

How Should We Evaluate Psoriatic Arthritis? What Is the Best Method?

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If the recently approved CASPAR¹ criteria (classification of psoriatic arthritis) demonstrate their usefulness, after undergoing validation by different task forces, an important step will have been taken for the unification of criteria when studying such a complex inflammatory disease as psoriatic arthritis (Psa). However, several aspects need a more precise definition that allows the clinician to understand which are the symptoms or signs that define an inflammatory joint disease in which arthritis, spondylitis, or enthesitis can converge. The precise definition of these points is fundamental, not only to accurately classify Psa, but also to establish which are the more appropriate measurement tools to evaluate the different aspects of the disease.

One of the more serious problems for evaluation of Psa is that it presents different patterns of joint affection. In this way, throughout time, modifications have been made to the 5 different types of joint involvement, without a clear consensus on how to carry out this classification in Psa. With the existing data published in the literature one can conclude that mutilans forms represent a complication of disease,² while distal isolated affection, though it can be maintained for a time, can also be associated to other types of joint affection. It is believed that the difference between the polyarticular and oligoarticular forms is merely quantitative; in addition, the progression of one form to another is frequent over the course of the disease (with or without influence of treatment). Finally, there is a form of axial affection (axPsa) that is not defined and currently represents a problem in the definition of the disease. From a clinical standpoint, an operative definition must include the largest number of dominions and therefore obtain the largest amount of information possible on the disease affecting the patient; in that sense, an operative definition of joint affection in Psa could be classifying it

into pure peripheral or axial forms, taking into account that an elevated percentage of the latter forms have a relevant peripheral component and these could be considered, on most occasions, mixed forms.

Taking the previous considerations into account, dominions of special interest regarding the evaluation of activity and therapeutic response in Psa are centered on joint affection, its peripheral or axial component, enthesitis, dactylitis and skin, and nail affection.³ Currently there is no validated instrument useful for specifically evaluating the activity or psoriatic arthritis, though the Psa response criteria (PsARC) or the modified response criteria of the American College of Rheumatology (ACR) have been employed in clinical trials, the information provided is relative to the patients previous baseline state, making the usefulness of its application questionable at best when it comes to evaluating disease activity in daily clinical practice. DAS (disease activity score), DAS-28, and the EULAR response criteria allow for the evaluation of disease and the therapeutic response in patients with rheumatoid arthritis (RA); however, these instruments employed in RA have not been validated for Psa and there are certain doubts regarding its usefulness in this affection; studies done to analyze patients in the context of clinical trials also indicate its utility⁴; nonetheless, a current study in the clinical practice environment poses serious questions on its trustworthiness.⁵ DAS in the clinical practice of Psa care does not “capture” axial disease, arthritis affecting the feet, or the distal interphalangeal (DIP) joints, and in patients with Psa would seem to measure 2 different aspects of the disease. Therefore, studies that lead adaptation and validation of this instrument for the evaluation of the peripheral forms of Psa, such as the evaluation of a version of DAS that adds the DIP hand and feet joints, are necessary.

Preliminary studies indicate that the axPsa forms could be defined according to, at least, 2 of the following criteria: clinical (pain), physical (rigidity), and radiologic (sacroiliitis) aspects (GRAPPA meeting, Washington, 2006); however, there are no currently accepted criteria for this definition as well as no validated instruments for the evaluation of activity and therapeutic response of the axPsa forms. Preliminary studies show that the measurements employed in ankylosing spondylitis are useful in the forms of axPsa

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Manuscript received May 5, 2007; accepted for publication May 22, 2007.

(INSPIRE study, OMERACT, Malta, 2006); in addition, when classifying these forms with a radiologic criterion, these measurements are capable of discriminating between the axial and peripheral forms.⁶ The results regarding the usage of BASDAI in the axPsa varieties is controversial and a study that classified patients in the axPsa forms depending on the signs or symptoms did not find any differences with the BASDAI between the axial and peripheral forms,⁷ but if the classification is done according to radiologic criteria, BASDAI is capable of discriminating among the 2 forms.⁸ This shows that studies are necessary in large sets of patients with axPsa to clarify these aspects and define the most appropriate measures to evaluate the disease.

Enthesal affection in Psa has received more attention in the past few years; however, the lack of an ample consensus for the use of a validated measurement instrument is complicating the integration of its evaluation as one more systematic component of the activity of Psa. Diverse data indicates that enthesitis, evaluated through the MASES index, is associated to the activity of Psa.⁹ Therefore, if enthesitis in Psa is one more component of the inflammatory process, any instrument proposed for the evaluation of activity of Psa will have to evaluate the entheses in a systematic way.

Though dactylitis is a specific characteristic of Psa and in spite of the development of a validated instrument for its measurement (Helliwell, personal communication), the fact that its presence can be assumed in the clinical practice as arthritis and that it requires more time for evaluation, makes it unlikely that its specific evaluation can be integrated in the general evaluation of the activity of Psa. Some dominions of Psa, which are not well limited with regard to who must evaluate it in patients with arthritis, are skin and nail affection. The most accepted instrument,¹⁰ though with some controversy, is the PASI (psoriasis area and severity index) and the BSA (body surface area), while for nail affection there has been a recent publication of an index that modifies its evaluation, the mNAPSI¹¹ (modified nail psoriasis severity index). It seems reasonable that patients with Psa that present a severe affection, both on the skin and nails, are treated in a shared manner with specialists in dermatology who are specially interested in this disease.

Though there are some doubts about its utility in the forms of axPsa, the HAQ is a validated instrument to measure function in peripheral psoriatic arthritis.¹² SF-36 is an adapted instrument used to evaluate the quality of life, while the PsaQoL was specifically developed for Psa and needs validation.

Though the efforts that have been in the past few years have contributed to the identification of different problem areas of Psa, there is still much work that must be done in order to precisely define which instrument is more adequate to evaluate the activity and therapeutic response in a disease as complex as Psa.

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