

Psoriatic Arthritis and Magnetic Resonance Imaging

Sir,

We read with interest the article by Offidani et al. entitled "Subclinical joint involvement in psoriasis: magnetic resonance imaging and X-ray findings" (1). Psoriatic arthritis (PA) is an inflammatory arthropathy occurring in 5–7% of patients with psoriasis. Several distinct pattern of PA are present, namely: oligoarthritic, arthritis mutilans, symmetric and asymmetric polyarthritis, and psoriatic spondyloarthritis. The interphalangeal joints of the fingers and toes are most commonly affected (2,3). In the study by Offidani et al., arthritic signs in the magnetic resonance imaging (MRI) of the hands of 25 psoriatic patients without any joint symptoms and signs are described. The clinical impact of these findings is not clear. Are these signs really early manifestation of articular involvement? A follow-up period and a control MRI of the patients will be more informative and may show the place of MRI for the early prediction of a future clinically apparent articular involvement.

Since approximately 5% of patients develop severe disabling and deforming arthritis during the course of PA, more aggressive treatment can be instituted in the selected patients. The classic radiographic features of PA are destructive lesions involving the distal and proximal interphalangeal joints of the fingers and the toes, periostitis of the large joints, pencil-in-cup appearance and absence of symmetry (4). It would also be more appropriate to include patients with clinically apparent PA as well, so correlation between the early and established sign of PA in MRI would be possible. Although the authors suggest that skin and nail psoriatic involvement cannot be regarded as an indicator or

predictable diagnostic marker of PA, PA usually follows well-established cutaneous or nail lesions and constitutional symptoms, such as malaise, morning stiffness and fever, can be present. A search for an association between clinical and laboratory activation markers, i.e. sedimentation rate and other acute-phase reactants, and MRI findings would be appropriate. MRI is an expensive method and the therapeutic and prognostic implications in psoriasis are not clear. It is also a highly sensitive method and false positive results are not rare. Thus, further study is necessary to determine the place of MRI in the diagnosis of PA.

REFERENCES

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Response to the Letter by Drs B. Yalçın and S. Yalçın

Sir,

We thank Drs B. and S. Yalçın for their comments on our paper entitled "Subclinical joint involvement in psoriasis: magnetic resonance imaging and X-ray findings" (1).

Magnetic resonance imaging (MRI), rather than the conventional X-ray method, allowed us to prove the frequent involvement of joints in psoriatic patients without clinical evidence of arthritis. In our opinion, MRI findings, as periarticular high signal intensity, probably represents one of the earlier signs of PA, preceding the appearance of clinical manifestation of disease.

Yet we think that the meaning of the subcondral abnormalities detected by MRI in our patients are not clear and should be further investigated, including by histological evaluation, because this might identify a PA-like hand pattern. We also believe that periodic evaluation with MRI would be useful, especially if associated with clinical and radiological follow-up. Considering the possible evolution of

PA into more serious clinically evident forms, MRI could be an important method of setting up the best therapeutic approach and of suggesting more appropriate living-habits as well for evaluating a possible link between MRI and the clinical phases of PA.

It would also be important to verify whether a similar MRI pattern could be found in apparently uninvolved joints of patients affected by PA.

As far as laboratory activation markers are concerned, they were all negative in our patients.

Our preliminary results are, thus, worth verifying in a larger sample of cases as well as using to evaluate the question posed by Drs B. and S. Yalçın.

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