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The Delayed Diagnosis of Psoriatic Arthritis when Psoriasis is Still Missing: How and Why

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LETTER TO THE EDITOR

Psoriatic Arthritis (PsA) is a chronic inflammatory evolutionary arthropathy associated with Psoriasis, characterised by heterogeneity of clinical presentation; in fact, it can involve the spine or not and it has different progression potential. The aetiology of PsA is not completely known; in fact, the aetiology is multifactorial, in which genetic predisposition (such as the higher incidence in patient's relatives then in the general population), immunological and environmental factors (trauma and infections) can be involved. Epidemiologically, the PsA is common in the Caucasian population (prevalence 1-3%) [1]. The disease affects equally men and woman, the age at onset is between 30-50 years old. Psoriasis may precede, occur simultaneously, or follow the onset of arthritis: in the 15% of cases they arise together, in the 75 % Psoriasis comes first then Joint Involvement and the opposite occurs in the 10%. [2]

In the latter case, the patient may be mistakenly diagnosed as having an inflammatory arthritis other than PsA. Like for other Rheumatologically diseases, classification criteria have been established also for PsA, the newer of them are those of ''Classification Criteria for Psoriatic Arthritis '' (CASPAR). [3] A patient must have inflammatory articular disease (joint, spine, or entheseal) before the CASPAR criteria are applied. To meet the criteria, a patient also must have at least 3 points from the 5 categories (Table 1).

The diagnosis of PsA is easier when Psoriasis occurs before Joint Involvement, vice versa the diagnosis can be delayed of many years if the Arthritis precedes the skin manifestation. [4] Psoriasis may be present but may be hidden or may be misdiagnosed especially by rheumatologists. Psoriasis may only be apparent in the natal cleft or some other "hidden" area such as under the breasts, around the umbilicus, or in the hairline. The psoriasis may only be evident in the nails.

In the true absence of psoriasis, a positive family history in a first degree relative may be of equal importance from a diagnostic point of view.

To avoid the risk of misdiagnosis, to diagnose PsA in the early stage and to avoid the risk of complications (anchyloses, joint dysfunction, rigidity, cardiovascular events) [5], the collaboration between rheumatologists and dermatologists has required to diagnose PsA also when Psoriasis is absent.

It can be performed through the right evaluation of Joint Pain (caused byan inflammatory disease rather than a mechanical one) and through a careful clinical examination of the dermatological history of the patient (to highlight a past psoriatic manifestation).

The best management of these cases should be characterised by a short follow up in which the patient is examined by a rheumatologist and a dermatologist together, with the purpose to treat the Inflammatory Arthritis and to evaluate if there is a development of skin manifestation compatible with Psoriasis. This allows

physicians to not underestimate Joint Involvement and similarly to confirm the diagnosis if the skin manifestation occurs.

Table1. *CASPAR criteria for PsA.*

To meet the CASPAR criteria for PsA, a patient must have inflammatory articular disease (joint, spine, or entheseal) and score ≥3 points based on these categories.	
	POINTS
1. Evidence of psoriasis Current psoriasis Personal history of psoriasis Family history of psoriasis	2 or 1 or 1
2. Psoriatic nail dystrophy Pitting, onycholysis, hyperkeratosis	1
3. Negative test result for rheumatoid factor	1
4. Dactylitis Current swelling of an entire digit History of dactylitis	1 or 1
5. Radiologic evidence of juxta-articular new bone formation Ill-defined ossification near joint margins on plain x-rays of hand/foot	1

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