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Beneath the Surface: Psoriatic Arthritis in Dermatology Practice

Announcer Introduction

Welcome to CME on ReachMD! This activity, **Beneath the Surface: Psoriatic Arthritis in Dermatology Practice**, is provided by Forefront Collaborative in collaboration with Interstate Postgraduate Medical Association and supported by an educational grant from Lilly.

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Your host is Dr. Matt Birnholz.

Dr. Birnholz:

Most people with psoriatic arthritis struggle with multiple symptoms over a period of years before they get properly diagnosed. In fact, an estimated 50% of patients with psoriasis have undiagnosed psoriatic arthritis, which can lead to irreversible joint damage when left untreated. This makes the need for dermatology and rheumatology providers working closely together more critical than ever.

This is CME on ReachMD. I'm Dr. Matt Birnholz. Joining me to help address the collaborative roles of dermatology and rheumatology providers in identifying and managing psoriatic arthritis are Dr. Rebecca Muntean and Lakshi Aldredge. Dr. Muntean is a clinical rheumatologist with Providence Health and Services and faculty member at the University of Washington, and Miss Aldredge is a nurse practitioner specializing in dermatology from the VA Portland Healthcare System in Portland, Oregon.

So to both of you, why don't we start our discussion with an overview of patient evaluation strategies? Miss Aldredge, at which point in your patient evaluations do you introduce the concept of psoriatic arthritis?

Ms. Aldredge:

That's a great question. So you should introduce the concept of psoriatic arthritis as well as other comorbidities at the initial interview with the patient. You may not wish to go into great details as it can be overwhelming to the patient in the first visit, but you should at least discuss the concept of systemic inflammation and comorbidities. In addition, you should take a thorough medical history at the first visit including a review of any joint pain or tenderness as well as any back pain the patient may be having, and in addition, you should ask about past treatments or therapies that the patient is using for any joint pain. In the initial physical examination, it should include not only a full body skin assessment for any psoriasis lesions but also evaluate the joints and the fingernails to assess for swelling, erythema, tenderness, and with the nails, consider looking for pitting or oil spots as well as dystrophic changes of the nail.

Dr. Birnholz:

Great, and on that subject of the physical exam, I want to open up my next question to both of you regarding what physical findings are important to note that lead you to suspect this diagnosis. So, Miss Aldredge, let's start from your vantage point in dermatology.

Ms. Aldredge:

So, again, just the importance of conducting a full body skin assessment, because we know that the more body surface area that has psoriatic lesions, that tends to lead to an increase in severity, and the more severe the psoriasis, it can lead to an increased risk of psoriatic arthritis development. Again, it's also important to screen the hands, the feet, the back and the entheses for any inflammation, pain, erythema or swelling, and these are really primary areas of initial psoriatic arthritis presentation. However, it can really present in

any joint or enthesis. It's also really important, and a lot of people don't consider this, but uveitis can be associated with inflammatory disorders, so think about asking your patients about any eye symptoms they may be having, specifically sharp, stabbing eye pain that results in redness as well. So an inflamed eye can be a signal for uveitis, which again can be associated with psoriatic arthritis.

Dr. Birnholz:

And, Dr. Muntean, as a rheumatologist, what do you look for in the physical exam?

Dr. Muntean:

Thanks for asking. I think that's very important, because as a rheumatologist, we tend to pay a little bit more attention to swelling of the joints—when we're looking at hands and feet, paying attention to if there's any swelling around the joints themselves, tendons. It's very important to pick up both swelling of joints and tendons and also having the patient go through range of motion to see if there's any limitations of range of motions to kind of point to which joints might be affected with psoriatic arthritis.

Dr. Birnholz:

And, Dr. Muntean, let me continue with you on that line. Are there any screening tools and guidelines that help you identify this condition?

Dr. Muntean:

Yes, there are definitely quite a few tools and screening guidelines that we have for primary care physicians and dermatologists that they can use for screening for psoriatic arthritis. The one that's easiest to use, it's called the Early Arthritis for Psoriatic Patients, and it has roughly about 10 questions that are easy to answer, and sometimes we recommend that maybe primary care physicians or dermatologists have a list of those questions that they just hand it to the patient, and they're as simple as, "Do you have joint pain?" And it's a yes and no question. "Do you take anti-inflammatories more than twice a week in the past 3 months?" etc. So there are definitely quite a few screening tools that come with different sensitivity and specificity, and one of the ones that's the easiest to use is this EARP tool, as well as a great physical exam and a great history taking.

Dr. Birnholz:

And, Miss Aldredge, let me open this up to you as well. What are your thoughts on this?

Ms. Aldredge:

I think that Dr. Muntean is absolutely correct. So there are several organizations that have put out guidelines that can be a great resource in assessing for psoriatic arthritis. The Group for Research and Assessment of Psoriasis and Psoriatic Arthritis, also known as GRAPPA, has provided guidelines, and they are also in the process of updating those guidelines, which will be helpful. The National Psoriasis Foundation has also put out a consensus statement including both dermatologists and rheumatologists focusing on treating-to-target, and that is really ensuring that patients are receiving the most appropriate treatment for their skin and joint symptoms. And then, there's the other tools, as Dr. Muntean had mentioned, the EARP and the PEST. But whatever guidelines you use, the key function is to make sure that you're assessing for symptoms, you're looking at the joints, especially the distal joints, and then also looking at the nails.

Dr. Birnholz:

So, Miss Aldredge, now that we know more about the screening tools and the guidelines, how often do you assess your patients for psoriatic arthritis?

Ms. Aldredge:

It's a really important question. So psoriatic arthritis should be on the forefront of everyone's mind. So I screen for psoriatic arthritis at the initial visit when I have a new patient sitting in front of me, and then we need to make sure that we're assessing it every follow-up visit as well. So psoriasis presents on average 7 years prior to joint symptoms, but that's not always the case, so patients may be well aware of their skin symptoms but may not be aware that joint symptoms are associated with their skin disease. They may mistake it for gout, old age arthritis, or trauma from a past injury, so they may really not recognize that it's an inflammatory arthritis that, again, is associated with their psoriatic disease. So we need to again make sure we're asking about the physical symptoms of joint and back pain and stiffness at each visit and do a good back, hand, foot and joint examination along with a good skin exam, again at every visit.

Dr. Birnholz:

Dr. Muntean, let me turn over to laboratory tests beyond the history and physical and ask you whether laboratory tests can help in diagnosing psoriatic arthritis.

Dr. Muntean:

That's a great question. By definition, psoriatic arthritis is classified as a seronegative arthritis, meaning that typically the rheumatoid factor is negative. However, a small percentage of patients with psoriatic arthritis, about 5–9%, will have a rheumatoid factor that's

positive as well as anti-CCP or the anti-citrullinated peptide antibody being positive. The only difference is usually those titers are very low in patients with psoriatic arthritis versus patients that actually have true rheumatoid arthritis where those titers would be much more elevated; though there are some patients that actually have coexisting overlap psoriatic arthritis and rheumatoid arthritis, and it's very difficult initially to separate which disease is the leading disease, but usually the antibodies themselves and the symptoms and the distribution of the arthritis helps with the diagnosis—at the same time, specifically the distribution, the distal joints being involved like the DIPs, looking for swelling of the tendons, entheses, and actually having the sausage finger or toe, which is the dactylitis, which are specific findings of psoriatic arthritis and not rheumatoid arthritis.

Also, the ANA, the antinuclear antibodies, have been reported in psoriatic arthritis patients up to 15% as well as elevated sed rate and CRP. Once patients have elevated sed rate and CRPs, patients with psoriatic arthritis that have elevated sed rate and CRP, it's usually a sign of poor prognosis and more aggressive disease compared to patients that have psoriatic arthritis with normal sed rate and CRP. Also, patients with psoriatic arthritis tend to have hyperuricemia, which is part of the metabolic syndrome, and therefore, it's sometimes even a sign of more involvement of skin. The more psoriasis they have, their uric acid tends to be more elevated. Another study that can be done in patients with psoriatic arthritis are actually aspirating fluid from a joint that's swollen, and that fluid usually tends to be inflammatory but with a neutrophilic predominance compared to rheumatoid arthritis and the other inflammatory arthritides that tend to have more lymphocytic predominance.

In summary, though, there's not one test that would help diagnose psoriatic arthritis. We don't have any specific labs that would diagnose psoriatic arthritis. Psoriatic arthritis is a clinical diagnosis looking at the distribution of the joints, entheses involved, and see if patients have involvement of their nails or skin psoriasis.

Dr. Birnholz:

So continuing with the diagnostic considerations, especially in consideration of the disease being labeled a clinical diagnosis, Dr. Muntean, what radiographic features help to differentiate psoriatic arthritis from other inflammatory diseases?

Dr. Muntean:

Psoriatic arthritis does present with different findings on imaging. About almost 45–50% of the patients will develop erosive findings within the first 2 years of their disease, and eventually over time, up to 70% of patients will actually have some kind of radiographic changes, and the radiographic changes that we see in psoriatic arthritis are asymmetry between limbs, left hand and right hand. They don't necessarily have symmetric findings. We don't see the typical periarticular osteopenia that we see in rheumatoid arthritis. We see that the distal joints, the DIPs, are more involved, rather than PIPs and MCPs. We see erosions of the terminal tufts of the distal fingers, something that we don't see in rheumatoid arthritis, but there's a decrease in size of the phalanges over time from osteolysis of the bone. More severe changes are the pencil-in-cup deformities where the finger itself telescopes on itself and creates something that we call psoriatic arthritis mutilans. So definitely the changes that we see radiographically in the psoriatic arthritis are different than the other inflammatory arthritides.

With psoriatic arthritis, in summary, we can see asymmetry, erosion, but we also can see bony ankylosis, new bone formation around different joints, and therefore, x-rays themselves are useful in diagnosis of psoriatic arthritis compared to rheumatoid arthritis. Ultrasound, the new form of imaging, can help detect enthesitis, swelling of the entheses, as well as dactylitis, which is joint swelling and tendon swelling at the same time over the same joint. MRIs can be used also to show enthesitis in bone marrow edema of the entheses as well as help with diagnosis of non-radiological findings of sacroiliitis since MRIs are very sensitive and more specific in finding early changes of sacroiliac joints compared to x-rays. Therefore, imaging, x-rays, ultrasounds, and MRIs are useful in diagnosing psoriatic arthritis.

Dr. Birnholz:

And, Miss Aldredge, from your perspective on the dermatology side, are there any labs or x-rays that you order to help you identify and treat this condition?

Ms. Aldredge:

I think Dr. Muntean did an excellent overview of x-ray and lab findings associated with psoriatic arthritis, but for most dermatology providers, I would say that we tend to refer to rheumatologists if we suspect that the patient is having signs and symptoms of psoriatic arthritis since they truly are the experts in that realm, so I would say that dermatology providers typically don't order labs or x-rays but rather just refer. However, if you have a good relationship with your rheumatologist and the rheumatologist does want to have certain x-rays or labs done ahead of time, that can certainly be done, so it's really having a good relationship with your rheumatologist and understanding what would be most helpful and meaningful for them when the psoriasis patient comes to their office for the first visit. I may occasionally order hand or foot x-rays if that's the specific area of concern. The key with ordering x-rays is to provide the radiologist with pertinent history of psoriasis and ask that I'm looking for signs and symptoms of an inflammatory arthropathy, specifically

psoriatic arthritis.

So again, remember, as Dr. Muntean had mentioned, psoriatic arthritis is really a clinical diagnosis, and ordering labs and x-rays may not be fruitful and could be costly to the patient, so that is a factor to consider, thereby not just ordering needless x-rays and labs unless your rheumatology provider really has mentioned that they find that helpful or useful.

Dr. Birnholz:

For those who are just joining us, this is CME on ReachMD. I'm Dr. Matt Birnholz, and I'm speaking with rheumatologist Dr. Rebecca Muntean and dermatology nurse practitioner Lakshi Aldredge about improving care collaborations for psoriatic arthritis.

So, Dr. Muntean, let's focus on the referral component of care collaborations. What workup is reasonable for the dermatology provider to do before referring the patient with suspected psoriatic arthritis to the rheumatologist? So, for example, in a case of a 43-year-old male, comes in with plaque psoriasis and he complains of joint pain in his hands and feet, has one hour of morning stiffness, what should the dermatology provider do?

Dr. Muntean:

As Lakshi mentioned earlier, I think key things if they suspect psoriatic arthritis is to refer. First thing would be to refer to a rheumatologist. If rheumatology care is delayed, then I would encourage the dermatologist or a primary care physician to start ordering some basic labs, a CBC, a metabolic panel, sed rate and CRP, a uric acid, and more to make sure patients don't have other comorbidities, that we're picking up anemias and they don't have fatty livers and we're looking at the liver enzymes, which would be helpful not, per se, in the diagnosis of psoriatic arthritis but helping in choosing the best and the safest drug when we're going to manage their psoriasis and psoriatic arthritis. Other things that they can order are the rheumatoid factor and the anti-CCP antibody more so to see if there's an overlap with rheumatoid arthritis rather than just psoriatic arthritis.

Imaging of hands and feet or joints that are involved, like if this patient only complains of hand and feet pain and swelling and morning stiffness, we're not concerned of axial involvement like the spine and SI joints, and therefore, there's no need to image those areas, and we would want only limited imaging of hands and feet. But overall, if a patient has psoriasis that needs to be treated and they have joint issues at the same time, I would encourage the dermatologist to start treating the patient for their skin psoriasis, and that way they would be treating their psoriatic arthritis as well and prevent damage, accumulated damage, and disability later in life for the patient.

Dr. Birnholz:

So let's turn to treatment priorities for those patients. Dr. Muntean, what types and severities of symptoms do you look for in helping you decide on a treatment for your patient, and are there any particular resources that you use?

Dr. Muntean:

Yes, and thank you, this is a very good question, because depending on what type of symptoms a patient with psoriatic arthritis has, the treatment will have to match the symptoms, and what I mean by that, the group of research for an assessment of psoriasis and psoriatic arthritis has put together an amazing guideline by domains that are affected, meaning if patients have only peripheral arthritis, if only small joints, hips and knees are affected, then we would start a disease-modifying drug first, a nonbiologic disease-modifying drug, but if they have axial involvement, SI joints, spine, dactylitis or enthesitis, the recommendations are to start with a biologic disease-modifying drug; and also, from a dermatology perspective, if they have nail involvement, then the first-line would be a biologic versus a nonbiologic disease-modifying drug. And therefore, it's really important to really do a great assessment of the patient to make sure we're treating the right symptoms, because if it seems that they only have peripheral arthritis but we're missing the enthesitis and then we choose a nonbiologic disease-modifying drug, the patient will continue to have pain in his heels or the plantar fascia or different entheses that a disease-modifying drug won't be able to cover.

Dr. Birnholz:

And, Miss Aldredge, can you speak to this as well?

Miss Aldredge:

Yes, I think Dr. Muntean did a great job of an overview of the treatment options, and she's absolutely correct in that if a patient has skin involvement and they're not complaining of joint symptoms or you cannot see any on the clinical examination any findings of joint deformity or tenderness when you palpate their heels or their feet or their fingers, then you can safely treat their skin without necessarily considering joint management. However, if the patient does have more significant skin involvement, they have those nail pitting, dystrophic changes of the nails, and they start complaining of a little stiffness and soreness in their hands or feet, you really do want to move quickly to a biologic agent. If they didn't have those symptoms, you might consider topical therapies or phototherapy, but the first hint of psoriatic arthritis involvement you need to move to a biologic agent. Why is that important? Because with skin disease, we can always produce more skin cells or new skin cells, so the skin can regenerate itself to look healthy. In the joints, once you start having

joint symptoms, that means that there is some damage that's occurring, and that can be progressive and debilitating, so we can't get the same kind of normalizing level of function that we can with the skin improvement. So, again, it's really important to identify the symptoms of psoriatic arthritis early and then treat appropriately with the guideline-recommended treatment recommendation.

Dr. Birnholz:

And on that subject of guidelines, Dr. Muntean, what do the GRAPPA recommendations specifically tell us about when to use biologics as first-line treatments for patients with psoriatic arthritis?

Dr. Muntean:

So the GRAPPA recommendations are pretty straightforward when it comes to specific domains. With dactylitis, axial disease and enthesitis, biologic disease-modifying drugs are considered first-line, so not wasting any time in starting a nonbiologic disease-modifying drug because we will not slow down the progression of disease by using those medications. So therefore, they have specific guidelines if you have dactylitis, the sausage finger or toe, axial disease, involvement of the SI joints or any areas of the spine as well as enthesitis, tendon insertion inflammation or nail disease to move right to a biologic disease-modifying drug.

Dr. Birnholz:

Let me ask you both then how we create the best circumstances to prevent joint damage from this condition. And, Dr. Muntean, can you describe your process first?

Dr. Muntean:

Sure, I'm more than happy to do so. I think the most important part is something that Lakshi has started on at the beginning of this discussion, screening for early arthritis as soon as possible, screening very early. You see a patient for psoriasis, keep in mind psoriatic arthritis and see if they have any joint pain, muscle pain, tendon pains, anything that would make you think they might have psoriatic arthritis, and then refer them to a rheumatologist. And if it takes too long to get to see a rheumatologist, start treatment early. Start the treatment that you think is best for their skin and nail disease, and that should cover their joints in psoriatic arthritis and prevent long-term disability and improve quality of life.

Dr. Birnholz:

And, Miss Aldredge, what's your process as a dermatology specialist?

Ms. Aldredge:

Dermatology providers typically are looking at the skin first, so our treatment algorithm would require us to identify the amount of body surface area that is involved. So if you have a patient with mild to moderate skin psoriasis, we would typically treat them with topical therapies or phototherapy and potentially even conventional systemic therapy. If they start having or complaining of early symptoms of psoriasis or psoriatic arthritis, morning stiffness or joint pain, it may be also appropriate to initiate the conventional systemic therapies including DMARDs. However, if patients do have more severe skin involvement, they have nail involvement including the pitting and the onycholysis, and they might have some symptoms of joint deformity in the distal joints of the fingers or toes, then it is absolutely appropriate to move then to biologic therapy.

Dr. Birnholz:

Excellent. Thank you, Miss Aldredge. And, Dr. Muntean, I'm going to pose my last question to you. I understand that the American College of Rheumatology and National Psoriasis Foundation plan to publish a new guideline for the management of psoriatic arthritis in 2018. What can you say about this upcoming guideline?

Dr. Muntean:

Both ACR and the National Psoriasis Foundation as well as GRAPPA are planning to update their guidelines this year, ACR and the National Psoriasis Foundation by late spring/summer 2018 as well as GRAPPA by the end of this year. The guidelines are very much anticipated since 2017 has been a great year in psoriasis and psoriatic arthritis with quite a few new biologics approved by the FDA. For psoriatic arthritis specifically, by the end of 2017, we had golimumab infusion approved, ixekizumab, abatacept and tofacitinib as well as some biosimilars, and therefore looking forward to the new guidelines that will include the new medications that have been approved by FDA by the end of 2017.

Dr. Birnholz:

And on that note, I'd like to thank my guests, Lakshi Aldredge and Dr. Rebecca Muntean, for speaking with me and our ReachMD audience. It was great speaking with both of you on the program. Thanks so much.

Dr. Muntean:

Thank you, Matt.

Ms. Aldredge:

Thank you.

Announcer Conclusion

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