

DISCUSSION

Discussion: Clinical features, epidemiology, classification criteria, and quality of life in psoriasis and psoriatic arthritis

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Are people going to be convinced that the multi/poly arthritis with time is still psoriatic arthritis and not a seronegative rheumatoid that has evolved?

This is an important issue. It highlights the difficulty in differentiating psoriatic arthritis (PsA) from seronegative rheumatoid arthritis (RA). Generally, the oligoarticular presentation is identified as a feature of PsA, but PsA does evolve from oligoarticular to polyarticular over time. It is just as important to consider the joints involved as the extent of joint involvement. Generally, the differentiation between PsA and RA is more difficult early in the course, before the more classic changes such as pencil in cup are evident. Later in the disease the radiological features are quite helpful. In the future, magnetic resonance imaging (MRI) and ultrasound may provide early clues.

How does one define symmetry in PsA?

The issue of symmetry has caused confusion in describing the clinical patterns. PsA is considered to be less symmetrical than RA. It clearly tends to be more asymmetrical at presentation due to the oligoarticular onset of psoriatic arthritis. However, as joints accrue over time, it may become more symmetrical. It has been shown that symmetry is indeed a function of the number of joints involved in an individual patient. Evaluating joint involvement by other modalities, such as ultrasound and MRI, may indicate more joint involvement and hence more symmetry. In other words, the observed difference may be quantitative rather than qualitative. Helliwell and colleagues have proposed a mathematical formula to describe symmetry. They suggest that if we divide the number of paired joints by the total number of joints, a value >0.5 suggests symmetry, whereas a value <0.5 suggests asymmetry. This has not yet been tested in a large cohort or clinical trial.

Is there a reliable way of differentiating seronegative RA with coincidental psoriasis from PsA?

Since RA occurs in about 1% of the population and psoriasis affects 1–3% of the population, the coexistence of both conditions would occur in 1:10 000 individuals by chance alone. This is an important differential. Generally, one looks for specific manifestations of PsA in these patients. For example, if a patient with psoriasis and an inflammatory arthritis has dactylitis, enthesitis, or inflammatory back disease, their disease is more likely to be PsA than RA.

Is there a reliable way of diagnosing PsA in the presence of a positive rheumatoid factor?

Similar to the answer above, this is an important consideration. The clinical features help in this context and the presence of features more typical of PsA facilitates the diagnosis. It is possible that a more specific test for rheumatoid factor, such as anticyclic citrullinated peptide (anti-CCP) antibody, will help differentiate these two groups of patients.

Can we make the diagnosis of PsA in a patient who does not yet have psoriasis?

Arthritis may precede psoriasis in 15–20% of patients. Sometimes a positive family history in a first degree relative is helpful. The clinical picture of PsA may help us make the diagnosis of PsA *sine* psoriasis. This is facilitated when the patient presents with classic features of PsA such as asymmetrical oligoarthritis, distal interphalangeal joint disease, dactylitis, spondylitis, or enthesitis. However, more times than not the problem is detecting the psoriasis. Patients need to be reviewed very carefully for skin lesions, with particular attention to hidden psoriasis. Nail lesions (particularly pits and onycholysis) are just as important, as these may be the only indication that the patient may have psoriasis.

Why do “pencil in cup” and ankylosis occur in the same finger in the same patient?

This remains unknown. It is likely due to differing concentrations of cytokines and chemokines in different joints with an imbalance towards joint lysis in one joint and joint ankylosis in others. Mechanical factors may also be important.

How do titres of rheumatoid factor differ between PsA and RA?

Rheumatoid factor titres are definitely lower in PsA, although there are some patients who have high titres even with PsA. Again, it is possible that the use of anti-CCP antibodies will help resolve this issue.

Should PsA be considered an entity separate from the spondyloarthropathies?

PsA has been classified with the spondyloarthropathies because of the asymmetrical joint distribution, enthesal inflammation, the inflammatory back disease, and the extra-articular features common to the group, including iritis, mucous membrane lesions, urethritis, bowel inflammation, tendinitis, and heart disease. However, there are differences in sex distribution, level of pain, symmetry, presence of peripheral arthritis, and prevalence of HLA-B27 between patients with PsA and patients with ankylosing spondylitis. Since PsA consists of peripheral joint disease, back disease, and skin disease, it makes sense to concentrate efforts on understanding this disease as a unique entity.

How often do patients with PsA have spondylitis?

About 40% of patients with PsA have spondylitis. Since most have peripheral arthritis, that would be the frequency overall. One study has found that the frequency of sacroiliitis may be as high as 78% in patients participating in a drug trial. Interestingly, more patients with PsA and spondylitis are HLA-B27 negative.

Abbreviations: PsA, psoriatic arthritis; RA, rheumatoid arthritis

What about bowel inflammation in PsA?

At least one group had suggested that there is an increased frequency of bowel disease in patients with PsA, just as is seen in ankylosing spondylitis. Perhaps we are looking at one giant spectrum but picking out subsets based upon what we are most interested in. It is hoped that the CLASSification of Psoriatic ARthritis (CASPAR) study will help sort this out.

How does the quality of life of people with psoriasis or psoriatic arthritis differ from other chronic inflammatory disorders?

Two studies have shown that the quality of life of patients with PsA (using the Health Assessment Questionnaire (HAQ)

and Medical Outcome Survey Short Form 36 (SF-36)) is reduced compared with the general population and is similar to that of patients with RA. Specific instruments have been developed for PsA and ankylosing spondylitis; these still need to be tested in these conditions to detect differences.

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