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Reply to the comments by Falsetti et al.

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Dear Editor,
We would like to thank Falsetti and colleagues for their interest in our recent case report regarding subcalcaneal bursitis in very early rheumatoid arthritis (RA) patients (1, 2), and we provide our response to their comments as follows.

DEFINITION AND NOMENCLATURE

Although there is only limited literature-based evidence, there are several textbooks and pictorial reviews describing plantar bursitis as adventitial (adventitious) bursitis, as they pointed out in their letter (3, 4). Therefore, we agree with their suggestion to use the term *subcalcaneal adventitial bursitis*.

CAN SUBCALCANEAL ADVENTITIAL BURSITIS BE CONSIDERED AN EQUIVALENT FOR SYNOVITIS?

On ultrasound, an adventitial bursitis usually appears as a poorly defined heterogeneous region without vascularization (5). In RA patients, however, adventitial bursitis often presents with power Doppler signals in the well-demarcated and thickened bursal wall. This observation makes us imagine that rheumatoid inflammation resembling synovitis has developed there, although an adventitial bursa essentially lacks a mesothelial lining and synovia. Histological data are needed for further discussion.

IS SUBCALCANEAL ADVENTITIAL BURSITIS SPECIFIC FOR RHEUMATOID ARTHRITIS?

We do not consider that subcalcaneal adventitial bursitis itself is specific for RA. However, we suppose that persistent inflammation in soft tissues other than articular synovium or tenosynovium can precede persistent synovitis at the onset of RA. We have previously reported cases of RA patients with a high ACPA titer whose initial manifestation of RA was paratenonitis or tendinitis (6, 7). It is intriguing to speculate that synovial membranes may not be necessary for the initiation of rheumatoid inflammation in the very earliest phase of the disease. Also from this point of view, a histopathological investigation of subcalcaneal adventitial bursitis that presented at the onset of RA is highly anticipated.

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