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ASSOCIATION BETWEEN CENTRAL SENSITIZATION AND CLINICAL AND ULTRASONOGRAPHIC PARAMETERS IN INFLAMMATORY ARTHRITIDES

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Background: Central sensitization (CS) is an important feature of patients with chronic pain, especially rheumatoid arthritis (RA) and psoriatic arthritis (PsA) patients. CS might interfere with the clinical evaluation of inflammation. Central Sensitization Inventory (CSI) is a validated instrument for assessing central sensitization.

Objectives: We seek to investigate the inference of central sensitization (assessed with the CSI) on clinical (disease activity scores) and ultrasound parameters (US 7-joints score) in RA and PsA patients.

Methods: We conducted a cross-sectional analysis on patients with an established diagnosis of RA or polyarticular PsA. Demographic, anamnestic and clinical parameters were collected. Disease activity was measured with SDAI in RA patients and with DAPSA in PsA patients. The presence and severity of synovitis was measured with the US 7-joints score. Exclusion criteria included: diagnosis of fibromyalgia, depression and patients with PsA with enthesitis predominant and/or spondylitis subtypes. Differences between variables were analysed with t-test and ANOVA for multiple comparisons. Correlation between continuous variables was analysed with Pearson correlation. CSI was analysed either as positive/negative (threshold 40 points) or divided in four categories, i.e., subclinical (≤ 29), mild (30-39), moderate (40-49), severe (50-59) and extreme (≥ 60).

Results: We enrolled 42 patients in the study. Descriptive characteristics of the study population are presented in table 1. We found no difference in clinical parameters between diseases, sex or age. Women had a higher CSI score compared to men (mean 39.3 vs 26.7 $p=0.005$). We found a correlation between CSI score and DAPSA (r^2 0.39, $p=0.001$), number of tender joints (r^2 0.13, $p=0.02$) and HAQ (r^2 0.47, $p<0.001$) (Figure 1) while we found no correlation between CSI score and SDAI or other clinical parameters. We found a significant difference in DAPSA, tender joints count and HAQ between CSI categories (ANOVA $p=0.01$, $p=0.02$ and $p<0.001$ respectively). US 7-joints score was associated with SDAI (r^2 0.33, $p=0.03$), number of swollen joints (r^2 0.28, $p=0.002$) and disease duration (r^2 0.35, $p<0.001$) but not with DAPSA or tender joints.

Table 1. Descriptive characteristics of the study population

Age (mean, SD in years)	55.9 (12.3)
BMI	25.9 (3.9)
CSI questionnaire score (mean)	35 (16)
CSI categories (n, %)	Subclinical 18 (42.9%) Mild 9 (21.4%) Moderate 8 (19.0%) Severe 4 (9.5%) Extreme 3 (7.1%)
Diagnosis (n, %)	PsA 52.4% 9 men 13 women RA 47.6% 2 men 18 women
CSI score in PsA (mean, SD)	34.4 (16.5)
CSI score in RA (mean, SD)	34.8 (15.5)
CRP (median, IQR in mg/L)	1.85 (1.0-4.6)
Tender joints (mean, SD)	2 (2)
Swollen joints (mean, SD)	1 (2)
SDAI categories (n, %)	Remission 4 (20.0%) Low disease activity 8 (40.0%) Moderate disease activity 7 (35.0%) Severe disease activity 1 (5.0%)
DAPSA categories (n, %)	Remission 6 (33.3%) Low disease activity 4 (22.2%) Moderate disease activity 7 (38.9%) Severe disease activity 1 (5.6%)
US 7-joints score (mean, SD)	6 (7)
HAQ (mean, SD)	0.6 (0.6)
Prednisone equivalent (mean, SD in mg/day)	1.47 (3.2)
Biological DMARD (n, %)	No 15 (35.7%) Yes 27 (64.3%)
Conventional DMARD (n, %)	No 13 (31.0%) Yes 29 (69.0%)

Figure 1. Correlation between DAPSA score and CSI score and between HAQ and CSI score

Conclusion: We found an association between CS and sex, functional disability, tender joints count and disease activity score in PsA patients while there was no correlation between RA disease activity and central sensitization. US 7-joints score was associated with swollen joints count, disease duration and disease activity in RA patients but not in PsA patients. In PsA patients, DAPSA might be more influenced by central sensitization, especially in female individuals.

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EXPERIENCE USING DIFFERENT CRITERIA OF FIBROMYALGIA IN PATIENTS WITH ANKYLOSING SPONDYLITIS: 1990 AMERICAN COLLEGE OF RHEUMATOLOGY CLASSIFICATION CRITERIA VS. NEW

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Background: Fibromyalgia (FM) is a very frequent condition in patients with diseases associated with pain syndrome, such as rheumatoid arthritis (RA), ankylosing spondylitis (AS) and other chronic rheumatic diseases. FM, RA and AS has different clinical characteristics, but can share symptoms such as pain, fatigue and sleep disturbance that leads to delay in appropriate correct diagnosis [1]. For today well known many different criteria for FM: 1990 American College of Rheumatology (ACR) classification criteria, modified 2010 ACR diagnostic criteria, 2016 Fibromyalgia Diagnostic Criteria and new AAPT Diagnostic Criteria for