OMERACT 7 psoriatic arthritis workshop: synopsis
D D Gladman, V Strand, P J Mease, C Antoni, P Nash, A Kavanaugh

OMERACT: PROCESS
The OMERACT process involves achieving consensus on outcome measures and is based on the “OMERACT filter”, which itself is based on a methodological framework described by Bombardier and Tugwell in 1982.7 The OMERACT filter simplified that methodology into three concepts: truth, discrimination, and feasibility.1 Truth encompasses face, content, construct, and criterion validity and addresses the question of whether the measure assesses what it was meant to in an unbiased and relevant way. Discrimination addresses the issue of reliability and sensitivity to change by answering the question of whether the measure discriminates between situations of interest. Feasibility relates to whether a measure can be applied pragmatically, given financial and interpretation constraints in longitudinal observational studies and randomised controlled trials. It is expected that measures used to assess rheumatological conditions will “pass” the OMERACT filter.

The OMERACT process thus begins with the accumulation of data on the outcome measures relevant to a disease in question. Following this the OMERACT filter is applied to the data. This evidence is shared with the participants at the OMERACT conference through plenary sessions. Then the participants discuss the information presented in breakout groups, add their own opinions, and begin to select domains and instruments important in the assessment of outcome. Subsequently a vote is carried out, with the help of an electronic voting system, which allows all participants to express their opinion on the relative importance of the proposed outcome measures.

OMERACT 7
The psoriatic arthritis workshop at OMERACT 7 was based on the information developed during the previous two exercises, the Delphi process6 and the nominal group process5 carried out through the Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA). A review of assessment instruments used in psoriatic arthritis was provided to all participants prior to the conference.10 The workshop began with a plenary session, at which the previous Delphi exercise and the nominal group process were presented by Dafna Gladman.11 A review of the outcome measures and instruments used in clinical trials in psoriatic arthritis was presented by Philip Mease. Gerald Krueger presented a review of outcome measures and instruments used in psoriasis clinical trials. Desireé van der Heijde discussed radiological assessment in psoriatic arthritis. The participants were then divided into 12 groups, and each group was asked to discuss domains that should be included in clinical trials in psoriatic arthritis, beginning with the results of the work of GRAPPA. During a meeting of GRAPPA members at OMERACT, each group’s scribe presented its deliberations. These were summarised into a composite table and presented at a second plenary session in which the final list of domains to be included in clinical trials in psoriatic arthritis was presented and ratified (table 1). Also, in this
A research agenda was developed from the proposed domains and the discussion at this GRAPPA meeting. The research agenda was also presented and accepted at the final plenary session at OMERACT 7.

Members of GRAPPA approved the list of domains and the research agenda at a subsequent GRAPPA meeting during the European League Against Rheumatism meeting in Berlin on 12 June 2004. At that meeting, committees were struck to address several issues on the research agenda, and these will be studied over the next 12–18 months.

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REFERENCES

Table 1 Results of Outcome Measures in Rheumatology Clinical Trials (OMERACT) voting on domains to be included in clinical trials in psoriatic arthritis

<table>
<thead>
<tr>
<th>No</th>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Joint activity</td>
<td>99%</td>
</tr>
<tr>
<td>2</td>
<td>Patient global</td>
<td>96%</td>
</tr>
<tr>
<td>3</td>
<td>All three components (total, joints, skin)</td>
<td>76%</td>
</tr>
<tr>
<td>4</td>
<td>Pain assessment</td>
<td>94%</td>
</tr>
<tr>
<td>5</td>
<td>Physical function</td>
<td>91%</td>
</tr>
<tr>
<td>6</td>
<td>Skin disease</td>
<td>86%</td>
</tr>
<tr>
<td>7</td>
<td>Quality of life</td>
<td>78%</td>
</tr>
<tr>
<td>8</td>
<td>Structural damage</td>
<td>66%</td>
</tr>
<tr>
<td>9</td>
<td>Acute phase reactant</td>
<td>64%</td>
</tr>
<tr>
<td>10</td>
<td>Axial involvement</td>
<td>61%</td>
</tr>
<tr>
<td>11</td>
<td>Participation</td>
<td>61%</td>
</tr>
<tr>
<td>12</td>
<td>Enthesitis</td>
<td>60%</td>
</tr>
<tr>
<td>13</td>
<td>Fatigue</td>
<td>48%</td>
</tr>
<tr>
<td>14</td>
<td>Dactylitis</td>
<td>48%</td>
</tr>
<tr>
<td>15</td>
<td>Physician global</td>
<td>41%</td>
</tr>
<tr>
<td>16</td>
<td>Magnetic resonance imaging</td>
<td>34%</td>
</tr>
<tr>
<td>17</td>
<td>Morning stiffness</td>
<td>25%</td>
</tr>
<tr>
<td>18</td>
<td>Damaged joint count</td>
<td>20%</td>
</tr>
</tbody>
</table>

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