

Dactylitis or “Sausage-Shaped” Digit

In the early 1980s, when our interest for the spondyloarthritides was born, we were impressed by a poorly defined and studied clinical manifestation of spondyloarthritis (SpA): dactylitis or “sausage-like” digit (Figures 1 and 2).

In the most popular classic rheumatologic books in Europe there was next to nothing on this manifestation. In the chapter dealing with psoriatic arthritis (PsA) in the 1978 edition of *Copeman’s Textbook of the Rheumatic Diseases*, Verna Wright wrote: “Involvement of the distal and proximal interphalangeal joints, together with tendon sheath involvement, may give the digit a sausage shape”¹. In the chapter written by Robert M. Bennett in the 1979 edition of *Arthritis and Allied Conditions* no mention was made of dactylitis². Only in the following edition, in 1985, a sentence on the topic appeared: “In some instances, involvement of a metacarpophalangeal or proximal interphalangeal joint is associated with a flexor tenosynovitis, giving the sausage-digit appearance”³.

In the 25 years that followed, important advances were made in the knowledge of this hallmark and highly specific manifestation of SpA. It is completely different from other digit diseases called dactylitis⁴. Although SpA dactylitis is more frequent in PsA⁵, it has been observed in all forms of SpA, including the undifferentiated ones⁶. Dactylitis is so specific for SpA that it was included among the clinical criteria suggested by Amor, *et al* for classification and diagnosis of the whole disease group⁷. In the European Spondylarthropathy Study Group (ESSG) study on classification criteria for the SpA group as a whole, the sensitivity and specificity of dactylitis were 17.9% and 96.4%, respectively⁶. In spite of this high specificity, dactylitis failed to be included in the best set of variables able to differentiate patients with SpA from controls. Recently, dactylitis has been included, due to its high specificity and sufficient sensitivity, in the classification criteria generated by the CASPAR (CIASSification criteria for Psoriatic ARthritis) Study Group for PsA⁸. In this study 50% of controls had rheumatoid arthritis. In undifferentiated SpA (uSpA), dactylitis usually occurs with the other manifestations of the HLA-B27-associated disease process: peripheral enthesitis, peripheral arthritis, inflammatory spinal pain, buttock pain, chest wall pain, acute anterior uveitis, and aortic regurgitation together

with conduction disturbances⁹. Like these, dactylitis may sometimes occur for a long time in isolation as the only clinically apparent manifestation of the HLA-B27-associated disease process¹⁰⁻¹³. This has been observed in children^{10,11}, in young and middle-aged adults¹², and in the elderly¹³. In addition, it should be remembered that there are patients with psoriasis who exhibit only dactylitis and/or enthesitis for months or years¹⁴.

Usually dactylitis involves few fingers and/or toes asymmetrically¹⁵⁻¹⁷. Sometimes it may simultaneously involve most of the fingers¹⁸. Like other peripheral manifestations of SpA, i.e., enthesitis and arthritis, the onset of dactylitis may be triggered by a physical injury¹⁹.

Physical examination of the dactylitic finger or toe always shows swelling and pain along the flexor tendons. In finger dactylitis, the swelling of the synovial sheaths is often so marked that the patients cannot flex the finger. So it was thought that the sausage-like appearance was due to concomitant flexor tenosynovitis and arthritis of the metacarpophalangeal (MCP) or metatarsophalangeal (MTP) and interphalangeal joints. In 1996 we used ultrasonography (US) and magnetic resonance imaging (MRI) to establish the role of tenosynovitis and arthritis in producing the sausage-like feature¹⁵. Twelve dactylitic fingers and their corresponding normal contralateral fingers were studied. The diameter of the flexor tendons and their sheaths was measured at the midpoint of the proximal phalanx on both examinations. The MCP and interphalangeal joints were examined for capsule distension and synovial proliferation. In all “sausage-like” fingers both MRI and US showed fluid collection in the flexor synovial sheaths. Of the 36 joints of the 12 dactylitic fingers, only one showed capsule distension. We concluded that dactylitis is due to flexor tenosynovitis and that the enlargement of the joint capsule is not an indispensable condition for the “sausage-like” feature. Another important conclusion was that clinical examination is a sufficient method for the diagnosis of tenosynovitis, since it showed 100% sensitivity and specificity compared with MRI. Subsequently, we showed that the same conclusions are valid for toe dactylitis¹⁶. Twelve sausage-like toes and the corresponding contralateral toes of 7 consecutive patients with SpA were studied by MRI.

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Figure 1. Dactylitis involving the second finger of the right hand.



Figure 2. Dactylitis of the second toe of the right foot.

All dactylitic toes showed fluid collection in the flexor synovial sheaths. Of the 36 joints of the 12 dactylitic toes only 2 MTP joints showed capsule distension. The only differences from the study on finger dactylitis were the presence of peritendinous soft tissue in 2 dactylitic toes and the involvement of extensor synovial sheaths in 4.

The results of our studies were confirmed by 2 other ultrasonographic studies on dactylitis^{20,21}. Both found flexor tenosynovitis in all dactylitic digits. The only difference from our studies was in the frequency of joint synovitis. Kane, *et al* found a frequency of 52%²⁰ and Wakefield, *et al* 62.5%²¹. In our 3 MRI studies on 36 dactylitic digits, we have observed a frequency of 16.6%¹⁵⁻¹⁷.

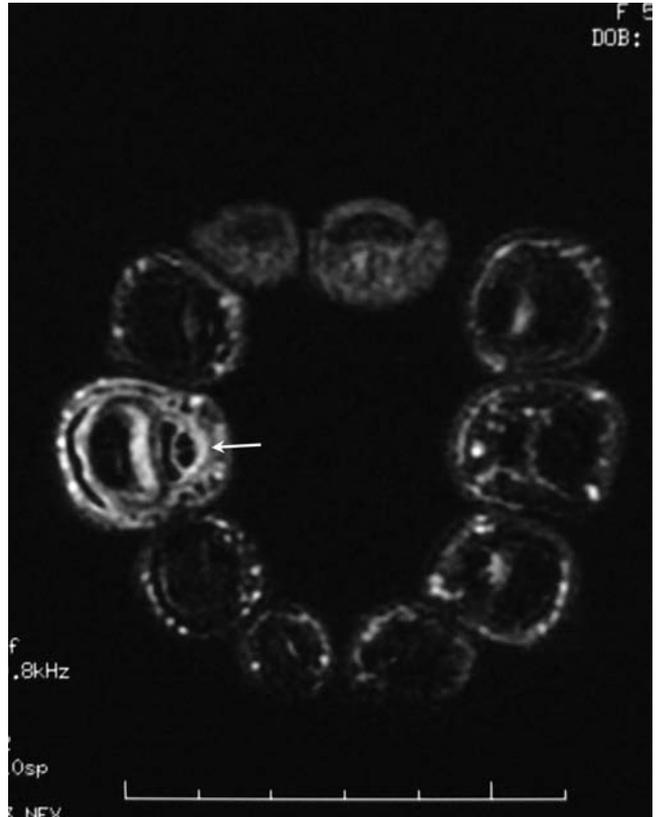
The involvement of the tenosynovial sheaths in finger

dactylitis may extend beyond the digit²²⁻²⁵. The most frequent pattern of digital and palmocarpal synovial sheaths is as follows. The index, middle, and ring fingers have synovial sheaths separate from those of the radial and ulnar bursae, which communicate, respectively, with the synovial sheaths of the thumb and the little finger. However, variants showing communication of the sheaths of index, middle, and ring fingers with the ulnar bursa are frequent. When dactylitis involves a finger with synovial sheaths communicating with the ulnar bursa, the painful swelling also extends into the palm of the hand^{22,23}. In addition, in dactylitis of the first and fifth fingers, synovial inflammation may spread to the radial and ulnar bursa, respectively^{24,25}.

Recently, McGonagle and colleagues hypothesized that

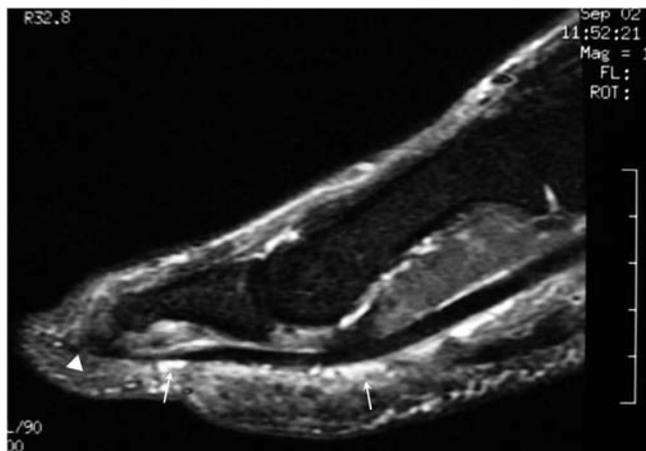


A

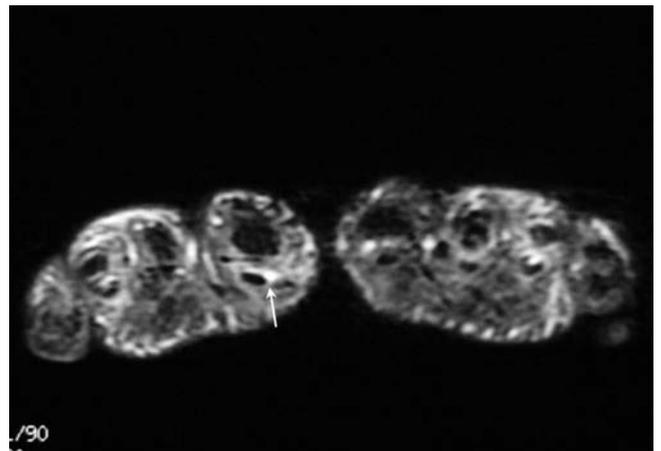


B

Figure 3. Finger dactylitis. Sagittal gradient-echo T2-weighted (A) and axial fast spin-echo T2-weighted image with fat saturation (B) showing fluid/synovitis in the flexor synovial sheaths (arrows), subcutaneous edema extending all around the circumference, and normal flexor and adjacent bone (arrowheads).



A



B

Figure 4. Toe dactylitis. Sagittal (A) and axial (B) FSPGR (fast spoiled gradient-echo) T1-weighted image with fat saturation obtained after contrast administration showing fluid/synovitis together with vascularization in the flexor synovial sheaths (arrows) and normal flexor entheses and adjacent bones (arrowhead).

enthesitis is the primary lesion in SpA, while synovitis of the various structures (joint, tendon, and bursa) represents a secondary phenomenon due to release of proinflammatory cytokines from the inflamed entheses^{26,27}. In their opinion,

flexor tenosynovitis of dactylitis is due to enthesitis caused by diffusion of cytokines along the tenosynovial sheaths²⁸. In a recent study we demonstrated, using fast spin-echo (FSE) T2-weighted sequences with fat saturation, that in

SpA dactylitis there is no evidence of enthesitis of the flexor digitorum tendons and joint capsule (Figure 3)¹⁷. The same seems to occur in toe dactylitis (Figure 4). McGonagle, *et al* have replied that in the digit there are also numerous “functional entheses” that are associated with the presence of fibrocartilage and that these may be the site of the primary inflammation in dactylitis²⁹. This could be true, because at the 2006 EULAR meeting the Leeds group reported signs of enthesitis together with joint synovitis, adipose tissue edema, and tenosynovitis³⁰. Future MRI studies on dactylitis should examine the enthesal insertions along the digit by using high resolution sequences. These studies should also examine the nail, since MRI nail findings have been shown to exist also in patients without onychopathy³¹.

Lately, Brockbank, *et al* have suggested that dactylitis can be a marker of disease progression in PsA³². They have observed increased radiological progression in digits showing dactylitis compared with those without the sausage-like aspect. The Group for Research and Assessment of Psoriasis and Psoriatic arthritis (GRAPPA) has proposed evidence based guidelines for PsA categorized by disease characteristics and disease organ involvement including dactylitis³³. Therapy for dactylitis usually begins with nonsteroidal anti-inflammatory drugs and local corticosteroid injections³⁴. Conventional disease modifying antirheumatic drugs (DMARD) and anti-tumor necrosis factor- α blocking agents such as infliximab can be used. So far, a valid, reliable, and responsive clinical outcome measure for dactylitis has not been used in clinical trial on PsA.

In this issue of *The Journal*³⁵ Healy and Helliwell test the responsiveness of the Leeds Dactylitis Index (LDI)³⁶ and its modified version (LDI-basic) in 28 patients with PsA receiving conventional DMARD or etanercept. They demonstrate that these measures meet the requirements for truth, discrimination, and feasibility of the OMERACT filter and could be used in future randomized trials on PsA.

Today we know more about dactylitis than 25 years ago. We hope that even more knowledge may soon be acquired on this interesting manifestation of SpA.

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