Asymptomatic erosive peripheral psoriatic arthritis: a frequent finding in Italian patients

Sir, Painless spondylitis [1], sacroiliac joint involvement [2] and enthesitis [3] have been well described in patients suffering from psoriatic arthritis (PsA). Two years ago we first described the occurrence of two cases of...
asymptomatic erosive psoriatic polyarthritis [4]. That report demonstrated that in the peripheral joints the inflammatory process of PsA can also induce bone damage without occurrence of pain, swelling and other clinical signs of arthritis. Furthermore, we showed that silent PsA can occur in a destructive manner too (arthritis mutilans). In order to assess if the asymptomatic erosive course is a common or rare finding in peripheral PsA, we studied, by standard radiographs, 22 patients with a very recent onset (6 weeks to 3 months) of symptomatic arthritis.

From January to December 2001 we observed, in our rheumatology centre, 136 subjects suffering from PsA. Psoriatic arthritis was diagnosed in patients with inflammatory joint involvement associated with cutaneous and/or nail psoriasis. All doubtful skin/nail lesions were examined by a dermatologist. Patients with rheumatoid arthritis, other spondylarthritides, crystal-induced arthritis, erosive osteoarthritis and connective tissue diseases were excluded. The clinical onset of arthritis was accurately stated on the basis of information from the patients, their relatives and their family doctors. We classified the subjects with a very recent clinical onset of peripheral PsA (6 weeks to 3 months) in a separate group, in order to demonstrate a previous erosive, but asymptomatic course of the disease. In effect, we believed that PsA with a course shorter than 3 months was unable to induce joint erosions identifiable on standard radiographs. All patients were classified clinically into five subgroups, according to the Moll and Wright subgroups. It appears unusual that all correlations between silent erosions and age, sex or Moll subclinical joint involvement is common in the hands of patients, who go on to develop clinically manifest PsA. It can be hypothesized that, using more sensitive techniques of imaging (echo-tomography and MRI), the number of patients showing joint erosions at the clinical onset of PsA could be even greater. The small number of the enrolled subjects does not allow us to find possible correlations between silent erosions and age, sex or Moll and Wright subgroups. It appears unusual that all clinical studies on silent peripheral PsA have involved

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age/sex</th>
<th>Subgroup</th>
<th>Onset of symptoms</th>
<th>Erosions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>68/f</td>
<td>‘Classic’</td>
<td>6 weeks</td>
<td>III DIP joint, right hand</td>
</tr>
<tr>
<td>2</td>
<td>54/f</td>
<td>Symmetrical polyarthritis</td>
<td>2 months</td>
<td>III, IV DIP joints, left hand</td>
</tr>
<tr>
<td>3</td>
<td>70/m</td>
<td>Symmetrical polyarthritis</td>
<td>3 months</td>
<td>IV MCP, right hand</td>
</tr>
<tr>
<td>4</td>
<td>59/f</td>
<td>Asymmetrical oligoarthritis</td>
<td>2 months</td>
<td>Osteolysis III and V distal phalanges, right hand</td>
</tr>
</tbody>
</table>

TABLE 1. Localization of erosions in four patients with recent-onset peripheral PsA

DIP, distal interphalangeal; MCP, metacarpophalangeal; PIP, proximal interphalangeal.

Among our 136 PsA patients we found 22 subjects with a very recent onset of peripheral arthritis. Fifteen were females and seven were males; the mean age was 62.9 ± 9.7 yr. Peripheral erosions were found on standard radiographs by all the examiners in four subjects (three females, one male) among 22 (18.2%) (the erosions are described in Table 1). Two of them had symmetric polyarthritis, one was affected by asymmetric oligoarthritis and the last one showed the ‘classic’ form of PsA. The mean age of this group was 62.8 ± 7.5 yr.

Elevation of ESR and/or CRP was found in 11 patients without erosions and in three of the four patients with erosions. Positive rheumatoid factor was detected only in two female patients without erosions. Cutaneous psoriasis was mild in 15 patients without erosive involvement, localized prevalently on the elbows, knees, hands and feet; three showed a diffuse skin involvement, with a guttate aspect in one case. A severe cutaneous psoriasis was also seen in one of the four patients with joint erosions. Nails were affected in 16 subjects without erosions and in three of the four patients with erosive damage.

In 1992, Buskila et al. [5] noted that inflamed joints were more tender in subjects with rheumatoid arthritis than PsA. This group suggested that the severity of articular inflammation may be underestimated in PsA patients. An Italian study demonstrated, by MRI, that a subclinical joint involvement is common in the hands of subjects with cutaneous psoriasis [6]. In particular, these authors found distension of the articular capsule and periarticular oedema. More recently, we described two cases of asymptomatic erosive psoriatic peripheral polyarthritis [4].

In the present work, we found four cases of erosive peripheral PsA among 22 subjects with a very recent onset of the symptomatic disease. We demonstrated that a silent erosive joint involvement is not rare in Italian patients, who go on to develop clinically manifest PsA. It can be hypothesized that, using more sensitive techniques of imaging (echo-tomography and MRI), the number of patients showing joint erosions at the clinical onset of PsA could be even greater. The small number of the enrolled subjects does not allow us to find possible correlations between silent erosions and age, sex or Moll and Wright subgroups. It appears unusual that all clinical studies on silent peripheral PsA have involved
Italian patients. In effect, in several rheumatology units of our country, PsA is more frequent than rheumatoid arthritis [7], whereas in the Anglo-Saxon countries the prevalence of PsA is indicated as low [8, 9]. An elevated disposition in Italian patients suffering from cutaneous psoriasis to develop PsA may explain these data [10].

Our present observations should be confirmed in more series with higher numbers of patients. Furthermore, it will be very interesting to search for joint erosions in subjects with a recent onset of PsA coming from different populations.

C. Palazzi, L. D’Agostino, E. D’Amico1, E. Pennese, A. Petricca

Division of Rheumatology, ‘Villa Pini’ Clinic, Chieti and 1First Division of Internal Medicine, ‘Spirito Santo’ Hospital, Pescara, Italy

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Correspondence to: C. Palazzi, Via Legnago 23, 65123 Pescara, Italy. E-mail: kaps57@virgilio.it