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Reply:

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REPLY:

We thank Dr Colina for his comments regarding our recent article "SAPHO Syndrome: Imaging Findings of Vertebral Involvement."[1] We agree that growing awareness of SAPHO syndrome and its clinical and imaging findings will lead to earlier diagnosis.

In response to the comment that sternocostoclavicular hyperostosis represented the first symptom in 70% of the patients reported in the study by Colina et al,[2] 39% of the patients in our series had concurrent sternoclavicular involvement and 22% involvement of the first costovertebral joint, supporting this being a common symptom. We believe knowledge of the typical vertebral findings is critical in making an appropriate diagnosis in the substantial minority of patients who do not present with sternocostoclavicular hyperostosis.

Because our article focused on the unique spinal manifestations of SAPHO syndrome, we did not investigate the frequency with which patients in our series presented to the emergency department with chest pain or a coronary work-up. This would be an interesting area for further investigation.

Finally, we agree that the diagnosis of SAPHO syndrome is challenging and requires a multidisciplinary approach. In patients presenting with the unique curvilinear or semicircular pattern of contiguous vertebral involvement that we described along with sclerosis along ligamentous attachment sites and the absence of abnormal T2 hyperintensity and enhancement of the intervertebral disc, SAPHO syndrome should be included in the differential diagnosis. A search for the concurrent sternoclavicular involvement and consultation with dermatology and/or rheumatology colleagues to identify the typical skin manifestations may prevent misinterpretation of the imaging findings as discitis/osteomyelitis or metastases, with subsequent potential reduction in the number of unnecessary biopsies and delayed diagnoses.

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