Transcript Details
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Beyond the Skin: Recognizing PsA and IBD in Psoriasis Patients

Announcer:
You're listening to *DermConsult* on ReachMD. Here's your host, Dr. Charles Turck.

Dr. Turck:
This is *DermConsult on ReachMD,* and I'm Dr. Charles Turck. Joining me today to share strategies for recognizing signs of psoriatic arthritis and inflammatory bowel disease in patients with psoriasis is Dr. Andrew Dorizas. He's a double board-certified dermatologist and Mohs surgeon affiliated with the University of Miami Health System and Advanced Dermatology of Alaska. Dr. Dorizas, welcome to the program.

Dr. Dorizas:
Thank you for having me.

Dr. Turck:
To begin, Dr. Dorizas, psoriasis is often thought of as a skin disease, but its impact can extend far beyond the skin. So what should dermatologists understand about its association with psoriatic arthritis and inflammatory bowel disease, and why should these conditions be on their radar when caring for patients with psoriasis?

Dr. Dorizas:
I'd frame psoriasis as a systemic disease driven by the interleukin-23 and interleukin-17 pathways that just happen to show up on the skin first. And naturally, this makes the dermatologist the first specialist to see it, often years before the joints or the gut are involved.

Psoriatic arthritis is probably the clearest example. Meta-analysis showed that one in five patients with psoriasis coexisted with psoriatic arthritis, and in roughly eight out of 10 of those patients, the skin disease came first. And among psoriasis patients routinely seen in clinic, about 15 percent have arthritis that has not been diagnosed yet, and these are patients who are being seen on multiple occasions.

Inflammatory bowel disease is the other piece. Meta-analysis in *JAMA Dermatology* found that patients with psoriasis had two and a half times the risk of developing Crohn's disease and about 1.7 times the risk of developing ulcerative colitis. This climbs even further when psoriatic arthritis is present.

So in absolute terms, it's still uncommon, but the message is to stay alert and not to alarm the patients.

Dr. Turck:
Well, with that connection in mind, let's zero in on the clinical clues for each condition that may warrant further evaluation. Starting with psoriatic arthritis, what musculoskeletal signs and symptoms should dermatologists look for in patients with psoriasis, particularly when those symptoms might be mistaken for everyday aches and pains?

Dr. Dorizas:
So as a dermatologist, I always start by looking before I ask. I look for nail disease, especially pitting or onycholysis, as that's a good predictor of psoriatic arthritis. And then I look at the scalp; I look at intergluteal psoriasis areas, and patients who tend to have more extensive disease or that family history of psoriatic arthritis are at risk.

Then I listen for how patients describe it because they're never going to come in and say, "I have arthritis." They might say, for example, "My heel hurts," or "The back of my ankle hurts when I get out of bed or walk downstairs." And that's often what we see in enthesitis. They might say that every now and again, they get a swollen finger. Or they think that they stubbed their toes because it was

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so painful, and that might be dactylitis. Sometimes, I ask if they have morning stiffness in any of their joints that gets better as they go throughout the day, and this might show something of an inflammatory pattern. And of course, any back or lower back pain that wakes up the patient in the night but gets better with activity points towards an axial disease or axial involvement.

What's striking is how ordinary these signs can be. Heel pain equates to about four times the risk of developing psoriatic arthritis, and when you couple that with fatigue and stiffness, that number can double. So these symptoms tend to get blamed for other things, like plantar fasciitis, working out, or getting old. But I would say that heel pain, a puffy toe, morning stiffness, and fatigue in a patient with nail psoriasis, for example, are not just irregular aches. These combinations can be the early phase of psoriatic arthritis.

Dr. Turck:
And when it comes to inflammatory bowel disease, would you tell us about the gastrointestinal symptoms or aspects of a patient's history that might suggest an underlying condition?

Dr. Dorizas:
So with bowel disease, patients rarely connect gut symptoms with their skin, although that's changing in our field. But they tend to not mention it in our visits. Usually, we have to ask the patients certain questions to bring up these red flags. So for example, diarrhea lasting more than four weeks, especially if they're sleeping at night but they wake up to go to the bathroom because of diarrhea, would be a very concerning sign. If, of course, they see any blood or mucus in the stool, that would be also something that points towards a possible inflammatory bowel disease. And then we have things like abdominal pain that keeps coming back, weight loss that they weren't planning on, fevers, and unexplained fatigue. All of these point away from irritable bowel syndrome and more towards inflammatory bowel disease.

Some clues can actually be seen in an exam. If you tend to examine the perianal area, for example, you might see things like fistulas, abscesses, or even just large skin tags. These can all suggest Crohn's disease, but they might be mistaken for hidradenitis or maybe inverse psoriasis in some cases. Inflammatory bowel disease doesn't just cluster with psoriasis. There are other classic cutaneous signs that we might see, things like recurrent aphthous ulcers in the mouth, erythema nodosum, and pyoderma gangrenosum. These, coupled with a family history of inflammatory bowel disease, more severe psoriasis, or coexisting psoriatic arthritis, all raise my suspicion.

The important thing here is that there is a coupled risk when we prescribe certain medications. There was a pharmacovigilance study that found that in patients who were on interleukin-17 inhibitors, there was an increased report of patients developing inflammatory bowel disease. And so if I have a patient that I want to prescribe a certain medication, I will screen their bowel habits ahead of time. And then of course, I will keep asking them every time I see them for the first six months of their treatment.

Dr. Turck:
For those just tuning in, you're listening to *DermConsult* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Andrew Dorizas about how we can recognize signs of psoriatic arthritis and inflammatory bowel disease earlier in patients with psoriasis.

Now, patients may not always bring up joint or gastrointestinal symptoms during a psoriasis visit. So, Dr. Dorizas, would you tell us a little bit more about how you screen for these conditions in your practice, and are there any particular questions or tools that you find most useful?

Dr. Dorizas:
Yeah. So I think the screening is definitely favored towards psoriatic arthritis. We have several tools at our disposal. My preference is to keep it simple for the patients, myself, and the staff.

So I like to use the psoriasis epidemiology screening tool. It's called the PEST screening tool, and this is something patients can complete in the waiting room. We can send it to them before they even have the visit. It's a simple five-item, yes-or-no questionnaire. Things such as, have you ever had a swollen joint? Has a doctor ever told you that you have arthritis? Have you noticed any pits or holes in your nails? Have you ever had heel pain before? Have you ever had a toe or finger that has swollen up for no apparent reason? After this screening tool is given to the patient and we see three or more yeses or positive answers, this is what would make me more suspicious of involvement of the joints in their psoriasis and then perhaps have a rheumatologist co-manage the patient or at least screen them. There is no perfect screening tool or questionnaire, so I like to confirm with examination. As I mentioned earlier, I like to look at the nails, the hands, and the heels.

Now for the gut, there is no validated screening tool. I think the difficulty here is, which patients do I escalate, either through lab testing or referrals? So I keep it simple. I just ask two questions. One is, have you had diarrhea lasting longer than four weeks? And then of course, have you had diarrhea waking you up in the night with any blood in the stool? If any of those things are a yes, I order a fecal calprotectin lab test. And so it's a good triage test because if it is positive, that raises suspicion, but it is not specific to just inflammatory

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bowel disease.

Dr. Turck:
When a dermatologist identifies symptoms of psoriatic arthritis or inflammatory bowel disease, what should the next steps look like? And how might recognizing these conditions earlier influence treatment decisions, including the use of advanced therapies when appropriate?

Dr. Dorizas:
For joints, urgency depends on the exam. A swollen joint, dactylitis, or enthesitis warrants a prompt rheumatology referral. A positive questionnaire such as a PEST screening tool that we talked about earlier with a normal exam can be less urgent. And I think having a relationship with your rheumatologist and knowing what they want to be done ahead of time is very important.

So in my case, they like us to order certain labs and X-rays prior to their visit with them to help expedite their diagnosis. Timing does matter, though. Waiting for more than six months to see a rheumatologist has been linked to about four times the odds of developing joint erosions.

For the gut, I do check CRP and fecal calprotectin when the patients answer positively to those screening questions that we talked about earlier. If those come back positive or the patient is on, for example, a medication like an interleukin-17 inhibitor and develops these new GI symptoms, I stop the medication and always refer to the gastroenterologist for evaluation.

But here's the point: finding psoriatic arthritis or inflammatory bowel disease isn't just a reason to refer. It changes the way that I prescribe the medications for my patients because there are certain medications that are approved across psoriasis, psoriatic arthritis, and inflammatory bowel disease. Things like interleukin-23 inhibitors are the choices that I tend to lean to in these particular patients. As for axial disease, I tend to lead towards more TNF inhibitors or interleukin-17 inhibitors because the guidelines and data still suggest that those two classes are best for axial involvement. Although there are now multiple studies looking at interleukin-23 blockers for axial disease and even for things that we haven't really accepted yet but think about in the back of our minds. Things like the PAMPA trial and looking prospectively at whether or not we can lower the risk of developing certain comorbidities are ongoing.

Dr. Turck:
Now, as we wrap up, Dr. Dorizas, what's one key change you'd encourage dermatologists to make during their next visit with a patient with psoriasis to help recognize potential signs of psoriatic arthritis or inflammatory bowel disease earlier?

Dr. Dorizas:
The more that we learn about the axis that connects the skin, the gut, and the joints, I think it's become more important for us to make a 60-second skin, joint, and gut check a part of every psoriasis visit, especially before you choose a systemic therapy for the first time for a patient.

Look at the nails, the scalp, and the intergluteal folds. Ask about the heel pain, morning stiffness that lasts more than 30 minutes, and any fingers or toes that have been swollen. Then ask about the gut. Ask about diarrhea that’s lasted for longer than four weeks, if they've seen blood in the stools, or if they get up at night for a bowel movement. Especially ask these questions before selecting certain medications such as interleukin-17 inhibitors, but always ask them during the six months if they're already on one of those as well.

It has to be at every visit because it's a moving target, right? Close to three percent of patients with psoriasis develop psoriatic arthritis each year. And this is why both the American Academy of Dermatology and the National Psoriasis Foundation guidelines call for evaluating these domains at every visit. About 15 percent of patients already have undiagnosed psoriatic arthritis. And remember, a simple six-month delay can quadruple the odds of developing erosions.

So look at the nails, ask about the heels, ask about the bowel habits, and then choose a drug that treats the whole patient, not just the plaques.

Dr. Turck:
Well, with that call to action in mind, I want to thank my guest, Dr. Andrew Dorizas, for joining me to share these practical strategies for identifying musculoskeletal and gastrointestinal signs in patients with psoriasis that may warrant further evaluation in psoriatic arthritis or inflammatory bowel disease. Dr. Dorizas, it was great speaking with you today.

Dr. Dorizas:
It was a pleasure. Thank you for having me once again.

Announcer:
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