Author's response to reviews

Title: Looking through the 'window of opportunity': is there a new paradigm of podiatry care on the horizon in early rheumatoid arthritis?

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Author's response to reviews: see over
Dear Editor

Re: MS 1028503166364081
Looking through the ‘window of opportunity’: is there a new paradigm of podiatry care on the horizon in early rheumatoid arthritis?
James Woodburn, Kym Hennessy, Martijn PM Steultjens, Iain B McInnes, Deborah E Turner

Response letter to reviewer’s comments

Reviewer: Marike van der Leeden

Thank you for your time to consider this manuscript and for the valuable comments and suggestions provided. This manuscript was originally submitted under the review category but better fits under ‘commentary’. This is based on the comments provided by both reviewers. We acknowledge that it is not a systematic review and we do not declare our literature search strategy. As indicated some of the ideas presented in the new paradigm are based on local clinical developments and experience and remain unproven. We have carefully considered those areas and indicated where necessary when evidence is lacking for statements made. Below we have provided a response to each of the comments raised:

Abstract
We argue to retain the comment, ‘Low disease state and remission with prevention of joint damage and irreversible disability are achievable therapeutic goals’. Whilst we recognise that this may be controversial, in particular the reference to joint damage, we believe it is now regarded as a fundamental concept governing treatment of rheumatoid arthritis. This will be a knowledge step change for the majority of the journals readers and any lesser statement would not reflect contemporary views. We do present a balanced argument in the paper highlighting evidence in support of continued joint destruction (page 4-5) and relatively low remission rates in routine clinical care (page 10). Moreover, rheumatologists would argue that evidence does exist for remission and radiographic joint damage (for example the COMET and BeST trials). Indeed the BeST study showed that Infliximab can induce remission in a proportion of early RA patients which is maintained upon cessation (Goekoop-Ruiterman et al 2007). The PREMIER study of adalimumab further supports remission/retardation of erosive progression (Breedveld et al 2006).
Early RA; Advances in early RA
In response to the query about mortality rates for RA as evidence to support early detection and treatment we argue to retain this statement. This is based on evidence which suggests that RA patients should be viewed as being approximately double the risk for cardiovascular disease, RA should be acknowledged as a new cardiovascular risk factor; traditional cardiovascular risk factors may be enhanced in RA; and the inflammatory process contributes significantly to the increased cardiovascular risk. Consequently effective anti-rheumatic treatment decreases the cardiovascular risk in RA supporting the need for early recognition and treatment.

We agree with the poor layout in the last four bullet point and have restructured this section.

Foot involvement in early RA
The suggestion to define oligo- and poly-arthritis is excellent and we have made these changes.

Last sentence first paragraph: These were RA patients and this has been added.

2nd sentence, 2nd paragraph: We agree that there are multi-factorial causes of pain and tenderness on clinical examination, particularly at the foot joints in RA. To keep the sentence simple the term ‘joint damage’ was intended to comprise damage to any tissue including bone, synovium, tendon, bursa, ligament or capsule, hence the concluding remark that it was best detected and graded using imaging. We have qualified damage by changing this to indicate ‘soft-tissue and structural joint damage’.

A new paradigm for podiatry, tight control of foot arthritis and disease monitoring
Table 4, we agree that radiographic erosions are unlikely to be routinely available for monitoring in primary care. We have opted to leave it as a core outcome but changed the first sentence of the second paragraph of this section to read, ‘radiographic erosions, scored using the Sharp-van der Heijde methods should be reviewed during routine follow-up in secondary care, if available.’

An incorrect spelling of Heijde was given. This has been corrected.

The domain of joint destruction: We acknowledge earlier comments and have changed the domain description to, ‘joint destruction/soft-tissue damage.’

Conclusions
We agree that the basis for the paradigm should be established at the outset and therefore we have moved the paragraph indicated to the start of the earlier section.
Reviewer: Philip Helliwell

Thank you for your time to consider this manuscript and for the valuable comments and suggestions provided. This manuscript was originally submitted under the review category but better fits under ‘commentary’. This is based on the comments provided by both reviewers. We acknowledge that it is not a systematic review and we do not declare our literature search strategy. As indicated some of the ideas presented in the new paradigm are based on local clinical developments and experience and remain unproven. We have carefully considered those areas and indicated where necessary when evidence is lacking for statements made. Below we have provided a response to each of the comments raised:

Despite our declaration that this is a commentary piece we fully acknowledge the lack of evidence for some of the statements made with regards to ‘specialist podiatrists’ and ‘extended scope practice’. In both cases we have indicated that evidence is lacking. We also indicate that multi-centre collaborations in the UK are forming to implement the necessary research trials to address the evidence gap (in conclusion section).