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Response to "Similarities in clinical course and outcome between juvenile idiopathic arthritis (JIA)-associated and ANA-positive idiopathic anterior uveitis: data from a population-based nationwide study in Germany"

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Abstract

We have read the article entitled "Similarities in clinical course and outcome between juvenile idiopathic arthritis (JIA)-associated and ANA-positive idiopathic anterior uveitis: data from a population-based nationwide study in Germany" by Heiligenhaus et al. While we appreciate the work conducted by the authors, we have several comments we would like to address. First, the follow-up interval of 2 years is too short to conclude that the clinical course between two chronic pathologies is not significantly different. Second, remission status was determined by uveitis inactivity during the 2-year follow-up visit without any mention of flare frequency or length of remission, which is not a reliable measure of uveitis control. Third, ANA-positive idiopathic anterior uveitis is not a classification with a distinct clinical phenotype, and additional reports of serologic investigations would have been helpful.

Dear Editor,

We read, with great interest, the article by Heiligenhaus et al. [1]. While we appreciate the work conducted by the authors, especially population-based data on relatively rare conditions, we wish to raise a few points.

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First, the study used a follow-up interval of 2 years to conclude that antinuclear antibody (ANA)-positive idiopathic uveitis and JIA-associated uveitis (JIA-U) do not significantly differ concerning the clinical course of uveitis, treatment, and response to corticosteroids and disease-modifying anti-rheumatic drugs (DMARDs). Although these pathologies may potentially behave similarly early in the disease course, this conclusion is potentially misleading because the clinical course of JIA-U is often much more chronic and stubborn than idiopathic anterior uveitis [2, 3]. Therefore, analysis over a longer period of time is necessary to more clearly elucidate differences in clinical course.

Second, remission status was determined by uveitis activity, or lack thereof, at the 2-year follow-up visit. While this is an important data point, this is an imprecise

way to gauge remission status. With the current methodology, a patient who had been in remission for the entire 2 years and a patient with recurrent flares but quiet at the 2-year visit would both be considered in remission. Within the 2-year follow-up period, the number of flares or the duration of quiescence since the most recent flare would be important data, as these data more completely portray remission status.

Finally, ANA-positive idiopathic anterior uveitis is not a homogeneous classification with a distinct clinical phenotype. Among patients with idiopathic non-infectious anterior uveitis, ANA positivity is not known to produce a distinct clinical phenotype. The authors mention that human leukocyte antigen (HLA) B27 status was recorded, but there is no breakdown of its presence in the uveitis patients. HLA-B27-associated anterior uveitis has a known clinical phenotype, potentially adding to the heterogeneity of the ANA-positive idiopathic anterior uveitis group. Further presentation of serologic investigations would have been helpful.

We thank this group for their research on an underrepresented topic in the literature and look forward to future work from this group.

Abbreviations

ANA	Antinuclear antibody
DMARDs	Disease-modifying anti-rheumatic drugs
HLA	Human leukocyte antigen
JIA	Juvenile idiopathic arthritis
JIA-U	Juvenile idiopathic arthritis-associated uveitis

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