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Detecting & Treating Arthralgia in IBD: What the Gastroenterologist Needs to Know

Dr. Nandi:
Welcome to *IBD Crosstalk* for *GI Insights* on ReachMD. I'm your host Dr. Neil Nandi. On today's program, we're going to be talking about arthralgia and every nuance you can possibly think of, so listen close. Joining me to discuss how to differentiate the different types of arthritis and arthralgia that affect our IBD patients today is Dr. Monica Schwartzman. Dr. Schwartzman is an assistant attending physician at the Hospital for Special Surgery and Clinical Instructor in Medicine at Weill Cornell Medical College and New York Presbyterian Hospital. She also holds a degree in clinical epidemiology and focus for research in particular inflammatory bowel disease-associated spondyloarthritis, psoriatic arthritis, and other imaging modalities related to these fields.

Monica, welcome to the program.

Dr. Schwartzman:
Thanks for having me. I'm excited to be here.

Dr. Nandi:
Well, we are excited. Pretty much every other clinic patient that I see has at some point had some form of arthralgia, and it's i almost eye-opening for them to learn that it could be at all mediated by the gut. So in IBD, we have a mantra, "Heal the gut, and we hope that extraintestinal manifestations improve." That's not always the case. Can you begin to just kind of give us a recap of how do we distinguish inflammatory arthralgia from noninflammatory arthralgia?

Dr. Schwartzman:
Sure. So as is your clinical experience, and I'm sure many other people's, musculoskeletal manifestations are actually the most common extraintestinal manifestations in IBD. They can occur in up to 60 percent of patients with inflammatory bowel disease, so it really is quite common. And the range of musculoskeletal disease is also quite wide, and really, the first branch point is to assess whether we think that the musculoskeletal disease is inflammatory, so something like spondyloarthritis, which I'm sure we'll talk about in more detail a bit later, or if it's noninflammatory, so something maybe mechanical like osteoarthritis or an injury or something more like fibromyalgia. So I think those are the first big, important distinctions to make when assessing musculoskeletal pain in inflammatory bowel disease patients.

Dr. Nandi:
I think that when it comes to inflammatory arthralgia, that the GIs have some good insights. They know what questions to ask. But when we don't elicit that it's inflammatory arthralgia, I don't know that all of us know what to tell the patient then. We say, "Go see the rheumatologist," but I'm hoping you could probably elucidate better: how do we pick up if a patient has fibromyalgia or osteoarthritis, these noninflammatory arthralgias, and what can we do about it for the patient?

Dr. Schwartzman:
That's a great question. So tackling the mechanical disease and degenerative disease, like osteoarthritis, I think the first question is always, is it injury-related, because that can be eye-opening for a lot of our patients and then also thinking about what joints are involved. Osteoarthritis usually affects weight-bearing joints, so things like knees and hips, much less likely in the wrists and the elbows, so just thinking about what joints are affected, and then I think getting into questions that can get at whether there is or isn't inflammation, and key questions here are whether there's associated swelling, whether symptoms are worse with movement. In degenerative disease, they'll usually be worse when you start to use them and get better with rest, whereas the opposite is true for inflammatory disease. Degenerative disease and osteoarthritis usually are worse at the end of the day, and I think about it when you've been using the joints for a long time throughout the your entire day, then they hurt at the end of the day, whereas in patients with inflammatory joint pain, will have pain worse in the morning, and these are patients that don't want to have that 8:00 a.m. appointment before work. Lastly, morning stiffness is an important question to ask. For patients with osteoarthritis or degenerative disease, they'll say they have about 5 or 10 minutes of morning stiffness just to get up and get out of bed, whereas patients with inflammatory arthritis will really have over half an hour to an hour, even up to hours of morning stiffness, so I think those are key questions to help distinguish between osteoarthritis, degenerative mechanical disease versus more inflammatory arthritis.

Dr. Nandi:
Now Monica, how should we look at arthralgia, and how should we break it down? In fact, how should we get in the mind as a GI doctor of the rheumatologist? Central, axial, peripheral, how do you break it down?

Dr. Schwartzman:
Sure. So now moving over a little bit to when we're thinking about inflammatory arthritis, I think there's a couple of important branch points here. So in rheumatology, there's an umbrella term for spondyloarthritis, and these are a group of inflammatory diseases that have shared characteristics, particularly inflammatory back pain, peripheral arthritis, HLA-B27 positivity, enthesitis, which is inflammation where the tendons insert to the bone, so like the Achilles tendon, dactylitis, or sausage digits, and then extraarticular features, so uveitis, psoriasis, and inflammatory bowel disease, and this is the type of inflammatory arthritis that affects patients with IBD. And the way we think about spondyloarthritis is that we group it into axial disease, which is when it affects the spine and the sacroiliac joints, or in general the back, versus peripheral joints, so hands, wrists, knees, elbows, really any of the other joints peripherally is how we categorize these in rheumatology.

Dr. Nandi:
For those of you just tuning in, you're listening to *GI Insights IBD Crosstalk* on ReachMD. I'm here with Dr. Monica Schwartzman, and we're talking about arthralgia and how it relates to our inflammatory bowel disease patient population.

So I have a lot of patients who commonly describe having lower back pain who have a history of IBD. How would I approach that patient if I'm worried that it's inflammatory or that they have some sacroiliitis? What should I do?

Dr. Schwartzman:
It's a great question. So there actually have been criteria that have been developed by the spondyloarthritis association known as ASAS, and they help differentiate mechanical versus nonmechanical pain. So important questions to ask would be how old were patients when it started? In particular, we're looking at patients who are less than 40 years old because, as people get older, then we're looking at things like herniated discs, spinal stenosis, there's a lot of other potential mechanical causes, so here, looking at patients who had back pain before the age of 40. Patients with inflammatory disease tend to have a more gradual or insidious onset, and then important questions to ask are whether it improves with exercise and whether there's no improvement with rest. And then the last question is whether patients have pain at night that improve on getting up. The criteria are "positive" if a patient meets 4 out of the 5 questions; though, of course, it's just a screening questionnaire, so even if a patient doesn't quite get 4 out of the 5 affirmative answers and you're still concerned, I think it's always important to refer or further evaluate.

There are a few other questions that aren't part of these classification criteria that can help identify inflammatory compared to mechanical back pain. Inflammatory back pain will usually have morning stiffness greater than 30 minutes, similarly to what we spoke about earlier. It will be characterized by alternating buttock pain, so really low back pain. Also, patients might awaken enduring the second half of the night with pain. And then lastly, we're also looking at pain that lasts for longer than 3 months, so we're getting at pain

that's really becoming chronic, not an acute back injury.

Dr. Nandi:
Absolutely. And when I'm listening to these questions, I'm kind of taking notes and trying to fine-tune what I'm going to ask my patient in clinic because if I have any hint that it's inflammatory, I'm going to refer to a rheumatologist, and if I have a hint that it's not inflammatory but impairing their quality of life, I still think there's a role to refer to the rheumatologist. Wouldn't you agree?

Dr. Schwartzman:
Absolutely. I think even for mechanical back pain, there's a lot of different modalities of treatment we can do to treat that to minimize the morbidity associated with mechanical back pain as well, so I think it's definitely important to refer because there are things that we can do to help improve patients' function and quality of life.

Dr. Nandi:
Absolutely. For that patient with back pain, Monica, I don't often order the imaging to work it up or order the HLA or labs, but in so doing, if I'm trying to help my colleagues out, are there some tests that you would recommend?

Dr. Schwartzman:
Sure. So I think actually I want to broaden this a little bit to just short discussion on the spectrum of axial involvement in spondyloarthritis or low back involvement. So I think, classically, when anyone thinks of back involvement in inflammatory bowel disease, we think of ankylosing spondylitis and this is when we see changes on the x-ray in the sacroiliac joint, but there's also another entity, which is increasingly being described known as nonradiographic axial spondyloarthritis, which I know is a bit of a mouthful, but this is where patients have negative x-rays, so we're not seeing sacroiliitis or inflammation of the sacroiliac joint on x-ray, but we do see it on an MRI of the sacroiliac joints. And this is a really important distinction because it can take upwards of 7 to 10 years for patients to develop x-ray changes, and MRI actually lets us identify disease at a much earlier time point, which is essential because it will help us prevent more permanent damage. So I think an important pearl here is that if you get an x-ray of your patient of the sacroiliac joints and it's negative, I wouldn't stop there. I think it's really essential to get an MRI because this might be a patient who just doesn't have as longstanding disease so the x-ray wouldn't pick it up, but an MRI would. And this is also an important point because I wouldn't think of nonradiographic axial spondyloarthritis or again spondyloarthritis that you see on MRI but not x-ray as a more benign disease. It has the same disability and disease burden, so I think it's really important that we make sure we pick it up. So I think a good workup here would be, again, starting with an x-ray, but if that's negative, going for an MRI of the sacroiliac joints.

Dr. Nandi:
A hundred percent, and that's actually where I was going with that question: What do we do with the back pain patient that has IBD?

Dr. Schwartzman, that's all the time we have for today, but I want to thank you for coming on this program and shedding light and your GI insights, if I will. It was wonderful to have you. Do you have any last closing remarks before we end the program?

Dr. Schwartzman:
No, I think it's great that we're setting up programs like this to help us both work together and learn from each other and hopefully improve the care of our patients.

Dr. Nandi:
And that is what it's all about. For ReachMD's *IBD Crosstalk*, I'm Dr. Neil Nandi. To access this and other episodes in this series, please visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. Thanks for listening.