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Arthritis and enthesitis in the hip and pelvis region in spondyloarthritis - OMERACT validation of two whole-body MRI methods

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ABSTRACT

Objective: To validate reliability, correlation and responsiveness of two whole-body MRI scores for the hip/pelvis region in spondyloarthritis.

Methods: Assessment of hip/pelvis inflammation in 4 multi-reader exercises using the OMERACT MRI Whole-body score for Inflammation in Peripheral joints and Entheses (MRI-WIPE) and Hip Inflammation Magnetic Resonance Imaging Scoring System (HIMRISS).

Results: In exercises 3–4 (11/20 cases, respectively; 9 readers) reliability was mostly good for the 3 best calibrated readers. Median pairwise single-measure ICC for status were 0.58–0.65 (WIPE-osteitis), 0.10–0.88 (HIMRISS-osteitis) and for status/change 0.38–0.72/0.52–0.60 (WIPE-synovitis/effusion) and 0.68–0.89/0.78–0.85 (HIMRISS-synovitis/effusion). SRM was 1.23 for WIPE-osteitis, while lower for WIPE-synovitis/effusion and HIMRISS.

Conclusion: MRI-WIPE and HIMRISS may after further validation be useful in future spondyloarthritis trials.

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Abbreviations: axSpA, axial spondyloarthritis; HIMRISS, Hip Inflammation MRI Scoring System; ICC, intraclass correlation coefficient; kappa, Cohen's kappa, quadratically weighted; MR, magnetic resonance; MRI, Magnetic resonance imaging; MRI-WIPE, OMERACT MRI Whole-body score for Inflammation in peripheral joints and Entheses in inflammatory arthritis; OMERACT, Outcome Measures in Rheumatology; OA, osteoarthritis; PsA, psoriatic arthritis; RETIC, real-time iterative calibration; SpA, spondyloarthritis; SRM, standardized response mean; STIR, short-tau inversion recovery; T1w, T1-weighted; TNF, tumor necrosis factor; Whole-body MRI, WB-MRI

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Introduction

Inflammation in patients with axial spondyloarthritis (axSpA) and psoriatic arthritis (PsA) affects joints and entheses. Magnetic resonance imaging (MRI) can capture inflammation in both bone (osteitis/bone marrow edema) and soft tissues [1,2], traditionally in a limited anatomical area. Whole-body MRI (WB-MRI) allows assessment of the overall inflammatory status in joints and entheses in arthritis patients [3–5]. To enhance the use of WB-MRI in clinical trials, the Outcome Measures in Rheumatology (OMERACT) MRI in Arthritis Working Group developed the OMERACT MRI whole-body

score for inflammation in peripheral joints and entheses in inflammatory arthritis (MRI-WIPE) based on definitions of core pathologies, with preliminary validation for the total body, including the hip and pelvis region [6–8]. More detailed scoring systems for assessing inflammation have been developed and validated for heels, hands and feet [8–11], but although hip arthritis is a key cause of functional impairment, no detailed scoring system for this region has been validated for inflammatory spondyloarthritides. Based on consensus in the international OMERACT MRI in Arthritis Working Group, it was decided to further develop and validate MRI-WIPE by investigating methods for evaluation of WB-MRI for individual regions, i.e. a modular approach.

The Hip Inflammation Magnetic resonance imaging Scoring System (HIMRISS), a semiquantitative method, was developed and validated in osteoarthritis (OA) showing good reliability for status and change in bone marrow lesions [12].

Consequently, the aim of the current study was to investigate the two WB-MRI methods (MRI-WIPE and HIMRISS) for evaluation of osteitis (bone marrow edema), synovitis and soft tissue inflammation in the hip/pelvis region in patients with SpA including PsA, and to assess interreader agreement, responsiveness and correlation between the scoring systems.

Materials and method

Materials

The OMERACT MRI-WIPE scoring system was developed and preliminarily validated by The OMERACT MRI in Arthritis Working Group [6,7]. In 2019 the group decided that a next step should be to investigate the hip/pelvis region with the MRI-WIPE and an alternative system to validate the scoring systems in accordance with the OMERACT Filter (2.1) Instrument Selection Algorithm (OFISA) [13]. HIMRISS, which has been developed and validated for hip joint OA [12,14,15], was chosen. In 2020, ten rheumatologists and two radiologists from 7 countries participated in 6 web-conferences and 4 web-based multi-reader exercises. Instructional written presentations for MRI-WIPE in the hip/pelvis region (WIPE-hip/pelvis) and an online real-time iterative calibration (RETIC) module for HIMRISS were available [16].

Anonymized coronal whole-body MRIs for the hip/pelvis (i.e. images obtained as part of a WB-MRI-examination) were uploaded to a web-based interface hosted securely by CARE Arthritis, Edmonton, Canada. Images were displayed with semitransparent overlays for assessment using HIMRISS and data entry schematics for WIPE-hip/pelvis. Images were scored according to the semiquantitative system OMERACT MRI-WIPE [6] and the more detailed semiquantitative HIMRISS [12,14–16] (Appendix). Images were evaluated independently in unknown order by readers with varying expertise in MRI and in the scoring systems.

In exercise 1, coronal T1-weighted (T1w) and short-tau inversion recovery (STIR) hip/pelvis images from 3 cases with axSpA were assessed by 12 readers (10/2 rheumatologists/radiologists) to train inexperienced readers and identify pitfalls.

In exercise 2, coronal T1w and STIR hip/pelvis images from 7 cases with axSpA were assessed by 9 readers (8/1 rheumatologists/radiologist) to subsequently discuss difficulties and discrepancies to further improve consensus.

In exercise 3, coronal T1w and STIR hip/pelvis images of 11 cases with axSpA or PsA and 2 timepoints (in 9 of 11 patients before and after tumor necrosis factor (TNF) inhibitor) were assessed by 9 readers (7/2 rheumatologists/radiologists). Interreader agreement was analysed for all readers and for the 3 readers with the overall highest agreement. The latter was done to evaluate the reliability among more calibrated and experienced readers. Subsequently, a selection

of reference images for WIPE-hip/pelvis were discussed online to enhance understanding and reliability for the next exercise.

In exercise 4, coronal T1w and STIR hip/pelvis images from 20 cases with axSpA, PsA or peripheral SpA, 10 with 2 timepoints (before and after TNF inhibitor therapy) and 10 cases with 1 timepoint were assessed by 9 readers (7/2 rheumatologists/radiologists). Inflammation in hip/pelvis region at baseline was not necessarily present. Interreader agreement was analysed for all readers and for the 3 readers with the overall highest agreement identified in exercise 3.

Statistics

For exercises 3–4 agreement at patient level was evaluated using intraclass correlation coefficient (ICC; two-way mixed model, single-measure, absolute agreement definition) [17,18]. Correlations between methods were assessed with Spearman's rank correlation coefficient (ρ), changes from baseline to follow-up with the Wilcoxon signed-rank test and responsiveness with the standardized response mean (SRM) [19]. Agreement at lesion level for MRI-WIPE was evaluated using Cohen's kappa (quadratically weighted) [20]. Statistical analyses were performed in SPSS version 25.0 or R version 3.6.1. $P < 0.05$ was considered statistically significant.

Results

Twelve rheumatologists and radiologists from 7 countries participated in web-meetings and exercises. The first two exercises were used to calibrate readers. Six readers completed the RETIC modules for HIMRISS before exercise 3. Two of 3 readers with overall highest interreader agreement in exercise 3 did not complete calibration modules prior to exercise 3 but were experienced readers (1/1 radiologist/rheumatologists) and developers of one of the scoring systems.

In exercises 3–4, variations in reliability for status and change in sum scores between reader pairs were seen and overall agreement (ICC and kappa) improved when data from the readers with the overall highest interreader agreement in exercise 3 was analyzed. In exercise 3, agreement for status in osteitis was good for WIPE-hip/pelvis with ICC 0.63 (WIPE-osteitis) and very good for HIMRISS with ICC 0.88 (HIMRISS-osteitis). Interreader agreement for change in osteitis was not done due to minimal change over time in this parameter. Interreader agreement for status and change in synovitis/effusion was good for WIPE-hip/pelvis and very good for HIMRISS with ICC 0.60/0.60 (WIPE-synovitis/effusion) and 0.89/0.78 (HIMRISS-synovitis/effusion) (Table 1).

In exercise 4, agreement varied from poor to very good. For osteitis ICCs for all patients were 0.58 (WIPE) and 0.10 (HIMRISS). For synovitis/effusion, ICCs for all patients' status/change were 0.38/0.52 (WIPE), and 0.73/0.85 (HIMRISS). In the subgroup with two timepoints ICCs for WIPE osteitis and synovitis status were 0.65 and 0.72 (Table 1).

WIPE-hip/pelvis and HIMRISS correlated significantly regarding osteitis status and for status and change in synovitis/effusion (Table 2). In exercise 4, Wilcoxon signed-rank test showed a significant change in osteitis between baseline and follow-up using WIPE-hip/pelvis and SRM was large (1.23), while it was lower for WIPE-synovitis/effusion as well as for HIMRISS (Table 2).

Discussion

In this OMERACT study a modular approach to whole-body MRI was applied. Inflammation in the hip/pelvis region was evaluated in patients with SpA using the two different scoring methods MRI-WIPE for the hip/pelvis region and HIMRISS. The study showed variable, but mostly good reliability for status in osteitis and for status and change in synovitis/effusion for the two methods.

Table 1
MRI-WIPE in the hip/pelvis and HIMRISS interreader reliability for exercises 3 and 4.

	No. patients (cases)	Type of score	MRI-WIPE hip/pelvis						HIMRISS			
			Osteitis			Synovitis/effusion			Osteitis		Synovitis/effusion	
			Mean score	ICC	Kappa	Mean score	ICC	Kappa	Mean score	ICC	Mean score	ICC
Exercise 3 (9 readers)	11	Status	2.3 (0–10)	0.69 (0.23–0.93)	0.50 (0.15–0.93)	1.4 (0–4)	0.58 (–0.06–0.96)	0.62 (–0.06–0.96)	8.2 (1–60)	0.84 (0.56–0.99)	12.8 (3–25)	0.52 (0.00–0.91)
	11	Change	–0.2 (–1–1)	NA	NA	–0.2 (–3–1)	0.50 (0.10–0.87)	0.30 (–0.25–0.90)	–0.35 (–3–1)	NA	–1.8 (–17–10)	0.50 (–0.05–0.89)
Exercise 3 (3 readers)	11	Status	1.8 (0–10)	0.63 (0.46–0.93)	0.47 (0.27–0.62)	1.7 (0–5)	0.60 (0.34–0.80)	0.78 (0.68–0.85)	6.6 (0–65)	0.88 (0.77–0.94)	12.8 (2–28)	0.89 (0.87–0.91)
	11	Change	–0.12 (–1–1)	NA	NA	–0.12 (–3–2)	0.60 (0.48–0.83)	0.48 (0.24–0.90)	–0.7 (–7–0)	NA	–1.6 (–21–8)	0.78 (0.70–0.87)
Exercise 4 (9 readers)	10 (case 1–10)	Status	1.2 (0–4)	0.21 (–0.39–0.91)	0.21 (–0.03–0.66)	1.1 (0–2)	0.19 (–0.31–0.69)	0.17 (–0.20–0.61)	1.8 (0–6)	0.07 (–0.17–0.83)	16.4 (9–23)	0.31 (0.00–0.89)
	10 (case 11–20)	Status	1.6 (0–6)	0.51 (–0.08–0.99)	0.55 (0–0.92)	1 (0–3)	0.40 (–0.17–0.88)	0.52 (0.02–0.90)	3.5 (1–8)	0.08 (–0.21–0.95)	11.2 (5–24)	0.49 (0.00–0.94)
	10 (case 11–20)	Change	–0.4 (–2–0)	NA	NA	–0.39 (–2–0)	0.22 (–0.68–0.83)	0.31 (–0.09–0.71)	–2.2 (–7–2)	NA	–5.2 (–18–0)	0.57 (0.02–0.92)
	20 (case 1–20)	Status	1.4 (0–6)	0.41 (–0.35–0.92)	0.44 (0–0.76)	1.0 (0–3)	0.27 (–0.07–0.75)	0.36 (0.01–0.83)	2.7 (0–9)	0.09 (–0.17–0.85)	13.8 (5–25)	0.45 (0.01–0.90)
	10 (case 1–10)	Status	0.8 (0–4)	0.29 (0.01–0.78)	0.25 (0.10–0.36)	1.3 (0–2)	–0.02 (–0.29–0.12)	0.01 (–0.20–0.13)	0.4 (0–2)	–0.04 (–0.04–0.04)	15.8 (5–26)	0.73 (0.59–0.89)
	10 (case 11–20)	Status	1.8 (0–9)	0.65 (0.52–0.76)	0.63 (0.54–0.75)	1.2 (0–4)	0.72 (0.62–0.81)	0.71 (0.62–0.80)	1.7 (0–5)	0.06 (–0.17–0.35)	9.2 (2–26)	0.68 (0.53–0.88)
Exercise 4 (3 readers)	10 (case 11–20)	Change	–0.6 (–2–0)	NA	NA	–0.5 (–3–1)	0.52 (0.49–0.55)	0.48 (0.41–0.59)	–0.2 (–2–1)	NA	–2.8 (–19–6)	0.85 (0.82–0.88)
	20 (case 1–20)	Status	1.3 (0–9)	0.58 (0.43–0.69)	0.55 (0.46–0.66)	1.2 (0–4)	0.38 (0.31–0.44)	0.42 (0.35–0.49)	1.0 (0–5)	0.10 (–0.09–0.33)	12.5 (2–26)	0.73 (0.69–0.77)

Sum scores are mean (range) of the patient scores (each patient's score is the average of the scores assigned to that patient). ICC and Kappa values are mean (range). NA: not done, due to minimal findings/change over time in this parameter. MRI-WIPE hip range for osteitis is 0–48 and for synovitis/effusion 0–6[6]. HIMRISS osteitis total range is 0–100 and range for synovitis/effusion is 0–30[12, 14, 16]. ICC is 2-way model, single measure, by absolute agreement. ICC values ≤ 0.49 were considered as poor, 0.50–0.79 as good, ≥ 0.80 as very good. Scorings at lesion level were assessed using Cohen's kappa, quadratically weighted. Kappa 0–0.20 was considered as no agreement, 0.21–0.39 as slight, 0.40–0.59 as weak, 0.60–0.79 as moderate, 0.80–0.90 as strong and >0.90 as almost perfect agreement[20]. Readers: IE*, MW, MØ*, PB, SJP, WPM* (all exercises), RGL*, VF (exercise 1, 3, 4), MS (exercise 1, 2, 4), AM (exercise 1–3), SK (exercise 1, 2), FG (exercise 1). *Musculoskeletal radiologist. *the readers with overall highest agreement in Exercise 3 (MØ, RGL, WPM). HIMRISS, Hip Inflammation MRI Scoring System; ICC, intraclass correlation coefficient; Kappa: Cohen's Kappa, quadratic weighted; MRI-WIPE, OMERACT MRI Whole-body score for Inflammation in Peripheral joints and Entheses in inflammatory arthritis.

Table 2
Sensitivity to change and correlation between methods in exercises 3 and 4¹.

Exercise 3		Baseline	Follow-up	Change	p-value	SRM
MRI-WIPE hip/pelvis	Osteitis	1.8 (3.13)	1.7 (3.21)	−0.1 (1.19)	0.279	0.10
	Synovitis/effusion	1.7 (1.66)	1.6 (1.74)	−0.1 (0.34)	0.891	0.35
HIMRISS	Osteitis	6.6 (19.32)	5.9 (17.35)	−0.7 (1.99)	0.109	0.35
	Synovitis/effusion	12.8 (8.84)	11.2 (8.80)	−1.6 (7.23)	0.562	0.23
Correlation MRI-WIPE hip/pelvis vs. HIMRISS						
	Osteitis	0.77** (0.006)	0.63* (0.04)	0.32 (0.337)	–	–
	Synovitis/effusion	0.89*** (<0.001)	0.77** (0.006)	0.63* (0.039)	–	–
Exercise 4						
MRI-WIPE hip/pelvis	Osteitis	1.8 (2.62)	1.2 (2.51)	−0.6* (0.51)	0.011	1.23
	Synovitis/effusion	1.2 (1.46)	0.7 (0.96)	−0.5 (1.22)	0.203	0.41
HIMRISS	Osteitis	1.6 (1.68)	1.4 (1.73)	−0.2 (0.72)	0.465	0.28
	Synovitis/effusion	9.2 (7.33)	6.4 (2.08)	−2.8 (7.24)	0.415	0.39
Correlation MRI-WIPE hip/pelvis vs. HIMRISS						
	Osteitis	0.72* (0.019)	0.94*** (<0.001)	0.53 (0.115)	–	–
	Synovitis/effusion	0.83** (0.003)	0.16 (0.651)	0.73* (0.017)	–	–

¹Values are shown for the 3 readers with overall highest interreader agreement in exercise 3 (WPM, RL, MØ).

Data are shown as mean (SD) and correlation coefficient (p-value). Comparison of scores at timepoints are done with Wilcoxon signed-rank test. Spearman Rank Correlation analysis is done for baseline and change for MRI-WIPE versus HIMRISS. Standardized response mean (SRM) is calculated as mean change score divided by standard deviation (SD) of the change score and interpreted as follows: no: <0.20; small: ≥0.20 and <0.50; moderate: ≥0.50 and <0.80; large ≥0.80[19]. **p*<0.05, ***p*<0.01, ****p*<0.001.

HIMRISS, Hip Inflammation MRI Scoring System; MRI-WIPE, OMERACT MRI Whole-body score for Inflammation in Peripheral joints and Entheses in inflammatory arthritis; SRM, standardized response mean.

This is the first OMERACT validation of HIMRISS in patients with SpA. Furthermore, this is the first study where the OMERACT MRI-WIPE is used to assess individual regions on whole-body MR images. The interreader agreement was very variable between reader pairs, in accordance with varying reader experience, training and calibration. Better agreement between experienced readers indicates that the methods will be reliable among experienced and well-calibrated readers, and that improved pre-reading calibration is required before future reading exercises.

It should be noted that WIPE-hip/pelvis and HIMRISS do not measure the same. In WIPE-hip/pelvis soft tissue and bone marrow inflammation at various locations in the hip/pelvis region are assessed individually, including enthesal regions such as the greater trochanter and ischial tuberosity. HIMRISS provides detailed assessment of osteitis and synovitis/effusion in the hip joint itself and does not include assessment of enthesal regions. Thus, the scoring systems cannot be directly compared and can be considered complementary.

Our study included a relatively small number of cases and osteitis and/or enthesitis were not necessarily present in the hip/pelvis region. The observed range of scores for osteitis was overall very small compared to the maximum possible score and only minimal change was seen. Therefore, we chose not to assess interreader agreement for change in this parameter. It would have been ideal to have an image dataset with more osteitis, synovitis/effusion and change over time. However, our WB-MRI image dataset was limited and did not allow this. Furthermore, experience of readers varied (some readers had no previous experience in scoring MRIs of this region) and not all completed the calibration modules. This was not considered obligatory, since the study was preliminary. This should be taken into consideration when interpreting the results.

In conclusion, two complementary semiquantitative MRI scoring systems, MRI-WIPE for the hip/pelvis region and HIMRISS, allow assessment of inflammation in the hip/pelvis region in SpA. The methods showed mostly good, but varying from poor to very good agreement between reader pairs. Before future reads, obligatory

completion of prespecified calibration should be included. Furthermore, an atlas with reference images for WIPE-hip/pelvis should be available for future exercises.

The hip/pelvis region is an important part of whole-body MRI assessment in spondyloarthritis. WIPE-hip/pelvis and HIMRISS are promising outcome tools, which need further validation before general use in randomized controlled trials in patients with spondyloarthritis can be recommended.

Disclosures

RGWL has received consulting fees from CARE Arthritis, Parexel and Pfizer. WPM is Chief Medical Officer CARE Arthritis Limited and has acted as a paid consultant/participated in advisory boards for AbbVie, Boehringer Ingelheim, Celgene, Eli Lilly, Galapagos, Janssen, Novartis, Pfizer and UCB, received research and/or educational grants from AbbVie, Novartis, Pfizer and UCB, and received speaker fees from AbbVie, Janssen, Novartis, Pfizer and UCB. SJP has been an advisory board member for AbbVie and Novartis, received research support from AbbVie, MSD, and Novartis and speaker fees from MSD, Pfizer, AbbVie, Novartis and UCB. PB participated in advisory boards and received speaker fees from Janssen, Abbvie, UCB, Celgene, BMS, Novartis, Pfizer, Gilead, Eli-Lilly. HMO has received research grants from Janssen and Novartis, and honoraria/speaker fees from AbbVie, Celgene, Janssen, Lilly, Novartis, Pfizer, Takeda and UCB. PC has received research grants from UCB, MSD and Pfizer, speaker/consultant fees for Pfizer, MSD, Novartis, BMS, AbbVie, UCB, Eli Lilly, Gilead and Celgene. PGC has received speaker or consultancy fees from AbbVie, AstraZeneca, BMS, Eli Lilly, EMD Serono, Flexion Therapeutics, Galapagos, Gilead, Novartis, Pfizer and Stryker. MØ has received research support, consultancy fees and/or speaker fees from Abbvie, BMS, Boehringer-Ingelheim, Celgene, Eli-Lilly, Hospira, Janssen, Merck, Novartis, Pfizer, Regeneron, Roche, Sandoz, Sanofi and UCB. MW, IE, MS, SK, AJM, VF, FG, JP, GDM, AEF and JLJ have no declarations for this work.

Declaration of Competing Interest

None.

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Appendix

Fig. A1, Fig. A2

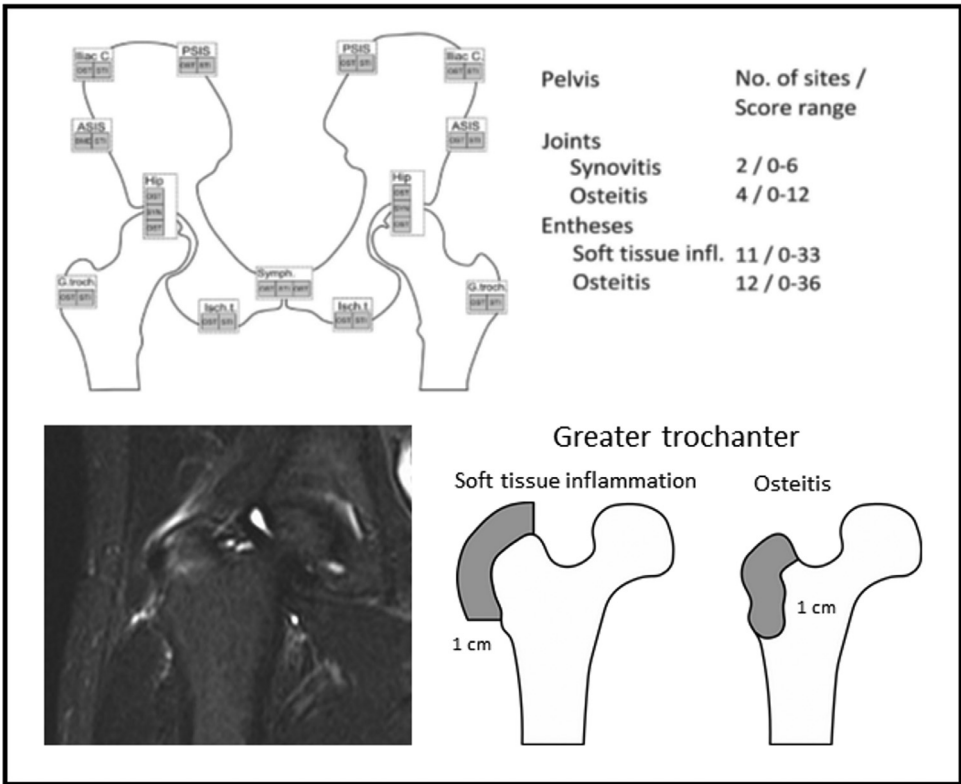


Fig. A1. MRI-WIPE schematic and scoring ranges for the hip and pelvis insertion of region (upper row), from Krabbe et al. [6], and a schematic drawing of the principle of scoring osteitis and soft tissue inflammation using MRI-WIPE (lower row), illustrated by the greater trochanter (coronal STIR whole-body MR image of hip region shown to the left). The top row illustrates that osteitis of the hip/pelvis is assessed separately for acetabulum and femur and osteitis of the pubic symphysis is assessed separately for left and right pubic bone. Using MRI-WIPE osteitis is assessed in the bone from the articular surface/entheseal insertion to a depth of 1 cm on all available images (as shown in schematic of the greater trochanter assessment). The osteitis grading scale is 0–3 based on the proportion of bone with edema, compared to the “assessed bone volume”, judged on all available images: 0: normal; 1: mild (1–33% of bone oedematous); 2: moderate (34–66% of bone oedematous); 3: severe (67–100% of bone oedematous). Soft tissue inflammation is assessed inside the ligament/tendon and in its immediate surroundings to 1 cm from the entheseal insertion: 0: normal; 1: mild; 2: moderate; 3: severe – by thirds of the maximum potential volume of inflammatory tissue. Synovitis is assessed in the entire synovial compartment on all available images: 0: normal; 1: mild; 2: moderate; 3: severe – by thirds by thirds of the maximum potential volume of enhancing tissue in the synovial compartment[6]. ASIS: anterior superior iliac spine; G. troch: greater trochanter; Iliac C.: iliac crest; Isch.t.: ischial tuberosity; MR, magnetic resonance; MRI-WIPE, OMERACT MRI Whole-body score for Inflammation in peripheral joints and Entheses in inflammatory arthritis; OST, osteitis; PSIS, posterior superior iliac spine; STIR, short-tau inversion recovery; STI, soft tissue inflammation; Symph.: pupic symphysis; SYN, synovitis;

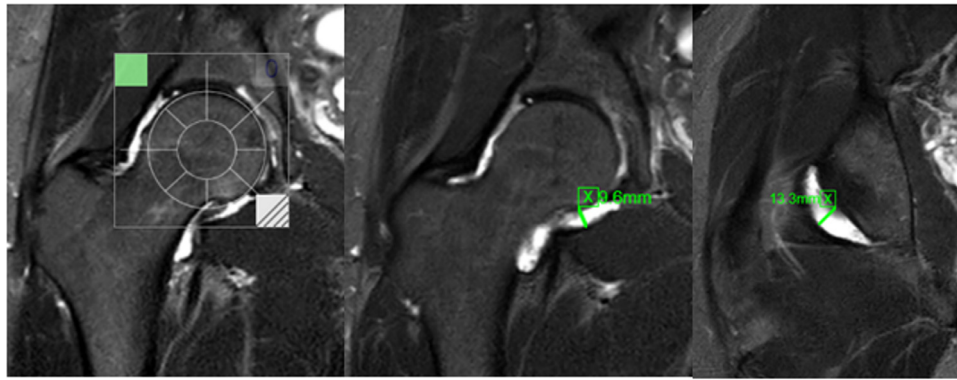


Fig. A2. Coronal STIR whole-body MR image of the hip with the web-based semi-transparent HIMRISS overlay positioned for osteitis scoring in femoral head and acetabulum (right hip) and 2 examples of synovitis/effusion measuring according to HIMRISS. Osteitis is scored on consecutive sagittal slices through the hip joint. The reader marks the first slice and the last slice where femur bone is visible, and the overlay is moved by the reader to fit the central slices (the slice where the femoral head appears the largest). The overlay separates subarticular bone in the femoral head and acetabulum into approximately 1×1 cm regions. On each slice, the reader clicks each area with osteitis and sum scores of these regions are automatically calculated and adjusted for the scoring range of each region (total scoring range 0–100). Hip synovitis/effusion is measured in each coronal image as the longest diameter perpendicular to the longest axis of synovitis/effusion collection (score 0: 0–1.9 mm; score 1: 2–3.9 mm; score 2: ≥ 4 mm, scoring range 0–30)[12, 14–16].

HIMRISS, Hip Inflammation MRI Scoring System; MR, magnetic resonance; STIR, short-tau inversion recovery.

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