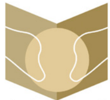
Reumatol Clin. 2018;14(2):68–74



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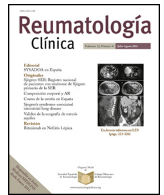

Special Article

# Screening of Inflammatory Bowel Disease and Spondyloarthritis for Referring Patients Between Rheumatology and Gastroenterology☆,☆☆

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ARTICLE INFO

*Article history:*
Received 5 March 2017
Accepted 3 July 2017
Available online 11 March 2018

*Keywords:*
Spondyloarthropathies
Inflammatory bowel diseases
Screening
Early diagnosis

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 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.

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

*Palabras clave:*
Espondiloartropatías
Enfermedades inflamatorias del intestino
Cribado
Diagnóstico precoz

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.

☆ 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. Reumatol Clin. 2018;14:68–74.
☆☆ This article is published simultaneously in Gastroenterología y Hepatología: 10.1016/j.gastre.2017.07.013, with the consent of the authors and editors.

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◊ The members of the PIIASER Project Working Group are listed in Appendix A.

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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.
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## 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.

## Material and Methods

### General Design

Systematic review of the literature and consensus using the two-round Delphi method.

### Selection of Scientific Committee and Panel Members

To make this selection, the experience (both clinical and investigational) of the candidates with regard to the project subject matter and their research CVs (publications from the last five years and participation in research projects) were evaluated. In the case of the scientific committee members, their personal qualities and attitude towards working in a group were also evaluated. For the selection of panellists, the geographic representation of the Spanish territory and the type of hospital (level 1 or basic hospitals, level 2 or reference hospitals, and level 3 or high-tech hospitals) were also evaluated.

The scientific committee was made up of two rheumatologists and two gastroenterologists. The panel of experts included seven rheumatologists and seven gastroenterologists.

### Literature Review

Two systematic reviews of the literature were conducted, one of which focused on the screening tools or the suspected IBD gastroenterologist referral criteria, and the other focusing on screening tools or suspected SpA (not including psoriatic arthritis) rheumatologist referral criteria. Both were limited to a population under the age of 18. The searches (Appendix B) were performed using Pubmed, Embase and Cochrane Library, and include articles in Spanish and English published until January 2016.

### Definition of the Screening Criteria

Using the results obtained in the systematic review stage and considering their experience, the members of the scientific committee defined the potential components of the screening criteria. In this respect, the sensitivity, specificity, ease of use in normal clinical practice and standardisation (ensuring that variability in their application is as low as possible) criteria were considered.

The two-round Delphi method was then initiated. The selected panellists evaluated the proposed criteria electronically. The panellists were provided with systematic review reports from the literature in advance. The scores for each criterion were calculated according to the following scale: 1 = absolute disagreement; 2 = moderate disagreement; 3 = neither agree nor disagree; 4 = moderate agreement, and 5 = absolute agreement.

For each of these criteria, the panellists could make comments about changes that may be considered necessary in the wording or reasons explaining their evaluation if deemed necessary, or provide additional evidence (not collected in the systematic review reports) that supported their scoring. The panellists could also propose additional criteria.

After analysing the results of this first Delphi round, the scientific committee evaluated the criteria for which there was no consensus, as well as the suggestions for additional criteria. A second document was then prepared outlining the criteria for which there had been no consensus in the first round, together with the changes made by the scientific committee according to the comments and suggested criteria. The first round scores and comments from the panellists for the non-consensual criteria were also

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