

Screening Instruments for Psoriatic Arthritis

To the Editor:

In a recent study, Walsh, *et al*¹ sought to compare 3 published, validated screening tools for psoriatic arthritis (PsA): the Psoriasis Epidemiology Screening project (PEST), the Toronto Psoriatic Arthritis Screen (ToPAS), and the Psoriatic Arthritis Screening and Evaluation (PASE)^{2,3,4,5}. We would like to address how PASE may not have been appropriately compared in this setting.

The PASE questionnaire, developed by our group, is the only one of these 3 tools where scores have demonstrated sensitivity to change with disease activity⁶. PASE has similarly been shown to correlate with response to therapy⁷. PASE was designed to screen for symptoms of inflammatory musculoskeletal disease among patients with psoriasis, as seen in the dermatology clinic (not necessarily in the rheumatology clinic or primary care). Specifically, the rationale was to screen patients with psoriasis who were not undergoing systemic therapy, but who may need additional systemic therapy with methotrexate or biologics for inflammatory arthritis.

These points are further evidenced by the findings by Walsh, *et al*¹ that the PASE questionnaire had the highest sensitivity and specificity when used in patients who were not on systemic therapy (Table 2). This distinction regarding screening patients on and off systemic therapy is critically important. Among participants without previous PsA diagnosis and not on immune modulatory therapy, the sensitivity for PsA is highest with the use of PASE44 than with any of the other tools reviewed (73%). This information was not included in the abstract.

The PASE questionnaire, having been designed as a screening tool for use in the dermatology clinic among patients with known psoriasis, allows PASE to remain a brief, clinically relevant screening tool. In the study by Walsh, *et al*¹ the ToPAS questionnaire was completed by a smaller number of participants compared to the shorter PASE and PEST tools. There is no need for psoriasis screening and an increased burden on respondents with the PASE tool because it assumes the presence of dermatologist-diagnosed psoriasis.

In Table 4 of their article, PASE distinguishes the majority of the PsA traits compared to any of the other tools. PASE cannot be assessed for skin indicators as it was designed to be a low-burden tool for PsA screening in the patient with known psoriasis.

The PASE questionnaire scores correlate with PsA disease activity and response to therapy, its sensitivity is highest and it performs better in patients naive to systemic therapy based on this study, and it is a brief and practical screening tool focused on the patient with diagnosed psoriasis in the dermatology clinic. We agree that other PsA screening tools may be useful in different settings. Early diagnosis and treatment of PsA can have a positive influence on these patients. We emphasize that when comparing screening tools, it is helpful to be aware of the underlying premise of the tools and their appropriate clinical use.

JOSEPH F. MEROLA, MD, Department of Dermatology, Department of Medicine, Division of Rheumatology, Allergy and Immunology, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts; M. ELAINE HUSNI, MD, MPH, Department of Rheumatologic and Immunologic Disease, Cleveland Clinic, Cleveland, Ohio; ABRAR A. QURESHI, MD, MPH, Department of Dermatology, Channing Division of Network Medicine, Department of Medicine, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts, USA. Address correspondence to Dr. A.A. Qureshi, Department of Dermatology, Brigham and Women's Hospital, 221 Longwood Avenue, Boston, MA 02115, USA; E-mail: aqureshi@bics.bwh.harvard.edu

Dr. Qureshi has licensed the PASE questionnaire to Merck and Pfizer, has received a grant from Amgen, and has been a consultant for Jansen, Novartis, and Abbott. Dr. Merola is a consultant for Biogen IDEC. Dr. Husni has licensed the PASE questionnaire as above, and has also served as a consultant for UCB, Amgen, Novartis, Bristol Myers Squibb, and Abbott.

REFERENCES

1. Walsh JA, Callis Duffin K, Krueger GG, Clegg DO. Limitations in screening instruments for psoriatic arthritis: A comparison of instruments in patients with psoriasis. *J Rheumatol* 2013;40:287-93.
2. Dominguez PL, Husni ME, Holt EW, Tyler S, Qureshi AA. Validity, reliability, and sensitivity-to-change properties of the psoriatic arthritis screening and evaluation questionnaire. *Arch Dermatol Res* 2009;301:573-9.
3. Gladman DD, Schentag CT, Tom BD, Chandran V, Brockbank J, Rosen C, et al. Development and initial validation of a screening questionnaire for psoriatic arthritis: The Toronto Psoriatic Arthritis Screen (ToPAS). *Ann Rheum Dis* 2009;68:497-501.
4. Husni ME, Meyer KH, Cohen DS, Mody E, Qureshi AA. The PASE questionnaire: pilot-testing a psoriatic arthritis screening and evaluation tool. *J Am Acad Dermatol* 2007;57:581-7.
5. Ibrahim GH, Buch MH, Lawson C, Waxman R, Helliwell PS. Evaluation of an existing screening tool for psoriatic arthritis in people with psoriasis and the development of a new instrument: The Psoriasis Epidemiology Screening Tool (PEST) questionnaire. *Clin Exp Rheumatol* 2009;27:469-74.
6. Soriano ER, McHugh NJ. Therapies for peripheral joint disease in psoriatic arthritis. A systematic review. *J Rheumatol* 2006; 33:1422-30.
7. Husni ME, Qureshi AA, Koenig AS, Pedersen R, Robertson D. Utility of the PASE questionnaire, psoriatic arthritis (PsA) prevalence, and PsA improvement with anti TNF therapy: results from the PRISTINE trial. *J Dermatolog Treat* 2013 May 20. [E-pub ahead of print]

J Rheumatol 2013;40:9; doi:10.3899/jrheum.130474