Magnetic Resonance Imaging in Psoriatic Arthritis — Update on Current Status and Future Perspectives:
A Report from the GRAPPA 2010 Annual Meeting

MIKKEL ØSTERGAARD and RENÉ PANDURO POGGENBORG

ABSTRACT. The potential of magnetic resonance imaging (MRI) for use in clinical practice and research has gained increasing interest over the last decade. International collaborative initiatives from GRAPPA (Group for Research and Assessment of Psoriasis and Psoriatic Arthritis) and/or OMERACT (Outcome Measures in Rheumatology) may contribute to facilitating research, identifying appropriate areas for use, and reaching consensus on the optimal examination technique. Accordingly, GRAPPA, a primary driver of international research in psoriasis and psoriatic arthritis (PsA), has focused on the current use and future development of MRI and other modern imaging modalities in PsA. This review, presented at the GRAPPA 2010 annual meeting, describes the current status of MRI in PsA, with a focus on its use in diagnosis, monitoring, and prediction of the disease course and treatment response. Important areas for future research are also outlined. (J Rheumatol 2012;39:408–12; doi:10.3899/jrheum.111235)

Key Indexing Terms:
PSORIATIC ARTHRITIS  MAGNETIC RESONANCE IMAGING  ARTHRITIS  GRAPPA

MRI Findings in Psoriatic Arthritis
The clinical appearance of psoriatic arthritis (PsA) is varied, involving axial and peripheral joints and periarticular structures such as entheses. Similarly, magnetic resonance imaging (MRI) findings are diverse. PsA shares clinical manifestations with rheumatoid arthritis (RA) and spondyloarthritis (SpA), including MRI features1.

MRI can visualize peripheral and axial musculoskeletal anatomy as well as disease manifestations, including synovitis, enthesitis, tenosynovitis, tendonitis, peritendonitis, soft tissue edema, bone edema, bone erosion, and bone proliferation (Figures 1 and 2)2,3,4. MRI features like synovitis and erosions are not disease-specific to peripheral PsA, and MRI bone edema can involve any bone. In SpA, dactylitis has been shown on MRI to be due to tenosynovitis with effusion, sometimes associated with diffuse soft tissue edema and/or synovitis in nearby finger or toe joints5,6. There are few MRI studies in axial PsA, but findings are similar to those in ankylosing spondylitis, although more frequently asymmetric7. The enthesis has attracted attention as a possible primary location of disease8. Nail disease is common in PsA, and distal interphalangeal (DIP) joint inflammation on MRI has been described to extend to the nail bed9.

How to Perform MRI in PsA?
General agreement on which joints to image to assess PsA activity and damage is not established and probably should be individualized based on disease pattern. Often the hand with the highest clinical disease activity is examined. Generally, T1-weighted sequences should be in 2 planes, supplemented by a T2-weighted fat-suppressed or short-tau inversion recovery sequence, preferably also in 2 planes. Intravenous contrast injection is optimal for assessment of synovitis and tenosynovitis, but can be omitted if the aim is purely to detect bone erosion, bone edema, and/or bone proliferation2.

Differential Diagnostic Value of MRI
Most studies have compared patients with known diagnoses. MRI has generally not been able to distinguish between peripheral PsA and RA1, even though some findings (e.g., periostitis) are characteristic for PsA10, and dynamic contrast-enhanced MRI has shown similar patterns in PsA as in RA11,12 and in osteoarthritis (OA)13.

Of note, no studies have documented that MRI in an early undifferentiated arthritis cohort can be used to differentiate PsA from other arthritides.

MRI in Psoriasis without Clinical Signs of Arthritis
PsA can be clinically silent. In patients with psoriasis without arthritic signs or symptoms, pathological findings on MRI (including periarticular edema, tendon sheath effusion, intraarticular effusion, synovial pannus, bone erosion, bone cysts, subchondral changes, and joint subluxation) have been reported in more than two-thirds (68%–92%) versus 0–1 in 12 healthy controls14,15,16. The clinical importance of these find-
ings, especially the predictive value regarding development of clinical PsA, is not yet clarified.

**Monitoring with MRI**

Most studies report only qualitative MRI assessments of the different pathologies of PsA. Quantitative assessment of contrast enhancement has been reported, but is insufficiently validated for clinical use. Several scoring systems for synovitis, bone marrow edema, and/or erosions have been described, but most have been limited to a few patients. In a study of 11 patients with PsA treated with the anti-tumor necrosis factor (TNF) agent adalimumab for 24 weeks, MRI of a wrist or knee showed significant improvements from baseline at 24 weeks in both clinical measures of disease activity and in MRI bone marrow edema and effusion, but not in synovitis. Therapy-induced decreases in dactylitis (clinical and MRI assessments) have also been observed.

The international MRI in inflammatory arthritis group of OMERACT (Outcome Measures in Rheumatology) has developed the OMERACT Psoriatic Arthritis Magnetic Resonance Image Scoring System (PsAMRIS) for evaluation of inflammatory and destructive changes in PsA hands. This system is the most validated assessment system available, and has a documented good intra- and inter-reader reliability for status scores of all variables. For the inflammatory variables, the intra- and inter-reader reliability were high for change scores, and the sensitivity to change was moderate. The damage measures, i.e., bone erosion and bone proliferation, showed very limited change after 1 year of TNF inhibitor therapy.

In a recent placebo-controlled trial, 22 patients with PsA were randomized to receive the bisphosphonate zoledronic acid or placebo. Bone edema scored according to PsAMRIS decreased significantly in the zoledronic acid group, but not in the placebo group. No differences in MRI bone proliferation or bone erosion progression could be identified.

In another recent randomized controlled PsA trial, MRI synovitis, bone edema, and bone erosion scored according to the OMERACT RAMRIS (the RA equivalent of PsAMRIS, using similar definitions of pathologies) were applied as exploratory endpoints in the comparison of treatment with abatacept and placebo. Synovitis and bone edema decreased in the abatacept-treated patients, whereas it increased slightly in the placebo group. These studies suggest that the OMERACT scoring systems could be useful as sensitive outcome measures in PsA clinical trials. Longitudinal, randomized MRI data similar to the abatacept study would be well suited for further validation of the PsAMRIS system, particularly the

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*Figure 1.* Tenosynovitis, synovitis, bone marrow edema, and periarticular inflammation. Axial T1-weighted precontrast (A) and postcontrast (B) MR images of the 3rd (left) and 4th (right) finger at the level of the 4th proximal interphalangeal (PIP) joint; and sagittal STIR MR image (C) of the 4th finger. Tenosynovitis (short white arrows) is seen in the 3rd flexor tendon sheaths in (B) and more proximal in the 4th tendon sheath in (C). Synovitis (short black arrow), bone marrow edema (long black arrow), and considerable periarticular inflammation (long white arrows) around the 4th PIP are also seen.
sensitivity to change (standardized response mean and effect size) of its various components.

**Prognosticating with MRI**
Based on a cross-sectional MRI study of 11 patients with the aggressive arthritis mutilans (AM) form of PsA and 17 patients without AM (erosive PsA without bony lysis), in which there was a close association between presence of erosion and bone edema, the authors suggest that MRI bone edema in PsA is a forerunner of structural joint damage. Longitudinal studies are needed to clarify the prognostic significance of various MRI findings in PsA.

**Axial MRI in PsA**
Information about MRI of axial involvement in PsA originates primarily from studies of spondyloarthritis (SpA) in general. In patients with axial SpA, MRI can identify active disease (inflammation) and structural “chronic” lesions (erosion, fat infiltration, spurs/ankylosis) in the sacroiliac joints and spine. MRI permits early diagnosis of axial SpA. The clinical value of MRI in the monitoring and prognostication of axial PsA requires further research.

**Whole-body MRI and Dynamic Contrast-enhanced MRI**
Whole-body MRI can visualize the entire body at one MRI examination and will potentially allow simultaneous assessment of peripheral and axial disease manifestations. Disadvantages of whole-body MRI include a lower image resolution than conventional MRI and a suboptimal slice positioning for the individual joint regions. Validation in PsA is required.

Dynamic contrast-enhanced (DCE) MRI data from patients with PsA are scarce, but in a small study of wrists in PsA and RA patients, no difference in synovial dynamic contrast enhancement measures was observed between the PsA and RA patients (matched for disease activity), but all PsA patients had significantly higher enhancement than healthy controls. In another comparative study of 10 PsA and 10 RA patients with at least 1 swollen metacarpophalangeal joint, conventional and DCE-MRI was unable to differentiate between the diagnoses, but more diffuse extracapsular enhancement/enthesal-based pathology was found in patients with PsA. Two recent studies compared DCE-MRI in PsA versus OA and RA and found no statistically significant differences in the early enhancement rates. DCE-MRI has not yet been systematically investigated as an outcome measure of PsA disease activity.

**Conclusion**
In summary, MRI is an excellent tool for evaluation of patients with PsA, because both peripheral and axial disease manifestations can be detected and monitored. However,
are poor predictors of sacroiliitis diagnosed by magnetic resonance imaging in psoriatic arthritis. Rheumatology 2004;43:85-8.

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