

2-Minute Screen Helps Identify Psoriatic Arthritis

BY DAMIAN McNAMARA

SINT MAARTEN, NETHERLANDS ANTILLES — 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 advised 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), he 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 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. The Classification Criteria for Psoriatic Arthritis (CASPAR) for diagnosis (*Arthritis Rheum.* 2006;54:2665-73) are widely used.

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, he 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.”

In terms of treatment, NSAIDs can control PsA symptoms, including pain, but they do not prevent structural damage, Dr. Crump said. Methotrexate 7.5-20 mg/week can slow radiographic progres-

sion, 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, adalimumab, and infliximab. “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. ■

Cardiac Risk Factors

Serving Size: 1 Adult Male
Servings Per Container: 1

| Amount Per Serving | |
|-------------------------------|-----|
| Age | 48 |
| Weight | 243 |
| Total Cholesterol | 259 |
| LDL | 169 |
| HDL | 47 |
| Coronary Calcium Score | 397 |
| Body Mass Index | 37 |
| Waist Circumference | 48 |
| Blood Pressure | |
| Systolic | 150 |
| Diastolic | 90 |
| Fasting Blood Glucose | 146 |


Ingredients for Coronary Artery Disease Risk:
Family History, Diabetes, Hypertension, Smoker, Occasional Chest Discomfort

Refer

Nuclear stress testing for reliable diagnostic and prognostic results^{1,2}

1. Klocke FJ, et al. *Circulation.* 2003;108:1404-1418.
2. Hachamovitch R, et al. *Circulation.* 1998;97:535-543.

©2008 Astellas Pharma US, Inc. ADS10413-MK 11/07

 **astellas**
Astellas Pharma US, Inc.