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Multidisciplinary Perspectives on Peripheral Arthritis in IBD

Dr. Nandi:
On this episode of *GI Insights*, we have Dr. Monica Schwartzman returning to talk to us more about how to understand peripheral arthritis and other musculoskeletal manifestations that we may see in our inflammatory bowel disease patients. Now, Dr. Monica Schwartzman is a rheumatologist who holds a master's degree in Clinical Epidemiology and Health Services Research from Weill Cornell Medical College where she focused her research on spondyloarthritis and in particular inflammatory bowel disease patients with associated spondyloarthritis, psoriatic arthritis, and even studied other imaging modalities to address these common illnesses.

Monica, welcome back to the program.

Dr. Schwartzman:
Thanks for having me. It's great to be back.

Dr. Nandi:
A hundred percent. We had a great discussion our first go-around just approaching inflammatory arthralgia, but there's so much more yet to uncover. I'm hoping that in this episode we can talk about a couple of different topics surrounding the exam and diagnosis of arthritis, particularly peripheral arthritis, and other musculoskeletal manifestations that we might see in our IBD patient population.

Dr. Schwartzman:
Absolutely. When we think of spondyloarthritis, the prototype is ankylosing spondylitis where it affects the spine, but it's actually peripheral arthritis, so in the hands, the knees, the elbows, ankles, other joints that are much more common. We recently did a literature review, and the median prevalence of axial disease where it affects the spine and sacroiliac joints in IBD was 5% while peripheral arthritis was 16%, which is almost three times that, so it's something that I think is going to come up more frequently in an IBD clinic, though maybe gets a little less press than ankylosing spondylitis or back involvement.

Dr. Nandi:
So how can the GI doctor in the clinic with our IBD patient population approach the exam or diagnostic workup for these peripheral discomforts?

Dr. Schwartzman:
Sure. I think joint pain is something that comes to mind immediately, so I think first recognizing true arthritis or joint pain and swelling from inflammation compared to just mechanical disease. But I think also recognizing that there are other manifestations that can affect the skeleton as well. And what I mean by this is something called enthesitis, which is pain where the tendon inserts to bone specifically. Common locations of this are the Achilles tendon, plantar fascia, among others. Something known as dactylitis, which is sausage digit, your entire finger swells up like a sausage. And then there is also skin manifestations, so things like nail disease and psoriasis. So I think big picture is just recognizing the other rheumatologic manifestations in addition to joint pain that can exist in IBD

patients.

Dr. Nandi:
Are there any other conditions that kind of like mimic these things, or are they sensitive or specific for these?

Dr. Schwartzman:
We'll start with enthesitis; it's hard to differentiate these from mechanical overuse injuries, and it can be hard to differentiate these from fibromyalgia because it's hard to see objective swelling in these locations from true inflammatory disease, so first is to have an idea of where you want to look. So I think common locations of enthesitis are on the sides of the elbows where you have the medial and lateral epicondyles, and these are classic areas for things like tennis elbow or golfer's elbow, so first asking if the patient has pain there, and then asking if there's any repetitive motions that cause these symptoms can start to tease apart whether it's a true overuse injury versus something perhaps more inflammatory. And then the way to examine it is really just to put pressure on the lateral aspect or the medial aspect of the elbow to see if there's tenderness there. We like to say you press until you can see your fingernail blanching so that you know you're applying enough pressure. And what I like to do to help differentiate this from fibromyalgia or diffuse widespread pain which can affect both patients with spondyloarthritis and IBD is also put a little bit of pressure a couple centimeters up above the arm and as well as lower along the forearm to really differentiate whether there's just tenderness over the entheses or whether it's perhaps something a little more diffuse affecting the entire arm, which we would see in something more like fibromyalgia. Other common places to look for enthesitis would be the back of the heel—that's the Achilles tendon—as well as on the sole of the foot where the plantar fascia inserts are other good places to look for enthesitis.

Dr. Nandi:
That was great. So if a gastroenterologist is observing this and trying to expand their physical exam repertoire, what can they do? If they're thinking, " I need to send this patient to rheumatology," what can they do to help the workup along rather than risk delay of the workup until the patient sees the rheumatologist?

Dr. Schwartzman:
Absolutely. We don't have one single diagnostic test or antibody that helps us here, but I think there's a constellation of both labs and imaging that might be helpful that you also might be getting routinely on your GI patients, so things like inflammatory markers, ESR, CRP. HLA-B27 positivity is seen in spondyloarthritis to different extents in different diseases in the spondyloarthritis family, but I think we always like to see that to help us kind of think about the likelihood of spondyloarthritis.

And then I think something really important is imaging. And whereas with back symptoms, MRI is really well-characterized in terms of finding early disease; this is something that's much less well-explored peripherally. Usually, we start with x-rays, but x-rays can tend to only see disease after it's been around for a long time, so if a patient's complaining of pain in a joint, always a good idea to x-ray, but an area that's really now becoming much more well-described and investigated in rheumatology is the utility of ultrasound of peripheral joints, which when our exam is maybe a little bit equivocal or we're not sure is a good way to idea subclinical joint disease.

Dr. Nandi:
That's very interesting. GIs are probably not going to be ordering the x-rays, however MRIs we commonly order, and ultrasound for joints we don't. Would you order an MRI lumbar spine? Would you order MRI peripheral extremity? What would you order specifically?

Dr. Schwartzman:
So I think it depends where the patient's having pain. Certainly if there's evidence of pain in the lower back, we would usually start with x-rays of the sacroiliac joint, presumably expecting them to be negative for someone who's not had pain for years, and then if the x-rays of the sacroiliac joints are negative, I get an MRI because I'm not expecting the x-rays to be positive. So I would say one key thing here is to not be discouraged if an x-ray of the lower back or the sacroiliac joints is negative. I would still probably get an MRI because we can see disease so much earlier, and that really helps us help our patients to make sure that they're on therapy that appropriately

treats any sort of sacroiliitis.

Dr. Nandi:
In terms of joint ultrasound, that's a new concept for me. We're starting to introduce ultrasound for bowel to look for strictures or inflammation of the bowel, but that's still new in North America. But it sounds like that's an exciting development in sort of the diagnostics, and hopefully, we can get that in both our specialties more available in terms of ultrasound. So Monica, I know there's a lot of validated questionnaires in the rheum world. Are there any to address these types of inflammatory manifestations? Can you walk us through some of these questionnaires?

Dr. Schwartzman:
Sure, that's a great question. So I think your point is well-taken that the questionnaires are validated, which is very useful, but the key thing underlying all of them in the clinical setting is just that they're good clinical questions and to help us stratify in our heads how likely we think that someone's joint pain is associated with their inflammatory bowel disease.

So earlier last year, an Italian group published a very short screening questionnaire that they validated. It's known as the DETAIL questionnaire. And it's I think about six questions that gets into the various manifestations of spondyloarthritis in IBD. So they ask questions about arthritis. In particular, "Have you ever had a swollen finger or toe for no reason?"—getting at the arthritis aspect. They ask about dactylitis. The third question gets at enthesitis, so where the tendon inserts to bone, and it just asks whether you've had any pain in your heels. And then the last three questions get at inflammatory-type back pain, so these questions are, "Have you ever had back pain lasting at least three months that was not injury-related?" "Do you have low back pain in the morning or after resting that improves with exercise?" And then the last question is, "Do you wake up at night because of low back pain?"

And the way to "score" this is that they found a combination of three positive answers gives you a greater than an 80% post-test probability of spondyloarthritis, but of course, the caveat here in clinical practice as opposed to, perhaps, a research setting is that even if someone has one or two questions, by your clinical judgment you're concerned, I think that should still trigger a referral to a rheumatologist to investigate in a more in-depth, musculoskeletal-focused manner.

Dr. Nandi:
That was a great breakdown. And GIs often ask our IBD patients: “Does the pain wake you up at night?” But I think the flipside of that is rheum: “Does it last a long time in the morning or get better with exercise?” I think those are really easy questions that we can ask. Monica, this was great. Before we close, are there any last take-home points you want our listeners to know?

Dr. Schwartzman:
Yes, one last thing. I think sometimes skin manifestations can be a little overlooked in inflammatory bowel disease, so I just want to point out that patients with inflammatory bowel disease and also in spondyloarthritis can also have nail involvement, and what I mean by this is, something that could almost look like nail fungus or onychomycosis that doesn't respond to antifungals is not uncommon. And then another interesting phenomenon is nail pitting, so it will literally look like someone poked a needle into patients' nails,. So I think taking a look at a patient's nails is important. And then lastly, also looking for psoriasis, which I always tell my patients is a red, scaly rash usually on extensor surfaces, so things like your elbows or your kneecaps but also likes to hide; it can be behind the ears, in the scalp, and also in the intergluteal cleft, so I think doing a good skin exam is something that can also be a clue that a patient is sort of falling into a spondyloarthritis type of phenotype and is also important both to look for and also to have patients be aware of.

Dr. Nandi:
I'm so happy that you brought up the dermatologic manifestations that can overlap with rheumatologic disease and gastrointestinal disease. That's exactly what we want to discuss on this program. Monica, thank you so much for joining us and sharing your GI insights with our greater GI community. We appreciate your perspective as a rheumatologist.

For ReachMD, I'm Dr. Neil Nandi. To access this episode and others from *GI Insights*, please visit ReachMD.com/GIInsights, where you can Be Part of the Knowledge. As always, thanks for listening.