Gastroenterol Hepatol. 2018;41(1):54–62

Gastroenterología y Hepatología

www.elsevier.es/gastroenterologia

REVIEW

Screening of inflammatory bowel disease and spondyloarthritis for referring patients between rheumatology and gastroenterology☆,☆☆

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Received 5 March 2017; accepted 3 July 2017
Available online 17 January 2018

PALABRAS CLAVE
Espondiloartropatías;
Enfermedades inflamatorias del intestino;
Cribado;
Diagnóstico precoz

Abstract
Objective: To define clinical screening criteria for spondyloarthritis (SpA) in patients with inflammatory bowel disease (IBD) and vice versa, which can be used as a reference for referring them to the rheumatology or gastroenterology service.
Method: Systematic literature review and a two-round Delphi method. The scientific committee and the expert panel were comprised of 2 rheumatologists and 2 gastroenterologists, and 7 rheumatologists and 7 gastroenterologists, respectively. The scientific committee defined the initial version of the criteria, taking into account sensitivity, specificity, standardisation and ease of application. Afterwards, members of the expert panel assessed each item in a two-round Delphi survey. Items that met agreement in the first or second round were included in the final version of the criteria.
Results: Positive screening for SpA if at least one of the following is present: onset of chronic low back pain before 45 years of age; inflammatory low back pain or alternating buttock pain; HLA-B27 positivity; sacroiliitis on imaging; arthritis; heel enthesitis; dactylitis. Positive screening

☆ Please cite this article as: Sanz Sanz J, Juanola Roura X, Seoane-Mato D, Montoro M, Gomollón F, Grupo de Trabajo del proyecto PIIASER. Criterios de cribado de enfermedad inflamatoria intestinal y espondiloartritis para derivación de pacientes entre Reumatología y Gastroenterología. Gastroenterol Hepatol. 2018;41:54–62.

☆☆ This article is published simultaneously in Reumatología Clínica: 10.1016/j.reuma.2017.07.001, with the consent of the authors and editors.

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for IBD in the presence of one of the major criteria or at least two minor criteria. Major: rectal bleeding; chronic diarrhoea with organic characteristics; perianal disease. Minor: chronic abdominal pain; iron deficiency anaemia or iron deficiency; extraintestinal manifestations; fever or low grade fever, of unknown origin and duration >1week; unexplained weight loss; family history of IBD.
Conclusion: Screening criteria for IBD in patients with SpA, and vice versa, have been developed. These criteria will be useful for early detection of both diseases.

KEYWORDS
Spondyloarthropathies;
Inflammatory bowel diseases;
Screening;
Early diagnosis

Criterios de cribado de enfermedad inflamatoria intestinal y espondiloartritis para derivación de pacientes entre Reumatología y Gastroenterología

Resumen
Objetivo: Definir criterios clínicos de cribado de espondiloartritis (SpA) en pacientes con enfermedad inflamatoria intestinal (EII) y vice versa, que sirvan de referencia en la derivación entre Reumatología y Aparato Digestivo.
Material y métodos: Revisión sistemática de la literatura y Delphi a dos rondas. Formaron parte del comité científico 2 reumatólogos y 2 digestólogos; del panel de expertos, 7 reumatólogos y 7 digestólogos. El comité científico definió los componentes potenciales de los criterios, teniendo en cuenta aspectos de sensibilidad, especificidad, facilidad de uso y estandarización. A continuación, se realizó el Delphi. Aquellos ítems para los que hubo acuerdo en primera o segunda ronda formaron parte de la versión final de los criterios.
Resultados: Cribado positivo de SpA si se cumple al menos uno de los siguientes: dolor lumbar crónico con inicio antes de los 45 años; dolor lumbar inflamatorio o dolor alternante en nalgas; HLA-B27 positivo; sacroilitis en pruebas de imagen; artritis; entesitis del talón; dactilitis. Cribado positivo de EII si uno de los criterios mayores o al menos dos de los menores. Mayores: rectorragia; diarrea crónica de características orgánicas; enfermedad perianal. Menores: dolor abdominal crónico; anemia ferropénica o ferropenia; manifestaciones extraintestinales; fiebre o febrícula, sin focalidad aparente y de más de una semana de duración; pérdida de peso no explicable; antecedentes familiares de EII.
Conclusiones: Se han definido criterios de cribado de EII en pacientes con SpA y viceversa. Estos han de ser de utilidad en la detección precoz de dichas patologías.

Introduction

Musculoskeletal symptoms are the extraintestinal manifestations most frequently associated with inflammatory bowel disease (IBD). Patients with IBD frequently develop spondyloarthritis (SpA). According to a meta-analysis published in 2016, the prevalence of peripheral arthritis is around 13%, sacroiliitis around 10% and ankylosing spondylitis 3%.[1]

In a cohort of 269 patients with IBD evaluated for joint pain, 50.5% were diagnosed with SpA; an average diagnostic delay of 5.2 years was observed.[2]

In another study of 122 patients with IBD, the prevalence of SpA was 28.7%, of whom 45.7% were not previously diagnosed despite a history of inflammatory lower back pain and/or peripheral arthritis.[3]

By comparison, according to the data of a meta-analysis published in 2015, the prevalence of IBD in ankylosing spondylitis is 6.8%.[4] The studies also revealed a link between psoriatic arthritis and the onset of IBD, although to a lesser degree.[5–7]

And although not as long as with SpA, there is also a diagnostic delay in the case of IBD. In a series of 1591 patients with IBD, in 25% of cases this delay exceeded two years for Crohn's disease (CD) and one year for ulcerative colitis (UC).[8] In another series of 1196 patients, the delay times were 18 months for CD and three months for UC.[9]

For both SpA and IBD it is very important to avoid diagnostic delay because it is associated with a worse clinical course and poorer response to treatment.[10–13]

Currently, there are no tools aimed at providing an early diagnosis for SpA in patients with IBD, and vice versa, that are adapted to the Spanish healthcare system. The objective of this article is to define clinical screening criteria for SpA in patients with IBD and vice versa, which serve as a reference in patient referral between the Rheumatology and Digestive System departments for the early detection of these diseases.