Background: Fatigue is a major problem in various rheumatic diseases. Only a few studies so far have focused on the occurrence of fatigue in psoriatic arthritis (PsA) [2].

Objectives: The aim of this study was to explore the prevalence and impact of fatigue in patients with PsA and its potentially association with disease activity in daily routine rheumatologic care.

Methods: 105 consecutive outpatients with definitive PsA (mean age 62 years, mean disease duration 8 years) were included in this prospective study. Patients received a clinical examination and laboratory tests. Furthermore, following assessments were used: assessment of disease activity (patient (PG) and physician global (PhG), NRS, 0–10), DAS28, CDAI, pain (NRS, 0–10), HAQ, SF-36, fatigue (NRS (0–10) and Chalder Fatigue Scale (CFS; bimodal: 0–3 no fatigue, 4–11 fatigue; Likert scale: 0–3 no fatigue, 4–33 fatigue, 19–33 severe chronic fatigue syndrome) [2].

Results: In the CFS questionnaire 56/105 patients (53%) were classified as fatigue cases (bimodal score >4). 22/105 (21%) suffered from severe fatigue/chronic fatigue syndrome (score >19, Likert scale). Mean fatigue was 14.9 (CFS, Likert Scale) and 4.5 (NRS). In n=47 (45%) patients fatigue was present <3 months, in 22 (21%) patients 3–6 months, whereas in n=34 (32%) >6 months. Intraday fatigue occurred in 75–100% of full daytime in 20 patients (19%).

An extensive impairment of the health related quality of life has been shown in all categories of SF36 (PF=46, RP=52, BP=42, GH=53, V=45, SF=74, RE=51, MH=68). Fatigue strongly correlated with 6 dimensions of SF36: RP r= –0.61, BP r= –0.73, GH r= –0.66, VI r= –0.79, SF r= –0.54, MH r= –0.59.

On average disease activity was low (mean DAS28 = 2.5) with a range from 0.5 to 7.8. Fatigue strongly correlated with the PG (r=0.72) as well as with DAS28 (r=0.49), CDAI (r=0.57), pain (r=0.71), tender joint count (r=0.41), and HAQ (r=0.57). The PhG showed only a poor correlation with fatigue (r=0.29).

There was no correlation with ESR (r=–0.01), CRP (r=0.14) and swollen joint count (r=0.17).

63/105 (60%) patients were in DAS28 remission (DAS28 < 2.6) but 24/63 (38%) of them suffered from fatigue. 39/105 (37%) patients were exhibiting DAS28 disease activity (DAS28 > 2.6). All these patients suffered from fatigue, 29/39 (74%) had severe fatigue.

Conclusion: Our results show that fatigue is a major problem in PsA with relevant impact on the health related quality of life. The relatively high percentage of patients suffering from fatigue despite clinical remission or low disease activity suggests that fatigue could be an independent outcome criterion in PsA that should be considered as an additional dimension of remission.

It seems that the clinical routine assessments of disease activity including laboratory tests and PhG do not identify fatigue in PsA sufficiently. Therefore a standardized acquisition of fatigue should be part of studies and daily routine care for PsA patients.

References:


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