MATTERS ARISING

Late onset spondyloarthropathy: comparison with early onset patients

We read with interest the article by Caplanne and colleagues[1] and note the association between psoriasis and spondyloarthropathy in three of their eight cases. We have reviewed our series of 228 cases of psoriasis and inflammatory arthritis. Forty five patients (20 female) had spondyloarthropathy according to the Amor criteria.[2] Five of 45 (three female) had their first symptoms at the age of 55 or older according to patient recall and case note review.

The older onset spondyloarthropathy group had a higher rate of cervical spine involvement than those with younger onset (χ^2=4.73, p=0.0296) in agreement with Caplanne *et al*, but we were unable to demonstrate higher rates of thoracic spine involvement (p=0.852), shoulder involvement[3] (p=1.000) or chest wall arthritis (p=0.847). All five of the older onset subjects with spondyloarthropathy had peripheral joint involvement. Peripheral joint involvement was more frequent with older age of onset compared with those with age of onset at 54 years or younger, although confidence limits are wide because of the small numbers (maximum likelihood estimate of OR 7.13, 95% CI 1.11, 300.09, p=0.023), but statistical significance was lost if compared with those with onset before age 40 years (p=0.270). Enthesopathy was present in one of five patients with late onset spondyloarthropathy compared with 13 of 33 with onset before age 40 years. Dactylitis was not found. Only three of five patients were currently taking non-steroidal anti-inflammatory agents: one had had little or no benefit from naproxen, and another had discontinued diclofenac because of gastrointestinal discomfort. Only one patient (the first listed, table 1) has used DMARDs, presumably for peripheral joint disease; she is also the only patient to have undergone joint replacement or to have erosions on hand radiograph. In all five cases of older onset arthritis the erythrocyte sedimentation rate was 15 or lower on the most recent recording. Two subjects were HLA-B27 positive (compared with 16 of 33 with onset below 40 years of age); one was also seropositive for rheumatoid factor with a titre of 1 in 320.

In summary we have found that among patients with psoriasis and spondyloarthropathy late onset arthritis is associated with more frequent peripheral and cervical spine involvement but no other clinical differences have been shown. Taking together the subjects reported by Caplanne and our own series it seems that patients with late onset spondyloarthropathy and late onset psoriatic spondyloarthropathy share a number of clinical features not shared with spondyloarthropathy patients of younger onset. As Caplanne's series contains a comparatively high proportion of patients with psoriasis, it is not clear whether these clinical features are associated with late age of onset alone, or whether psoriasis may also have an effect on the clinical expression of the arthritis.

Table 1 Clinical features of patients with spondyloarthropathy and onset of arthritis at age 55 or over

Sex	*Age*	*Age of onset*	*Perpiheral arthritis*	*Psoriatic nail dystrophy*	*Dactylitis*	*Enthesopathy*	*Rheumatoid factor*	*HLA-B27*
F	68	60	Yes	Yes	No	No	Negative	Negative
M	77	57	Yes	Yes	No	No	Negative	Negative
F	62	57	Yes	No	No	Yes	Negative	Negative
M	61	57	Yes	Yes	No	No	Positive	Positive
F	75	55	Yes	No	No	No	Negative	Positive

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1 Caplanne D, Tubach F, LeParc JM. Late onset spondyloarthropathy: clinical and biological comparison with early onset patients. Ann Rheum Dis 1997;57:176-9.
2 Amor B, Dougados M, Mijiyama M. Criteres de classification des spondylarthropathies. Rev Rhum 1990;57:85-9.
3 Calin A, Elswood J, Edmunds L. Late onset ankylosing spondylitis. A distinct disorder? Br J Rheumatol 1991;30;69-70.

Authors' reply

We thank Dr Kay and colleagues for their interest in our short report on late onset spondylarthropathy.[1]

Although they have restricted their description to patients with psoriasis, they have identified clinical differences in their late onset patients.

They found an equal number of women and men, but no variations of acute phase proteins.

Defining onset with strict criteria is not easy, especially in old patients. Simple recall may lead to important bias.

For example, in the case of spondylarthropathy pelvic *x* rays must exclude silent sacroiliitis. This allowed us to separate 'true' late onset from late first flare of otherwise clinically silent or mild arthritis.

To quote one of our reviewers, studying the influence of age on the presentation of arthritis is some kind of a 'brave attempt'. With the increase of an elderly population this task has to be done for an improved treatment of arthritis in the elderly, and the understanding of the influence of age on the various forms of synovial and enthesitic inflammation.

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1 Caplanne D, Tubach F, LeParc JM. Late onset spondyloarthropathy: clinical and biological comparison with early onset patients. Ann Rheum Dis 1997;57:176-9.