



Comment on the Scientific Letter “Adult-Onset Still’s Disease Mimicking Acute Rheumatic Fever”

To the Editor,

I read with great interest the article titled “Adult-Onset Still’s Disease Mimicking Acute Rheumatic Fever” by Karagöz et al., published in December 2014 in Turkish Journal of Physical Medicine and Rehabilitation. The article has points that contribute to the differential diagnosis of Adult-onset Still’s disease (AOSD). However, I disagree with a statement in the article. The authors mention that high levels of serum and glycosylated ferritin (GF) are characteristics of AOSD. In my opinion, this statement does not fully reflect the truth about GF levels in patients with AOSD. In order to avoid confusion, I would like to shed some light on the levels of serum ferritin and GF in AOD.

Levels of both ferritin and GF, an isoform of ferritin, have a diagnostic value in AOSD, but they are not completely specific. Approximately 50%–80% serum ferritin is glycosylated in healthy individuals. The amount of GF levels decreases to 20%–50% in inflammatory conditions, and GF levels drops to $\leq 20\%$ in AOSD. The reason for this decrease is the saturation of glycosylation mechanisms. A combination of both markedly elevated ferritin levels and GF levels $\leq 20\%$ improves the sensitivity and specificity of AOSD diagnosis (1-3).

In conclusion, levels of serum ferritin and GF do not increase concurrently. A concurrent increase in serum ferritin levels and a decrease in GF levels is a diagnostic marker for AOSD.

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Author’s Reply

To the Editor,

We have read the reply by Guzelkucuk in relation to our paper titled “Adult onset Still’s disease (AOSD) mimicking acute rheumatic fever” with great interest. We would like to thank the author for his valuable contribution and correction of the sentence in the Discussion section of our manuscript. The respondent has highlighted an important point about the relationship between serum ferritin levels and AOSD.

It is crucial to underline that a combination of “high” serum ferritin levels and a “low” percentage of glycosylated ferritin ($< 20\%$) has been demonstrated to be a specific marker of AOSD (1). In addition, it is important to note that glycosylated ferritin, which has a low specificity (64%), alone does not seem to be a useful marker to follow up disease activity and response to treatment (2,3). The combination of this parameter with serum ferritin level increases the specificity up to 93% (2). Therefore, the combined use of both parameters has been recommended, and it is a part of the Fautrel et al. (3) criteria.

In conclusion, I would like to end this correspondence with a scientific quote by Howard E. Gruber. "The power and beauty of science do not rest upon infallibility, which it has not, but on corrigibility, without which it is nothing" (4).

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