Reply

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To the Editor:

Drs. Wolfe and Walitt argue that fibromyalgia may have been overdiagnosed in the NHIS, and that this may pose a problem with regard to updating the projected prevalence of self-reported doctor-diagnosed arthritis and arthritis-attributable activity limitation. We appreciate the opportunity to explain these issues in greater detail.

First, we used a self-report case definition that has been used since 2002 (i.e., "Have you ever been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus or fibromyalgia?"), which was designed to capture conditions that would be treated by a rheumatologist or considered arthritis or a rheumatic condition by health care providers, the public, and decision makers. In our article we do indicate by citation that this *broad* case definition question was cognitively tested and validated for population surveillance purposes (1), but we make no such claim for self-reported diagnosis of *specific* conditions such as fibromyalgia. In fact, it is well recognized that selfreport of specific rheumatic conditions is a problem and results in misclassification (2–5), and our own experience with developing questions for the Behavioral Risk Factor Surveillance System suggested that the majority of respondents did not know what type of arthritis they had. Such misclassification was part of the original rationale for developing the broad case definition used, which assumes that self-reported specific rheumatic conditions may be misclassified, but that the correct classification is likely within the bounds of the broad case definition. Wolfe and Walitt may well be correct in saying that fibromyalgia is overdiagnosed in the NHIS, but the underlying medical condition is likely something that should be captured, albeit difficult to ascertain.

Second, there is a need for estimating the burden and impact of arthritis (broadly defined) using self-reported surveys because many people do not mention their arthritis when interacting with the health care system, so it is not captured by medical records or claims-based administrative data. Surveillance using self-reported survey data is essential to better document and not underestimate the real population burden. Therefore, this broad definition is not for clinical purposes where a diagnosis is critical for determining the appropriate treatment plan. Rather the definition is for public health purposes which have different objectives, such as informing policymakers, targeting resources, and evaluating intervention programs (6).

Third, Wolfe and Walitt raise the very interesting issue of "the creation and expansion of disease," which might compromise surveillance efforts. Our previous projections of arthritis prevalence, based on 2003 NHIS data (7), were closely matched later by cross-sectional

rolling estimates using the 2010–2012 NHIS (8), suggesting that our broad case definition has not yet been affected by that possible trend.

For those interested in broad case definitions of arthritis, changes are coming. The NHIS is in the midst of a major redesign that will take effect in 2018; it is currently unknown how changes to the survey may impact arthritis case definitions or trends over time. With the use of International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Clinical Modification (ICD-10-CM) codes in medical records since October 1, 2015, and in other national health care utilization surveys, a new ICD-based case definition will be needed.

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