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## PSORIATIC ARTHRITIS: CLINICAL OBSERVATION

Psoriatic arthritis is a chronic inflammatory disease of the joints, spine, and spondylitis arthritis that is commonly seen in patients with psoriasis. The prevalence of this severe pathology in patients with psoriasis, according to different authors, ranges from 13.5 to 47% (an average of 36%), and the prevalence of psoriasis in the population is 0.06 - 1.4%. Important factors in the development of psoriatic arthritis include a genetic predisposition, immune disorders associated with collagen disorganization, type II, as well as the presence of foci of bacterial, chlamydial and other types of infections. Clinically, psoriatic arthritis has similarities with rheumatoid arthritis, which requires careful differential diagnosis. In this regard, specialists will be interested in the clinical observation of a family case of psoriasis with the addition of a complication such as psoriatic arthritis.

**Keywords:** psoriasis, psoriatic arthritis, dermatosis.

**Introduction.** Psoriatic disease is a systemic inflammatory disease that affects the skin, joints and joints [9]. Psoriatic diseases of the skin, enthesion and joints have a common pathophysiology based on activation of the innate immune system, as well as on the generation of pathogenic T cells that cause inflammation. Immunopathology in psoriasis and psoriatic arthritis (PA, PsA) is controlled by a combination of genetic factors and external factors, such as mechanical stress, which accelerate inflammation [2]. Inflammation in the context of psoriatic disease is considered systemic, and not least because both conditions are associated with increased cardiovascular risk, osteoporosis, and metabolic disorders [9]. The prevalence of PA in patients with psoriasis, according to different authors, ranges from 13.5 to 47% (an average of 36%), and the prevalence of psoriasis in the population is 0.06 - 1.4%. The causes of joint damage have not yet been elucidated. Important risk factors for PA include a genetic predisposition, immune disorders associated with collagen disorder, type II, as well as the presence of foci of bacterial, chlamydial and other types of infections [1-4]. In 2006, diagnostic criteria for CASPAR PA were proposed, which are presented in Table [6].

Psoriatic arthritis (PsA) is an immune-mediated, clinically heterogeneous disease characterized by arthritis, enthesitis, dactylitis, spondylitis and psoriasis of the skin and nails. Persistent joint inflammation in patients with PA can lead to structural damage, which can lead to a

decrease in physical function and quality of life. Structural damage can occur quickly, and permanent damage to the joint can occur if patients do not receive timely and appropriate treatment [5].

Difficulties in the diagnosis of PA are associated with similarities to rheumatoid arthritis, gout due to the absence of specific clinical markers [7]. The diagnosis of rheumatoid arthritis (RA) is mainly based on the clinical symptoms and serological positivity of rheumatoid factor (RF) and / or antibodies to anti-citrulline peptides (anti-CCPs), while only clinical and imaging features help diagnose the disease [7].

We present a clinical observation of a family case of psoriasis complicated by psoriatic arthritis.

**Purpose of the study** is a demonstration of a family case of psoriatic arthritis and differential diagnosis with rheumatoid arthritis, gout.

**Materials and research methods.** The data of the clinical observation of a patient with a diagnosis of Psoriatic arthritis, polyarthritic variant, severe course, activity of the II stage, functional insufficiency of the II – III stage are presented. Background: Common vulgar psoriasis, exudative, off-season, stationary stage.

From the anamnesis, it is known that the patient has been ill for about 11 years, when for the first time pinkish-red papules appeared on the scalp and extensor surface of the elbow and knee joints, covered with loose silver-white scales clearly distinguished from healthy skin. Later, pain in all joints of the 3rd and 4th toes of both feet joined. Within two years, the pain spread to the knee joints. The patient was diagnosed with Rheumatoid arthritis. Psoriasis. The patient refused the proposed therapy.

In the last two years, severe exacerbations with increased arthralgic syndrome involving new joints and subfebrile temperature about two times a year. A "radish-like" deformation of the toes and a "sausage-like" deformation of the fingers

appeared. Patient is constantly taking Nise 2 tablets 2 times a day.

Development was according to age. Contacts with infectious patients denied. Blood transfusion denied. Hereditary history: a mother aged 52 was diagnosed with Psoriasis, psoriatic arthritis.

The patient suffers from arterial hypertension for 6 years: an increase in blood pressure up to 150/90 mm Hg, she constantly takes antihypertensive therapy with the drug Prestanz once a day in the morning.

An allergic history is not burdened.

Objectively: Height 175 cm, body weight 95 kg. BMI of 31.02 kg / m<sup>2</sup>, which corresponds to obesity of 1 degree. The presence of psoriatic plaques on the scalp, on the extensor surfaces of the right shoulder, elbow joints, as well as both knee joints. There is a psoriatic triad: stearin stain, terminal film and the phenomenon of "blood dew" Polotebnov. "Radish-like" deformation of the toes and "sausage-like" deformity, edema and hyperemia of the 2nd, 3rd and 4th fingers of the right hand and 2nd and 3rd fingers of the left hand. All joints of the feet and hands are enlarged. Pathological mobility in the distal interphalangeal joints of the fingers.

General blood test: Red blood cells -  $4.5 \cdot 10^{12} / l$ ; hemoglobin - 145 g / l; white blood cells -  $6.5 \cdot 10^9 / l$  (segmented - 68%, lymphocytes - 31%, monocytes - 1%); platelets -  $353 \cdot 10^9 / l$ ; ESR - 42 mm / h.

Urinalysis - without features.

Rheumatic tests: CRP - 2 mg/L, RF - OTR, Antistreptolysin-0 - 152 U ml, uric acid - 0.3 mmol/L, A-CCP - 20 U/L.

Bacterial inoculation of synovial fluid - without features.

ECG: Sinus rhythm. Left ventricular hypertrophy. EOS is rejected to the left. Heart rate 68 in 1 minute.

X-ray of the hands: The articular fissures of the proximal interphalangeal joints of the 2nd, 3rd, 4th fingers are narrowed. The heads of the 2nd, 3rd and 4th

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## Diagnostic criteria for psoriatic arthritis, CASPAR

Psoriatic joint inflammation can be diagnosed in a patient with peripheral arthritis, spondylitis and sacroiliitis or enthesitis and $\geq 3$ points from the following:	
<b>1. Symptoms of psoriasis (psoriatic skin changes detected by a rheumatologist or dermatologist):</b> - psoriasis in a personal or family history (in a relative of I or II degree) - psoriatic changes are present at the moment	1 point 2 point
<b>2. Typical psoriatic changes in the nails</b> (separation of the nail, depressions in the nail plate and hyperkeratosis), established during an objective examination	1 point
<b>3. A negative result of determining the rheumatoid factor by any method</b> (with the exception of the latex test), it is best ELISA or nephelometric method	1 point
<b>4. Dactylitis</b> , defined as swelling of the entire finger (the so-called sausage finger) at the moment or in the history recorded by a rheumatologist	1 point
<b>5. Radiological signs</b> of periarticular bone proliferation in the form of fuzzy limited ossification at the edges of the joint (with the exception of osteophytes) on radiographs of the wrist or foot	1 point

metacarpal bones are corroded, reduced in size, with the presence of marginal patterns and cystic enlightenments. There are no heads of the 1st metacarpal bone on the right and heads of the proximal phalanx of five fingers (osteolysis).

X-ray of the feet: Erosion in combination with proliferation of bone tissue in the interphalangeal joint of the big toe, the first tarsal-metatarsal joint and dislocation in the II-V metatarsophalangeal joints. In several fingers erosion of the tuberosity of the distal phalanges.

X-ray of the knee joints in 2 projections: uneven narrowing of the joint gap, marginal bone growths, subchondral osteosclerosis are determined.

Dermatologist consultation: Common vulgar psoriasis, exudative. Off-season option. Stationary stage.

Differential diagnosis with rheumatoid arthritis, gout and other systemic lesions was carried out. According to the CASPAR scale, the patient has 6 points: psoriasis in a personal family history (for mother) - 1 point, psoriatic changes are present at the moment - 2 points, a negative result for determining rheumatoid factor - 1 point, dactylitis - 1 point, radiological signs of periarticular bone proliferation in the form of a fuzzily limited ossification at the edges of the joint - 1 point [9]. Thus, on the basis of

complaints, medical history, clinical and paraclinical data, the diagnosis was established: Psoriatic arthritis, polyarthritic variant, severe course, activity of the II stage, functional insufficiency of the II – III stage. Background: Common vulgar psoriasis, exudative. Off-season option. Stationary stage. Concomitant: Hypertension 2, AH-2, risk -3. Obesity I Art.

The therapy was carried out with non-steroidal anti-inflammatory drugs (NSAIDs), cytostatic therapy with methotrexate with an initial dose of 10 mg followed by an increase to 20 mg, hepatoprotectors, sodium thiosulfate to relieve exacerbation of psoriatic elements, salicylic acid externally. During treatment, psoriatic elements on the skin decreased, infiltration around the rashes became less noticeable, Voronov's pseudo-atrophic rims formed, itching completely disappeared, inflammation of the affected joints became less, and arthralgic syndrome regressed.

**Conclusions.** This case makes doctors wary of psoriatic arthritis, the difficulty of differential diagnosis with such specific diseases as rheumatoid arthritis, gout. The active identification of patients with psoriatic arthritis requires, first of all, the correct interpretation of anamnestic, clinical, laboratory, radiological data. The presented clinical observation indicates

a significant contribution of the genetic predisposition to the development of the disease. The presented clinical observation indicates a significant contribution of the genetic predisposition to the development of the disease. An important point is that patients with psoriatic arthritis have an increased risk of cardiovascular disorders [8]. A correctly diagnosed diagnosis is the appointment of the only correct treatment and the prevention of complications that can lead to disability of the patient.

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