On Defining Musculoskeletal Inflammation: A Report from the GRAPPA 2011 Annual Meeting

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ABSTRACT. At the 2011 annual meeting of the Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA), members discussed the need to develop a framework for defining inflammatory arthritis, enthesitis, dactylitis, and spondylitis, particularly as they relate to psoriatic arthritis (PsA). GRAPPA members first addressed this subject at their 2010 meeting, where the CASPAR (Classification of Psoriatic Arthritis) criteria were discussed. Although these are classification criteria, the CASPAR are also often applied as a diagnostic measure by clinicians screening for PsA, particularly its core criterion: recognizing the presence of inflammatory musculoskeletal disease. In breakout group discussions, GRAPPA members discussed the difficulties in recognizing overlapping or mimicking features that may result in underdiagnosing or misdiagnosing PsA. (J Rheumatol 2012;39:2214–15; doi:10.3899/jrheum.120827)

Psoriatic arthritis (PsA), described in early studies as a disease with mild prognosis, has now been recognized for its potential for joint damage and functional disability outcomes similar to rheumatoid arthritis (RA). Because of this, a high degree of suspicion should exist for recognizing the presence of PsA among caretakers of psoriasis patients, and ideally, for discriminating other causes of musculoskeletal (MSK) pain. Because a significant proportion of psoriasis patients may have MSK problems that do not necessarily establish a diagnosis of PsA, the clinical recognition of PsA has been a challenge, even among rheumatologists.

In a review of medical records from patients with psoriasis presenting to one interdisciplinary clinic that included a rheumatologist, MSK pain was attributable in 43% of patients to osteoarthritis, gout, or fibromyalgia. In this report from the 2011 annual meeting of the Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA) also, the authors’ experiences in their respective interdisciplinary clinics reflect a variety of diagnoses other than PsA that account for joint and other MSK pain. Conversely, many patients go undiagnosed with PsA for long periods because their source of pain is considered to be degenerative, mechanical, or traumatic and not inflammatory in nature.

The discussion of a single sensitive and specific diagnostic measure for PsA was begun in an earlier meeting (2010) of GRAPPA, where members discussed the CASPAR criteria. Although these are classification criteria, the CASPAR are also often used as diagnostic criteria. While this may be an incorrect use, there is some evidence that they may be relevant in this context. Therefore, it is appropriate to provide a better definition of the core criteria of CASPAR: recognizing the presence of inflammatory MSK disease. This is required because not all psoriasis patients who have articular symptoms may be classified as having PsA. The accurate identification of inflammatory features (erythema, warmth and swelling, prominent morning and rest stiffness, pain involving joints, spine, and/or enthesium, and laboratory or imaging abnormalities) may not be intuitive to dermatologists, who are in an optimal position to identify PsA arising in a patient with psoriasis.

Osteoarthritis and gout may coexist with psoriasis and mimic presentations of PsA. Features that distinguish osteoarthritis from PsA (distal and proximal interphalangeal joints) or degenerative Achilles tendinitis from PsA enthesitis may not be obvious to the untrained clinician, or sometimes to the experienced one. Even basic clinical features that may overlap, such as patterns of joint involvement, presence of swelling, and morning stiffness, present a dilemma in recognizing PsA. Alternatively, patients with psoriasis-like eruptions (i.e., seborrhea) and concomitant inflammatory arthritis such as RA or ankylosing spondylitis may be misdiagnosed with PsA.

In breakout group discussions at the 2011 meeting, GRAPPA members expanded on the need for better diagnostic criteria to identify PsA arising in a patient with psoriasis.
text of PsA in a manner that would have utility across clinical settings.

Practical definitions of inflammatory arthritis, enthesitis, dactylitis, and spondylitis must include individual features such as location and number of swollen or tender joints, warmth, swelling, erythema, duration of involvement, duration of morning stiffness, pain, constitutional symptoms, acute-phase reactants, and specific imaging findings. A research project to develop definitions of MSK inflammation in PsA will be proposed at the GRAPPA annual meeting in June 2012.

REFERENCES