

OMERACT III The "ACT" Revisited

OMERACT III, the proceedings of which are published in this issue of *The Journal* and in May and June, addressed the important issues of the development of endpoints for osteoarthritis (OA) and osteoporosis and psychosocial measures in musculoskeletal disease. The Outcome Measures in Rheumatoid Arthritis Clinical Trials (OMERACT), now redefined as Outcome Measures in Rheumatology and perhaps (since we have addressed osteoporosis) to be renamed Outcome Measures in Musculoskeletal Clinical Trials (but what an acronym!), began to take shape in the early 1990s. OMERACT I was held in Maastricht in 1992 and developed a core set of endpoints for rheumatoid arthritis (RA) clinical trials. This core set was then adopted as the World Health Organization/International Leagues of Associations for Rheumatology (WHO/ILAR) core set at a special task force meeting held in Geneva in 1993.

Other topics discussed at that first OMERACT conference included the development of improvement criteria and indices in RA trials. These discussions have since continued and have stimulated groups such as the American College of Rheumatology (ACR) Committee on Measurement in Rheumatoid Arthritis Clinical Trials to develop preliminary ACR criteria for improvement in RA. Further work continues on comparing various joint counts. The OMERACT movement has certainly generated the collection of good data on these issues.

The OMERACT movement has been very closely linked to the Cochrane Collaboration in musculoskeletal diseases, now the largest group of all the Cochrane initiatives. The Cochrane Musculoskeletal Collaboration has already led to the generation of a number of reviews now being entered on the Cochrane database, where they will be available for review. OMERACT newsletters continue to be produced by Maarten Boers and there is also an OMERACT group on the Internet.

OMERACT II, held in Ottawa in 1994, focused on the efficacy of rheumatic disease treatments and their costs. Clinicians, researchers, and health policy makers and repre-

sentatives of the pharmaceutical industry worked closely for 2 days on 3 major issues — toxicity measurement in clinical trials, health status measures, and economics. Important issues raised at OMERACT II have been carried on through the various working parties established to develop the research agenda. These include the drug toxicity working party, currently planning a meeting in Washington in 1997 to further develop drug toxicity reporting in clinical trials of antirheumatic drugs and to develop patient questionnaires of greater relevance to consumers. The quality of life working party has established a clinical trial to compare a variety of quality of life measures in RA. These 2 groups are developing agendas of their own, but remain very closely linked to the OMERACT movement.

OMERACT III, the first part of which is reported in this issue of *The Journal*, was held in Cairns, Australia, in April 1996. The balmy beaches could not compete with the standard of intellectual debate provided at this meeting. As in previous conferences, an enormous amount of preconference work was done with the precirculation of material on osteoarthritis, osteoporosis, and psychosocial measures. Participants came to the conference with a significant background in these areas and participated actively throughout the meeting. Debate was spirited, particularly in the areas of osteoporosis and OA. In the end a significant consensus was reached on the development of core sets of measures for osteoporosis and OA. As with development of any core set, these must now be tried in the field and not be seen as permanent structures. However, the inclusion of measures within the central core, i.e., those recommended as essential today, have been developed using the standard measurement principles that have been espoused throughout OMERACT. These relate to whether the measurements have been adequately tested, are reproducible, and show sensitivity to change. These endpoints will be developed over time and we will find that some of the measures presently in the outer core (thought to be useful but not fully validated as yet) may move into the inner core to become essential core components. Use of these core measures in trials, however, will

allow us to compare and contrast trials much better than in the past. This is important for the Cochrane initiatives, where metaanalyses of trials can help to clarify difficult clinical questions and direct appropriate therapy.

The OMERACT movement is now self-sustaining. It does, however, need the support of the musculoskeletal disease community and it needs active participation in its working groups and its biennial conferences. OMERACT IV is currently planned for 1997 and we hope to see many of you there. This issue includes the presentations on osteoarthritis. Future issues will contain the discussions on osteoporosis and on psychosocial measures in musculoskeletal trials.

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ADDENDUM: How to join and use the OMERACT electronic distribution list. As you may know, the list works by "reflecting" all messages sent to it: a message you send to the list will be sent to all subscribers, who can react in turn. To subscribe: send an e-mail message to listserv@nic.surfnet.nl with only this text in the body of the message: subscribe omeract firstname lastname. Put your real first name and last name in the specified places.

Subscription is "by owner", meaning the list owner has to approve. Apart from the normal subscription procedure, you must send a separate

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