PSORIATIC ARTHRITIS
CLINICAL ASPECTS

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PSORIATIC ARTHRITIS is an enthesopathy-related arthritis occurring in patients with a clinically evident psoriasis or with familial psoriasis in first or second-degree relatives.
CLINICALLY EVIDENT PSORIASIS

stable

remission

- drug induced
- spontaneous

PAST MEDICAL HISTORY
PSORIATIC ARTHRITIS could be an enthesopathy-related arthritis occurring in patients with:

- clinically evident psoriasis
- past medical history of psoriasis
- familial psoriasis
CLINICAL FEATURES OF PSORIATIC ARTHRITIS

1. articular

2. extra-articular
ARTICULAR FEATURES

1. established psoriatic arthritis
2. psoriatic arthritis “sine psoriasis”
3. early psoriatic arthritis
CLINICAL SUBGROUPS OF ESTABLISHED PSORIATIC ARTHRITIS*

1. DIP predominant
2. asymmetric oligoarthritis
3. symmetrical polyarthritis
4. predominant spondylitis
5. arthritis mutilans

*Moll and Wright - 1973
### Clinical Features of Established Psoriatic Arthritis in Large Reported Series

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>168</td>
<td>100</td>
<td>62</td>
<td>220</td>
<td>50</td>
<td>180</td>
<td>100</td>
</tr>
<tr>
<td>Asymmetric oligoarthritis (%)</td>
<td>53</td>
<td>54</td>
<td>16</td>
<td>11</td>
<td>14</td>
<td>37</td>
<td>43</td>
</tr>
<tr>
<td>Symmetric polyarthritis (%)</td>
<td>54</td>
<td>25</td>
<td>39</td>
<td>19</td>
<td>78</td>
<td>35</td>
<td>33</td>
</tr>
<tr>
<td>Distal (%)</td>
<td>17</td>
<td></td>
<td>7.5</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Back (%)</td>
<td>5</td>
<td>21</td>
<td>21</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Mutilans (%)</td>
<td>5</td>
<td></td>
<td>2.3</td>
<td>16</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Sacroiliitis (%)</td>
<td>16</td>
<td></td>
<td>27</td>
<td>36</td>
<td>20</td>
<td>20</td>
<td>15</td>
</tr>
</tbody>
</table>

Gladman D, 2004 (Revised)
Changes in pattern over time may be recorded in over 60% of the patients

Jones SM et al - 1994
PSORIATIC SPONDYLITIS

- is the most frequent subset (30%)
- may overlap with all peripheral subsets
- clinical features are less typical
**PSORIATIC SPONDYLITIS**

- asymmetric sacroiliitis
- non-marginal syndesmophytes
- low prevalence of HLA B27
- disco-vertebral erosions
PSORIATIC POLYARTHRITIS

- the second most frequent subset (20%)
- usual absence of IgM rheumatoid factor
PSORIATIC POLYARTHRITIS

- DIP joint involvement
- anterior chest wall involvement
- enthesopathies
- non-marginal syndesmophytes
- rarity of extra-articular features
PSORIATIC OLIGOARTHRITIS

• the third frequent subset (15%)
• clinical characteristic is the asymmetry of joint involvement
PSORIATIC OLIGOARTHRITIS

Dactylitis (sausage digit) is a typical feature
DACTYLITIS

Is due to swelling and inflammation in the flexor tendon sheaths, although joint synovitis, tenosynovitis and enthesitis may contribute to the clinical picture.
DISTAL INTERPHALANGEAL ARTHRITIS

- is the hallmark of the condition
- it may occur as an exclusive finding (5%) or may complicate all other articular subsets
ARTRITIS MUTILANS

- It is the most rare subset (1%) of arthritis.
- It is characterized by a progressive osteolysis of phalanges or metacarpal bones.
EXTRA-ARTICULAR FEATURES

- eye involvement
- heart involvement
- gut involvement
GUT INVOLVEMENT IN PSORIATIC ARTHRITIS

- Increase in lamina propria cellularity with lymphoid aggregates (100%)
- Neutrophilic polymorph infiltration (60%)
- Glandular atrophy (20%)
- Mucosal surface changes and crypt abnormalities (1%)
psoriatic disease?
PSORIATIC ARTHRITIS

“sine psoriasis”

In about 20% of patients with psoriatic arthritis, articular involvement precedes the onset of skin rash

Scarpa R. et Al - 1984
## CHARACTERISTICS OF PATIENTS STUDIED

<table>
<thead>
<tr>
<th>Patients</th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Age ± SD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With familial psoriasis</td>
<td>9</td>
<td>40.33 ± 12.27</td>
</tr>
<tr>
<td>Without familial psoriasis</td>
<td>17</td>
<td>43.71 ± 13.48</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>42.54 ± 12.93</td>
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</table>

Scarpa et Al, 2004
<table>
<thead>
<tr>
<th>Variable</th>
<th>wP n (%)</th>
<th>w/oP n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low back pain</td>
<td>19 (90.5)</td>
<td>34 (94.4)</td>
</tr>
<tr>
<td>Enthesopathy</td>
<td>17 (81.0)</td>
<td>30 (83.3)</td>
</tr>
<tr>
<td><strong>Dactylitis</strong></td>
<td><strong>13 (61.9)</strong>*</td>
<td><strong>4 (11.1)</strong></td>
</tr>
<tr>
<td><strong>DIP arthritis</strong></td>
<td><strong>15 (71.4)</strong>*</td>
<td><strong>5 (13.9)</strong></td>
</tr>
<tr>
<td>Spinal involvement</td>
<td>20 (95.2)</td>
<td>34 (94.4)</td>
</tr>
<tr>
<td>Discitis</td>
<td>14 (66.7)</td>
<td>20 (55.6)</td>
</tr>
</tbody>
</table>

* p<0.0001 wP vs w/oP (Fisher’s exact test)

Scarpa et Al, 2004
### FREQUENCY (%) OF HLA HAPLOTYPES IN 1089 CONTROLS AND IN 57 PATIENTS WITH UNDIFFERENTIATED SPONDYLOARTHRITIS, 21 WITH FAMILY HISTORY POSITIVE FOR PSORIASIS (WP) AND 36 WITHOUT (W/OP)

<table>
<thead>
<tr>
<th>HLA haplotype</th>
<th>Controls n (%)</th>
<th>wP n (%)</th>
<th>w/oP n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B 7</td>
<td>100 (9.18)</td>
<td>0 (0)</td>
<td>2 (5.60)</td>
</tr>
<tr>
<td>B 13</td>
<td>91 (8.35)</td>
<td>4 (19.00)</td>
<td>6 (16.70)</td>
</tr>
<tr>
<td>B 17</td>
<td>93 (8.60)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>B 18</td>
<td>230 (21.12)</td>
<td>3 (14.30)</td>
<td>9 (25.00)</td>
</tr>
<tr>
<td>B 27</td>
<td>28 (2.57)</td>
<td>0 (0)</td>
<td><strong>9 (25.00)</strong>&lt;sup&gt;2, 3&lt;/sup&gt;</td>
</tr>
<tr>
<td>B 38</td>
<td>57 (5.23)</td>
<td>2 (9.50)</td>
<td>7 (19.40)</td>
</tr>
<tr>
<td>Cw 6</td>
<td>223 (20.47)</td>
<td><strong>13 (61.90)</strong>&lt;sup&gt;1, 4&lt;/sup&gt;</td>
<td>5 (13.90)</td>
</tr>
<tr>
<td>DR 7</td>
<td>257 (23.61)</td>
<td>9 (42.90)</td>
<td>7 (19.40)</td>
</tr>
<tr>
<td>DR 11</td>
<td>540 (49.61)</td>
<td>10 (47.60)</td>
<td>22 (61.10)</td>
</tr>
</tbody>
</table>

1) p<0.0001 wP vs controls (Fisher’s exact test); 2) p<0.0001 w/oP vs controls (Fisher’s exact test); 3) p=0.019 wP vs w/oP (Fisher’s exact test); 4) p<0.0001 wP vs w/oP (Chi-square test)

Scarpa et Al, 2004
PSORIATIC ARTHRITIS

“sine psoriasis”

could be a seronegative spondyloarthropathy characterized by:

- familial psoriasis
- marked occurrence of dactylitis and DIP arthritis
- high prevalence of HLA Cw6

Scarpa R. et Al - 2004
EARLY PSORIATIC ARTHRITIS

includes patients with definite form (or with past medical history of psoriasis) or with the "sine psoriasis" one

Joint involvement lasts 12 weeks

Scarpa R. et Al – 2005
EARLY PSORIATIC ARTHRITIS

Oligoarthritis is the most common presentation while polyarthritis and spondylitis are less frequent

Scarpa R. et Al - 2005
## DISTRIBUTION (%) OF ARTICULAR INVOLVEMENT

<table>
<thead>
<tr>
<th>Articular involvement</th>
<th>Total n 47</th>
<th>P n 29</th>
<th>wP n 18</th>
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</thead>
<tbody>
<tr>
<td>Enthesopathy</td>
<td>53.2</td>
<td>34.5</td>
<td>83.3*</td>
</tr>
<tr>
<td>Dactylitis</td>
<td>42.6</td>
<td>31.0</td>
<td>61.1**</td>
</tr>
<tr>
<td>DIP arthritis</td>
<td>38.3</td>
<td>27.6</td>
<td>55.6***</td>
</tr>
<tr>
<td>Knee</td>
<td>29.8</td>
<td>31.0</td>
<td>27.8</td>
</tr>
<tr>
<td>Sacroiliitis (bil.)</td>
<td>14.8</td>
<td>20.7</td>
<td>5.6</td>
</tr>
<tr>
<td>Sacroiliitis (mono)</td>
<td>6.3</td>
<td>0</td>
<td>16.7</td>
</tr>
<tr>
<td>Ankle</td>
<td>19.1</td>
<td>20.6</td>
<td>16.6</td>
</tr>
<tr>
<td>Wrist</td>
<td>17.0</td>
<td>13.8</td>
<td>0</td>
</tr>
<tr>
<td>Hand</td>
<td>17.0</td>
<td>13.8</td>
<td>0</td>
</tr>
<tr>
<td>MTP</td>
<td>14.9</td>
<td>10.3</td>
<td>22.2</td>
</tr>
<tr>
<td>Elbow</td>
<td>6.4</td>
<td>10.3</td>
<td>0</td>
</tr>
</tbody>
</table>

*p=0.001; **p=0.04; p=0.055

Scarpa R. et Al - 2005
Clinical examination

With scintiscan examination

mean: 3.14

mean: 7.45

p<0.0001
Early Psoriatic Arthritis

Definite Psoriatic Arthritis

THERAPY

CHANGE OVERTIME?
Cattedra di Reumatologia
Università Federico II di Napoli
Direttore Prof. Raffaele Scarpa
Early Psoriatic Arthritis Clinic

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Direttore Prof. Fabio Ayala

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