

A Rare Enthesopathy in Psoriatic Oligoarthritis

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Peripheral enthesopathies have recently been attributed a crucial role in the definition of seronegative spondyloarthropathies. We report a case of psoriatic oligoarthritis in which a peripheral enthesopathy, occurring at the right olecranon, was the heralding sign of the disease. Key words: seronegative spondyloarthropathies; psoriatic oligoarthritis; peripheral enthesopathies; olecranon spur.

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Enthesopathies, bony proliferations around osseous erosions, are a prominent clinical aspect of seronegative spondyloarthropathies (SSp) (1). Characteristically, the process occurs at sites of tendon and ligament insertion on bone, with either an axial or a peripheral pattern. Sometimes, as an isolated finding, they may be a presenting feature of disease (2-4).

We describe a case of psoriatic oligoarthritis in which an isolated enthesopathy, occurring at an uncommon site, represented the onset of articular involvement.

CASE REPORT

In January 1992 a 68-year-old office clerk with psoriasis was referred to our Department, complaining of pain of 3 years' duration at his right olecranon. Psoriasis had manifested itself in January 1990 at both elbows. Five months later he suffered arthritic involvement of the left knee.

On admission, physical examination revealed psoriasis vulgaris on the scalp, elbows, hands and legs. In addition, swelling and reduced joint mobility of the left knee were recorded. Relevant laboratory data showed elevated sedimentation rate (ESR 28 mm 1st h) and increased C-reactive protein (8 mg/dl; NV <1 mg/dl). Rheumatoid factor was negative. Bilateral sacro-iliitis (grade 2 on the left, grade 3 on the right) was noted on X-rays, and an increased radionuclide uptake was detected by technetium-99 scintiscanning. Increased uptake was present also on the left knee region, without radiological evidence. Coarse syndesmophytes were randomly seen along the thoraco-lumbar spine. A bony proliferation at the triceps tendon insertion was evident in a film of the right elbow, while minimal changes were present at the contralateral site (Fig. 1a, 1b.)

DISCUSSION

For several decades, axial enthesopathies, consisting of sacro-iliitis and/or syndesmophytes, have been considered a useful hallmark for the classification of SSp. Recently, peripheral enthesopathies, have also been included among new sets of classification criteria, for both definite and unclassifiable spondyloarthritic patterns (5-6). We report a case of psoriatic oligoarthritis in which cutaneous and articular involvement had a simultaneous clinical onset.

Pain at the right elbow, recorded several years before the clinical appearance of both psoriasis and arthritis, could probably be related to the enthesopathic changes evidenced at the olecranon.



Fig. 1. (a) Right elbow: radiograph reveals an olecranon 'spur' at the site of triceps attachment to the ulna. (b) Left elbow: presence of only minimal changes.

Table I. Prevalence of symptomatic peripheral enthesopathies in 220 patients with psoriatic arthritis classified on the basis of different subsets (according to Moll and Wright)

Subsets of arthritis	No. of cases	Symptomatic enthesopathies Affected patients	
		n	(%)
DIP arthritis (PA1)	13	1	(7.6)
Mutilans (PA2)	2	0	(0)
Polyarthritis (PA3)	50	6	(12.0)
Oligoarthritis (PA4)	21	3	(14.2)
Spondylitis (PA5)	67	21	(31.3)
Overlap: PA5-1	11	3	(27.2)
PA5-3	49	7	(14.2)
PA5-4	7	2	(28.5)
	220	42	(19.0)

(PA5-1, PA5-3, PA5-4 are mixed subgroups with the overlap of spondylitis and DIP, polyarthritic and oligoarthritic subset).

In SSP, inferior and posterior surfaces of the calcaneum are commonly involved sites concerned with enthesopathies (1). Bony proliferations at the triceps attachment have seldom been reported in osteoarthritis and diffuse idiopathic skeletal hyperostosis (7-8).

In our series, symptomatic peripheral enthesopathies were found in psoriatic arthritic patients in 19.0% of the cases (42 out of 220) (Table I). Among the different clinical patterns, spondylitis, with exclusive spinal involvement (PA5) or associated with peripheral arthritis (PA5-1, PA5-3, PA5-4), was the most commonly observed. Calcification in the calcaneal region occurred in 88.0% of the cases (Table II), while femoral trochanters and ischial tuberosities were involved in 28.5% and in 14.2% respectively. Proliferative changes of the triceps insertion seems a very rare feature, having been recorded only once in the 42 psoriatic arthritic patients with enthesopathy (2.3%).

In our case, olecranon enthesopathy has been the heralding sign of a psoriatic arthritis of later development, and, as suggested by Resnick, the term "olecranon spur" may describe this

Table II. Percentage distribution of symptomatic enthesopathies at four different insertional sites in 42 patients with psoriatic arthritis

Anatomical site	No. of cases	%
Calcaneal	37	88.0
Femoral	12	28.5
Ischial	6	14.2
Ulnar	1	2.3

uncommon feature. On the other hand, this case reveals that a peripheral enthesopathy may represent an early finding of SSP. However, due to their low classification specificity when manifested in isolation, peripheral enthesopathies should stimulate a close follow-up of patients, in order to assign them to their proper diagnostic category.

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