

Interestingly, another therapeutic option that is Doppler-guided extratendinous sclerosing injections with polidocanol appear to be somewhat gender and age specific, too. A 2-year follow-up study following sclerosing polidocanol injections in mid-portion Achilles tendinopathy reveals that, among females, the differentiation between those aged <50 or >50 years was associated with inferior results among older symptomatic females regarding pain levels at 2-year follow-up [2 (3) vs 11 (17) on VAS 0–100] and patient satisfaction [66 (43) vs 97 (6)%, with 100% being fully satisfied] [5]. The pain levels before the sclerosing therapy were comparable between the two groups [74 (18) vs 77 (19)]. Both structural tendon changes in ultrasound (45 vs 14%) and the number of neovessels after therapy with colour Doppler ultrasound (0.29 vs 0.73) were worse among older females. In contrast, patient satisfaction among symptomatic males was 92 (9)% in those aged <50 years and 94 (10)% in those aged >50 years following sclerosing therapy with polidocanol. The reason for a potential differential gender-specific response to eccentric training and apparently extratendinous Doppler-guided sclerosing injections in Achilles tendinopathy is likely to be multifactorial.

Notably, a non-randomized pilot study sought to perform Doppler-guided extratendinous injections with either adalimumab as TNF- $\alpha$  blocker and anakinra as IL-1 receptor antagonist [6]. Over 12 weeks of follow-up, adalimumab was able to significantly reduce power Doppler flow, whereas anakinra did not associate with pain reductions in the aforementioned TNF- $\alpha$  blocker group only. In conclusion, I would suggest considering both the VISA-A questionnaire for outcome analysis and gender- and age-specific issues in patients suffering from Achilles tendon pain.

**Disclosure statement:** The author has declared no conflicts of interest.

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Accepted 9 February 2010

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*Rheumatology* 2010;49:1419–1420

doi:10.1093/rheumatology/keq103

Advance Access publication 28 April 2010

### Comment on: Monitoring Achilles enthesitis in ankylosing spondylitis during TNF- $\alpha$ antagonist therapy: an ultrasound study: reply

SIR, In his recent letter, Knobloch [1] raised two issues on our article about assessing the response of Achilles enthesitis to TNF- $\alpha$  antagonist therapies [2]. The first point was about using the VISA-A (the Victorian Institute of Sports Assessment-Achilles) questionnaire [3]. This index was validated to score the severity of Achilles tendinopathy, which was specifically defined as mid-portion or non-insertional symptoms in various studies. As a detailed scoring system including eight items assessing three domains—pain, functional status and activity—VISA-A gives a result on a scale ranging between 0 and 100, with 100 points representing the perfect status. It was demonstrated to be reliable in patients with Achilles tendinopathy and had been reproduced in several studies afterwards. However, this scoring system has not been validated for Achilles enthesopathy and was never tested in patients with AS. After a validation of this index in AS patients with and without Achilles enthesitis, we agree with Knobloch that using a more detailed questionnaire including more items specific for Achilles tendon and enthesitis might increase the sensitivity compared with our questionnaire.

Another concern about this index is its poor correlation with power Doppler ultrasound (US) observed in some studies [4, 5]. Other prospective studies were not able to find any correlation between power Doppler scores and VISA-A at baseline, and baseline US findings did not predict VISA-A responses after therapy [6, 7]. Since US findings were our major outcome, we believe comparing the two assessments would not be reliable.

The second point mentioned by Knobloch was the roles of gender and age in Achilles tendinopathies, supported with the data about differences in tendon microcirculation and responses to therapy. Females were reported to have a decreased success rate in eccentric training for Achilles

tendinopathy. However, the data about the response to anti-TNF- $\alpha$  treatment in AS show conflicting results with these observations. The British Society for Rheumatology Biologics Registry demonstrated that both genders have similar response rates for disease activity; females even have a better response rate in terms of functional improvement of global assessments [8]. Age was also not an independent predictor of the response. In another cohort of AS patients receiving adalimumab, younger age was a good predictor of treatment response rates [9]. Compatible with these observations, we found similar response rates in both genders in terms of US findings. However, the baseline US characteristics were more severe in males (who tend to have a more severe AS course), and we agree with Knobloch that gender-specific factors for enthesitis may play a role in disease progression, but not on therapy responses.

We also agree that since entheses are sites of stress concentration (especially under load) and are open to wear and tear, age may have influenced the findings related to enthesitis. However, our study was not designed to find age-related differences and the number of the participants was not sufficient to have the power to make subgroup analysis.

*Disclosure statement:* The authors have declared no conflicts of interest.

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Accepted 5 March 2010

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*Rheumatology* 2010;49:1420–1421  
doi:10.1093/rheumatology/keq119  
Advance Access publication 23 April 2010

## Comment on: Efficacy of acupuncture in fibromyalgia syndrome—a systematic review with a meta-analysis of controlled clinical trials

SIR, Langhorst *et al.* [1], in their systematic review of acupuncture for FM, mention our previous article on the same subject [2] and claim that we ‘found that the evidence for acupuncture in the treatment of FMS is mixed’ [1]. In fact, our conclusion read as follows: ‘The notion that acupuncture is an effective symptomatic treatment for fibromyalgia is not supported by the results from rigorous clinical trials. On the basis of this evidence, acupuncture cannot be recommended for fibromyalgia’.

*Disclosure statement:* The author has declared no conflicts of interest.

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Accepted 15 March 2010

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