸, which clarified knowledge gaps and need for development of a validated MRI enthesitis scoring system to be used as outcome measure in clinical trials. Enthesitis, often located at heels is a typical feature of SpA and is easily accessible for MRI¹². Furthermore, enthesitis in SpA may show changes both in inflammation (such as bone marrow edema and peri-entheseal inflammation) and damage (such as erosion and new bone formation)^{13,14}. Thus, both inflammatory and structural MRI findings were considered relevant to include in the scoring system. A series of multireader scoring exercises focused on the heel region, using an intuitive web-based data entry and image display platform. The preliminary heel enthesitis scoring system (OMERACT-HEMRIS) showed good inter-reader agreement for status scores and for change over time in inflammatory parameters. Considering that baseline heel enthesitis was not mandatory in exercise 3, the moderate SRM (0.70) supports that responsiveness of the HEMRIS score would likely be good in trials with baseline enthesitis as an inclusion criterion. Thus, HEMRIS appears promising for further validation and future use in randomized controlled trials.

The strengths of this initiative include taking a SLR as starting point to clarify unmet need, the involvement of experienced MRI researchers in the development of consensus-based definitions and scoring systems, the participation of multiple readers with both radiological and rheumatological backgrounds in interactive web-based exercises with standardized image display and scoring module. Limitations include varying experience and backgrounds of readers in the exercises which needs to be taken into consideration when interpreting the results. This was addressed by sub-analysis of scores of a subset of experienced readers, who had showed high scoring proficiency in previous exercises. Longitudinal studies incorporating T1w images are needed for assessment of the sensitivity to change of structural parameters. Future developments should also include an MRI enthesitis reference image atlas, and image sets for training and calibration. The definitions and scoring principle may be applicable to other entheses. Thus, validation of the definitions and scoring system in other anatomical regions are also suggested.

The heel enthesitis MRI score appears to be particularly reliable if the mean score of two readers (compared to one) is used in the final study analysis; the average measure ICCs for 2 readers were markedly higher (0.92-0.95 for inflammation total status/change score in last exercise) than single measure ICCs. This will be relevant in real life clinical trials where two independent readers generally score images.

Increasing novel therapeutic options in SpA and PsA increases the potential utility of an objective and reproducible enthesitis outcome measure. The proposed OMERACT MRI heel enthesitis scoring system (HEMRIS) is a promising tool for further refinement and validation through the OMERACT filter and for future use in clinical trials^{15,16}.

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- Index (LDI), Patient Global for Psoriatic Arthritis, Dermatology Life Quality Index (DLQI), Psoriatic Arthritis Quality of Life (PsAQOL), Functional Assessment of Chronic Illness Therapy-Fatigue (FACIT-F), Psoriatic Arthritis Response Criteria (PsARC), Psoriatic Arthritis Joint Activity Index (PsAJAI), Disease Activity in Psoriatic Arthritis (DAPSA), and Composite Psoriatic Disease Activity Index (CPDAI). *Arthritis Care Res* 2011;63 Suppl 11:S64-85
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