

Two-Minute Screen Identifies Psoriatic Arthritis

BY DAMIAN McNAMARA

Miami Bureau

SINT MAARTEN, NETHERLANDS ANTILLES — Primary care physicians can use a “2-minute drill” that combines questions and a physical exam to screen psoriasis patients for psoriatic arthritis.

Routinely ask patients with psoriasis about musculoskeletal complaints, and then determine whether their symptoms are inflammatory, Dr. Gary L. Crump recommended at the Caribbean Dermatology Symposium. Examine them for soft tissue joint swelling, joint tenderness, nail pitting, dactylitis, and pain on motion.

The final question is about morning stiffness that lasts longer than 30 minutes, which affects more than 50% of people with psoriatic arthritis (PsA), Dr. Crump said. “It’s important how you ask patients,” because some will have chronic back stiffness, for example. He recommended asking: “How long does it take you to get as loose as you are going to get?”

Patients with PsA also can present with erythroderma, psoriasis, onycholysis, conjunctivitis/iritis, and valvular heart disease. “Psoriatic arthritis is a true systemic inflammatory disease,” Dr. Crump said.

Clinical judgment and physical examination remain superior to laboratory tests, which can vary and are not very predictive. If acute PsA is suspected, erythrocyte sedimentation rate and rheumatoid factor assays are better than a C-reactive protein test, he said.

“If you are not sure, refer and let the rheumatologist figure it out,” said Dr. Crump, a private practice

rheumatologist in Louisville, Ky. The ideal approach is multidisciplinary, he added. “A dermatologist should confirm that it is psoriasis, and a rheumatologist should confirm that it is inflammatory arthritis.”

A clinical tip is to examine the patient’s feet. “If you see someone with ‘sausage toes’ or dactylitis, you’re done. They have psoriatic arthritis,” Dr. Crump said. Nail dystrophy is also very strongly associated with PsA, even if only one distal joint is affected.

Although not part of the 2-minute screen, Dr. Crump also recommends quality of life assessment for patients with PsA. Many rheumatologists use the validated Classification Criteria for Psoriatic Arthritis (CASPAR) for diagnosis (*Arthritis Rheum.* 2006;54:2665-73).

After initial confirmation of articular joint disease, the criteria stipulate 3 or more points, using a scoring system. Assign 2 points for current psoriasis, and 1 point for each of the following: dactylitis, nail dystrophy, juxta-articular bone formation, and negative rheumatoid factor assay. Patients without current psoriasis also score 1 point if they have either a personal or family history of psoriasis. “So you cannot diagnose PsA with just psoriasis and arthritis alone—you need something else,” Dr. Crump said.

A differential diagnosis includes exclusion of other forms of inflammatory arthritis. Some patients with psoriasis also have rheumatoid arthritis, gout, or osteoarthritis, for example. Asymmetry of affected joints is one tip that a patient does not have rheumatoid arthritis, Dr. Crump said.

An estimated 40% of patients have a family history

in first-degree relatives, Dr. Crump said. Even so, “the epidemiology has been hard to pin down.” Researchers have confirmed genetic polymorphisms related to tumor necrosis factor (TNF)- α promoters in patients with PsA (*Pharmacogenomics* 2008;9:195-205). Immunologic studies point to T-cell activation in the skin and increases in proinflammatory cytokines, including TNF- α , interleukin-1, IL-6, and IL-8.

Features of the five subtypes of PsA often overlap, further confounding diagnosis, Dr. Crump said. And although the distal pattern of PsA affects less than 20% of patients, “it is pretty diagnostic.” Asymmetric oligoarthritis, symmetric polyarthritis (indistinguishable from rheumatoid arthritis), arthritis mutilans, and spondyloarthropathy (usually with peripheral involvement) are other subtypes.

In terms of treatment, NSAIDs can control PsA symptoms, including pain, but they do not prevent structural damage, Dr. Crump said. There are also gastrointestinal, renal, and cardiovascular risks, he said. Methotrexate 7.5 mg/wk to 20 mg/wk can slow radiographic progression, but it is not effective for axial disease.

TNF inhibitors can slow or halt radiographic progression, including axial disease. “These are our ‘go-to’ class of drugs now.” This class includes etanercept (Enbrel, Immunex Corp.), adalimumab (Humira, Abbott Laboratories), and infliximab (Remicade, Centocor Inc.) “My impression of these agents is they all work well for the joints,” said Dr. Crump, who is on the speakers bureau for Centocor, Novartis, Bristol-Myers Squibb, Roche, and Abbott. ■

Arthroscopy Adds Little to Acute Swollen Knee Evaluations

BY MICHELE G. SULLIVAN

Mid-Atlantic Bureau

Two European medical societies have collaborated on the first treatment guidelines for acute knee swelling that incorporate both rheumatology and orthopedic surgery perspectives.

The European League Against Rheumatism (EULAR) and the European Federation of National Associations of Orthopedics and Traumatology (EFORT) based their 10-point guideline on an extensive literature search, Dr. Robert B.M. Landewe wrote in the *Annals of the Rheumatic Diseases* (doi:10.1136/ard.2008.104406).

Where data were insufficient, the joint panel relied on expert consensus, said Dr. Landewe of Maastricht (the Netherlands) University Medical Center. Both international societies will start to implement the recommendations by using them as a template for discussions with the stakeholders of the target population [including primary care providers].

The joint task force comprised 11 rheumatologists and 12 orthopedic surgeons, who met twice under the leadership of a clinical epidemiologist and a research fellow. The treatment guidelines were aimed at both acute and recent-onset (within the past 4-6 weeks) knee swelling, which, the experts reasoned, would encompass both trauma- and disease-related pathology.

The literature search yielded 48 articles upon which the panel based its 10 recommendations.

1. A clinical examination is necessary

to confirm acute knee swelling.

Acute knee swelling is a common problem, occurring in up to 54% of the population, the panel noted. However, many self-referred cases do not show an increase in the volume of the knee.

2. Timely referral is necessary when the examination yields a suspicion of septic arthritis, trauma, tumor, or inflammatory arthritis.

Suspected septic arthritis should be considered an emergency that requires an immediate expert examination. Patients with suspected trauma should also be seen immediately. Suspected bone tumors require a semiacute referral of within 1 week to an orthopedic surgeon with a speciality in bone tumors. Patients with possible inflammatory arthritis should be seen by a rheumatologist within 6 weeks.

3. A complete medical history is also an important diagnostic tool. A careful, thorough history should be taken, noting medical comorbidities, medication, malignancy, hemorrhage, and the speed of pain onset. Fever is also an important clue to the possible nature of knee swelling.

4. The physical exam should focus on the affected knee but include the unaffected knee as well as an assessment of other joints.

Joint assessment should include the localization and characteristics of the swelling, the presence of any effusion, joint stability, pain, skin temperature,



A plan radiograph is enough to identify trauma or erosive changes, cartilage calcification or thinning.

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and no acutely scheduled surgical intervention.” The panel agreed that aspiration is contraindicated in cases of suspected tumor, because of the possibility of seeding malignant cells.

7. A plain x-ray in two planes is enough to identify trauma or erosive changes, cartilage calcification, or cartilage thinning. An ultrasound may be helpful in detecting joint effusion and synovial hypertrophy.

Most studies indicate that ultrasound performs just as well, and that MRI could lead to an overestimation of pathology.

8. Diagnostic arthroscopy is indicated only in exceptional cases.

The data do not support the routine use of this procedure in patients with acute knee swelling, unless there is high suspicion of an intra-articular infection, such as by *Mycobacterium tuberculosis* or yeasts. “In light of the invasiveness of the procedure and the risk of complications, the expert committee felt unanimously that arthroscopy for diagnostic purposes solely cannot be justified and should therefore be abandoned.”

9. Specific therapies can’t begin until an appropriate diagnosis is made.

But because making a firm diagnosis may take some time, general measures can be employed to relieve pain and other symptoms.

10. Noninterventionist therapies, like cold packs, splints, and simple analgesics or nonsteroidal anti-inflammatory drugs, can be used to ease symptoms. ■

and appearance. A general physical exam is valuable only if the joint pathology may be part of a systemic illness.

5. Lab tests are advisable in patients with nontraumatic knee swelling.

These may include white blood cell count and acute phase reactants to help exclude septic arthritis. A baseline C-reactive protein level may be useful in patients with suspected inflammatory arthritis. For suspected gout, serum uric acid measurements are indicated.

6. Patients with suspected septic, crystal, or inflammatory arthritis should undergo joint fluid aspiration.

Joint fluid should be examined for leukocytes, crystals, and bacteria. In cases of trauma-related effusion, the panel was split on the usefulness of hemarthrosis aspiration. “Evacuation ... was considered only helpful in cases with major effusion