

Psöriatik artrit ve romatoid artrit: Birliktelik mi, yanlış tanı mı?

Psoriatic arthritis and rheumatoid arthritis: Association or misdiagnosis?

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Psöriatik artrit (PsA) periferik eklemler, omurga ve entezis bölgelerinin kronik inflamatuvar artropatisidir. Psöriatik artrit prevalansı psöriazisli hastalarda %7-11, genel toplumda ise %0,04-0,1 arasında bildirilmektedir. Romatoid artrit (RA) ise daha çok el bilek, metakarpofalangeal, proksimal interfalangeal ve metatarsofalangeal eklemleri tutan kronik simetrik inflamatuvar bir artrittir. Romatoid artrit prevalansı %0,2-1 olarak bildirilmektedir. Romatoid artrit ve psöriatik artrit tek başlarına sık görülen romatizmal hastalıklar olmalarına rağmen bu iki hastalığın birlikteliği halen tartışmalı bir konudur ve tanı zorluklarına yol açmaktadır. RA ve PsA hastalıklarının ayırıcı tanısı önemlidir, çünkü klinik, serolojik ve radyolojik olarak birbirlerine benzemesine rağmen patolojilerinin farklılığı farklı klinik sonuçlara yol açabilir. Erken tanı, doğru tedavinin belirlenerek olası eklem hasarını önlemede önemlidir. Bu vakada psöriazis zemininde simetrik poliartrit gelişen ve romatoid artrit ve psöriatik artrit birlikteliği tanısı düşünülen erkek hasta sunulacaktır.

Anahtar Kelimeler: Psöriazis, psöriatik artrit, romatoid artrit

Abstract

Psoriatic arthritis (PsA) is a chronic inflammatory polyarthritis affecting joints, spine and entheses. Psoriatic arthritis prevalence range from 0,04-0,1% and 7-11% in general population and psoriasis patients respectively. Rheumatoid arthritis (RA) is a chronic symmetric polyarthritis of wrist, metacarpophalangeal, proximal interphalangeal and metatarsophalangeal joints. Prevalence of RA is accepted around 0,2-1% in most populations. Although psoriatic arthritis and rheumatoid arthritis are common rheumatic diseases, coexistence of these diseases is still problematic and causes diagnostic challenges. The differential diagnosis of RA and PsA diseases is important because, although clinically, serologically and radiologically similar to each other, the difference in pathologies can lead to different clinical outcomes. Early diagnosis is important to prevent possible joint damage by determining the correct treatment. Here in we report a patient with psoriasis developing polyarthritis and rheumatoid arthritis and psoriatic arthritis coexistence were accepted as diagnosis.

Keywords: Psoriasis, psoriatic arthritis, rheumatoid arthritis.

INTRODUCTION

Psoriatic arthritis (PsA) is a disease presenting with chronic inflammatory polyarthritis of joints, spine and entheses in psoriatic patients, the prevalence of psoriatic arthritis is approximately 7-11% in patients with psoriasis (1, 2). Rheumatoid arthritis (RA) is one of the most common rheumatic diseases and prototype of rheumatic diseases causing chronic symmetric polyarthritis of multiple, especially small joints and affecting 0,28% in most populations (1). Because of both diseases presents with polyarthritis differential diagnosis of these frequently seen diseases is difficult especially when psoriasis accompanies rheumatoid factor and/or antibodies against cyclic citrullinated peptide (CCP) positivity in a patient presenting with polyarthritis. So that coexistence of PsA

and RA is still a problematic issue and very few cases were reported in the literatur. Herein we report a case of 72-year old patient with psoriasis since two years and presented with symmetric polyarthritis.

CASE REPORT

A 72-year-old man was admitted to our hospital with pain in shoulders, elbows, wrists and right knee for one month. He had morning stiffness that lasts for 30 minutes in all joints, especially in the shoulder girdle. He had night pain in multiple joints. From his history we learned he has been diagnosed with psoriasis two years ago and had been treated with 28 cycles of psoralen and ultraviolet A (PUVA) and methotrexate 10 mg once a week for 6 months. He had no systemic disease except hypertension. On

physical examination vital signs were as follows: body temperature 37, 4°, pulse rate 100/minute, blood pressure 135/80 mm Hg and respiratory rate 20/min. There were multiple tender and swollen joints including shoulders, wrists, proximal and distal interphalangeal joints and right knee. These joints were restricted on motion. He had multiple psoriatic plaques on left elbow, dorsum of hand and feet and scalp; also he had nail dystrophy. The results of laboratory studies showed a white blood cell count of 9500/mm³, (neutrophil %70), a hemoglobin of 13,4 g/dL, a platelet count of 300000/mm³, a erythrocyte sedimentation rate of 60 mm/hr, a C-reactive protein level of 13,2 mg/dL, a rheumatoid factor (RF) level of 164 IU/mL and an anti-cyclic citrullinated peptide antibody (anti-CCP) titer of > 3200 IU/L. Liver and kidney function tests were within normal ranges. Plain X-ray studies showed multiple erosions and joint space narrowing in proximal and distal interphalangeal joints. No significant abnormalities were detected in carpal and metacarpal joints. There were rough, hook-like and non-marginal osteophytes in cervical and lumbar vertebrae and compression fractures at T12 and L4 vertebrae. Shoulder ultrasonography revealed acute bicipital tendinitis in the left shoulder. Abdominal ultrasonography and thoracic computerized tomography scan showed no abnormality.

According to the criteria of current classification – psoriatic arthritis (PA) (CASPAR criteria 2006) and rheumatoid arthritis (RA) (ACR criteria/EULAR 2010) we assigned the diagnosis of late onset RA accompanied by PsA (3, 4). The patient had begun treatment with methotrexate (15 mg/wk.), naproxen sodium (750 mg/day). At 3 months after treatment patient's joint symptoms and psoriatic lesions except on dorsum of the right hand improved completely. The results of laboratory studies were as follows after three months: white blood cell count of 8500/mm³, (neutrophil %70), hemoglobin of 13,8 g/dL, platelet count of 265000/mm³,

erythrocyte sedimentation rate of 30 mm/hr, C-reactive protein level of 5,2 mg/dL.

DISCUSSION

Moll and Wright have identified five clinical patterns among patients with PsA: distal predominant, oligoarticular asymmetrical, polyarticular RA-like, spondylitis and arthritis mutilans. The frequency of distribution of patterns has varied; however according to analysis of CASPAR study symmetric polyarticular one was most frequent pattern (5). Some clinical features like distal interphalangeal joint involvement, enthesitis, dactylitis, spondylitis, nail dystrophy, low level of tenderness, erythema over the joints and ray pattern distribution of joint involvement help to distinguish PsA from RA. However, PsA presenting with polyarticular pattern must be rule out from RA. Sometimes this may be very difficult especially when RF and anti-CCP tests were positive in PsA. RF positivity may be found in 4,9% to 11% of patients with PsA. Also anti-CCP, highly specific for RA, also may be found 7% to 12% of patients with PsA (6, 7). Considering CASPAR criteria our patient scored 4 points: psoriasis (2 points), juxtaarticular new bone formation (1 point) and nail dystrophy (1 point). Therefore according to ACR criteria our patient scored 7 points: 4-10 small joint involvement (3 points), high positive RF or anti-CCP (3 points), abnormal ESR or CRP (1 point). So in the basis of these criteria our patient can be diagnosed with PsA and RA. According to Moll and Wright classification our patient had polyarticular-RA like and spondylitis pattern co-occurrence. Also, in our patient, absence of distal interphalangeal involvement, big joint involvements like shoulders, very high titers of RF and anti-CCP, long lasting morning stiffness directed us to RA diagnosis besides PsA. In such a patient alternate diagnosis may be miss out, a patient with presenting polyarthritis and psoriasis can be easily diagnosed as PsA. Serologic markers such as RF and anti-CCP may

be helpful, but also this laboratory tests may be confusing for diagnosis when they are positive.

The association between psoriasis and RA was rarely reported in the literature. Mazzucchelli et al. estimated the prevalence of this combination to be between 0.03-0.15/10,000 (8). MRI findings of the hand and wrist can help to distinguish between RA and PsA in the early stages of disease. MRI can be used to identify joint synovitis, bone and joint erosions, bone marrow oedema, spondylitis, periarticular inflammation, active enthesitis, nail disease and periostitis. The location of bone marrow oedema can help differentiate between PsA (near entheses) and RA (near capsular attachments), and diaphyseal bone marrow oedema is a characteristic feature of early PsA (9). Capillaroscopy may be a tool for differential diagnosis of PsA and RA (10). Also previously used DMARDs (disease modifying antirheumatic drugs) for psoriasis may have suppressed typical clinical features of RA. Newly developing laboratory tests, imaging tests and new diagnostic criteria will be developed in the future will help to differentiate these disorders.

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