

Psoriasis Plus Joint Pain Doesn't Always Equal PsA

Only 55% of a small series of patients with psoriasis and musculoskeletal pain had psoriatic arthritis.

BY KERRI WACHTER
Senior Writer

STOCKHOLM — It may be wrong to assume that patients with psoriasis and joint pain have psoriatic arthritis, according to data presented at an international conference on psoriasis and psoriatic arthritis by Dr. Elinor Mody.

"Joint pain in patients with psoriasis does not necessarily equal psoriatic arthritis," said Dr. Mody, a rheumatologist at Brigham and Women's Hospital in Boston.

She and her colleagues assessed 71 consecutive patients with psoriasis and musculoskeletal pain who presented to a combined dermatology/rheumatology clinic. Average patient age was 53 years and 52% of the studied patients were women. All

were evaluated by both a dermatologist and a rheumatologist.

Based on the Moll and Wright criteria (Semin. Arthritis Rheum. 1973;3:55-78), 41% were diagnosed with psoriatic arthritis alone. Based on the American College of Rheumatology criteria for osteoarthritis of the hand, and knee and hip radiographs, 27% were diagnosed with osteoarthritis alone. In addition, 3% were diagnosed with gout and 14% had no specific diagnosis. Fourteen percent were diagnosed with both psoriatic arthritis and osteoarthritis.

"These findings highlight that patients with psoriasis and musculoskeletal pain can have a variety of conditions causing this pain and cannot be assumed to have psoriatic arthritis," said Dr. Mody.

Differentiating between psoriatic arthritis and other arthropathies can be difficult but is "extremely important as psoriatic arthritis is deforming and crippling and requires aggressive early therapy," said Dr. Mody. "Better methods are needed for screening for psoriatic arthritis in a patient with psoriasis."

To address this need, Dr. Mody and her colleagues developed the psoriatic arthritis screening and evaluation (PASE) questionnaire intended for physicians to use to screen patients with psoriasis for evidence of psoriatic arthritis. The self-administered questionnaire includes 15 five-choice questions, separated into symptom and function subscales.

Forty-five consecutive patients (24 women) answered the questionnaire prior to systemic therapy. A rheumatologist and a dermatologist working together diagnosed 27 patients with psoriasis alone and 18 with psoriatic arthritis.

Patients with psoriatic arthritis had a median total PASE score of 53, compared with a median score of 40 for patients with psoriasis alone—a difference that was statistically significant. With a total score cutoff of 47—a score of 47 or greater indicates psoriatic arthritis—sensitivity of PASE was 83% and specificity was 70%.

"These patients need to be reevaluated periodically," said Dr. Mody. She and her colleagues recommend repeating the PASE every 6-12 months in patients with psoriasis and joint pain.

The median function score for patients with psoriatic arthritis was 27, compared with 19 for those with psoriasis alone. The median symptom score for patients with psoriatic arthritis was 24, compared with 21 for those with psoriasis alone.

The researchers are planning to assess retest reliability of the PASE, as well as to investigate changes in PASE scores following the initiation of therapy. ■

In Hip Replacement, Less Invasive Procedure Is More

BY BRUCE K. DIXON
Chicago Bureau

CHICAGO — Less invasive hip and knee arthroplasty techniques continue to progress and bring new advantages for patients, said Dr. Bryan J. Nestor.

Anterior two-incision total hip arthroplasty (THA), only recently touted as being "revolutionary," is falling into disfavor and many surgeons have abandoned this approach, said Dr. Nestor at a symposium sponsored by the American College of Rheumatology. "There are indications that the two-incision THA causes significant gluteus medius and minimus muscle destruction, so muscle sparing it's probably not," he said. Furthermore, the piriformis and conjoint tendons, which are the external rotators of the hip, are ruptured or damaged in about 70% of patients, "and you can't repair them. But most humbling has been the high complication rate associated with this procedure in the hands of very experienced total hip surgeons: femoral fracture, neuropraxia, a 25% incidence of lateral femoral cutaneous nerve palsies, and a 5%-10% reoperation rate," said Dr. Nestor of the Hospital for Special Surgery, New York.

The approach favored by Dr. Nestor is the posterior mini-incision THA. With this procedure, surgeons can gradually decrease the lengths of their incisions. It also affords good direct visualization and works well with cemented or uncemented components. The dislocation rate with posterior mini-incision THA is unchanged from that of the standard approach, recovery may be less

painful, and it produces only one relatively small scar. Patient body mass index should ideally be under 30 kg/m², but age is not a factor, he said.

"It's important to avoid the mini incision in complicated THA; patients who require hardware removal, osteotomy correction, or bone grafting at the time of the procedure are not candidates for a limited exposure to the hip," Dr. Nestor said, going on to describe the procedure: "The incision is placed along the posterior border of the greater trochanter, about 6-10 cm in length. It's slightly angulated anteriorly at the distal point, and it's centered on a point midway between the tip of the trochanter and the vastus ridge. Proximal extension of the incision facilitates femoral exposure, and distal extension facilitates acetabular exposure," he said.

Dr. Nestor is heading an ongoing study comparing 55 patients (62 hips) who underwent the mini posterior approach with 38 patients (46 hips) who had the standard surgical approach. Most of the stems were cemented. From 6-week to 1-year follow-up, there was no difference in clinical performance as measured by the Harris Hip Score. In addition, there were no significant differences in cup positioning, femoral component positioning, blood loss, or complications between the two groups. "Interestingly, there were more superficial wound problems in the standard approach than in the mini approach, and that probably reflects the larger body mass index of patients in the standard incision group," he said, concluding that the mini THA incision can be done safely. ■

Shoulder Injections, Often Inexactly Placed, Deemed 'Poor Tool' for Pain

BY MARY ANN MOON
Contributing Writer

Both diagnostic and therapeutic injections for shoulder pain are often placed inaccurately, even when clinicians are convinced they've injected the subacromial bursa rather than other structures, reported Dr. Hans-Erik Henkus of Medisch Centrum Haaglanden, the Hague, and his associates.

They found that only 66% of subacromial injections were accurate in a series of 33 patients, suggesting that the technique is "a poor tool" for diagnosing the source of shoulder pain and "worrisome" as a therapeutic strategy, the researchers said.

Rather than easing pain and restoring function, inaccurate injections worsen both.

Injecting a local anesthetic around the shoulder area is a widely used method for determining the source of the pain and for predicting the success of subacromial decompression surgery. Injecting corticosteroids is done to reduce inflammation and pain. Both strategies are "based on the assumption that these injections can be given with great accuracy," Dr. Henkus and his associates wrote (Arthroscopy 2006;22:277-82).

But few studies have examined the accuracy of shoulder injections.

The investigators assessed the technique in 33 patients with nontraumatic shoulder pain localized to the deltoid region. The 11 men and 22 women, with an average age of 46 years, were unable to lie on the affected side. Abduction, retroversion, or internal rotation of the glenohumeral joint against resistance provoked further pain.

With the subjects in an upright seated position, an experienced orthopedic surgeon injected all the shoulders with a mixture of bupi-

vacaine, methylprednisolone, and a contrast agent. The surgeon was randomly assigned to approach either anteromedially (16 cases) or posteriorly (17 cases). An MRI was performed immediately to determine the location of the infiltration.

The subacromial bursa was accurately targeted in only 22 (66%) of cases, even though the surgeon was confident that the injections had been accurate in 30 cases (91%) and "doubtful" in only 3.

Three injections infiltrated only the deltoid muscle and subcutaneous tissue, two the glenohumeral joint only, two the acromioclavicular joint only, and three the rotator cuff only.

Even when the subacromial bursa was correctly targeted, many surrounding tissues were infiltrated as well. The rotator cuff was infiltrated 13 times, the deltoid muscle 3 times, and the coracoacromial ligament 2 times.

Pain was reduced and function improved in the cases in which the subacromial bursa alone was injected. However, pain increased and function declined or showed no change when other structures, particularly the rotator cuff, were infiltrated.

"The rotator cuff muscle or tendon was hit in 17 patients," a "worrisome" incidence that could well have caused rotator cuff rupture, particularly if corticosteroids had been injected, the investigators noted.

Neither the type of approach (anterior or posterior) nor the patient's body mass index had any influence on the accuracy of injection placement.

Given that a single faulty injection to any of a variety of structures could produce either a false-positive or a false-negative result, these findings indicate that "the diagnostic use of local injections in the subacromial bursa [is] a poor tool," they said. ■

The rotator cuff muscle or tendon was hit in 17 of the 33 patients studied, a 'worrisome' occurrence that can lead to rupture of the rotator cuff.