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GRAPPA Guidelines: A Look at the Past and Present

Announcer:

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Here's your host, Dr Jason Liebowitz.

Dr Liebowitz:

In the world of psoriatic arthritis, the recommendations for treatment are constantly evolving. So what do we need to know about past and present therapeutic strategies? And how can we help provide optimal care for our patients? This is ReachMD, and I'm Dr Jason Liebowitz. Joining me to discuss past and present GRAPPA guidelines is Dr Laura Coates.

Dr Coates is an associate professor at Oxford University with a research focus on optimal therapeutic strategies for patients with psoriatic arthritis. She's also a member of the Steering Committee of the Group for Research and Assessment of Psoriasis and Psoriatic Arthritis, also known as GRAPPA, and the first author on the 2015 and 2021 GRAPPA treatment recommendations for psoriasis and psoriatic arthritis. Dr Coates, thanks for being here today.

Dr Coates:

Thank you very much for inviting me.

Dr Liebowitz:

To start us off, Dr Coates, can you briefly describe what GRAPPA is? What is the organization's key mission?

Dr Coates:

Yeah, so GRAPPA is the Group for Research and Assessment of Psoriasis and Psoriatic Arthritis, and it was formed in 2003 following on the success of the CASPAR study. So there was a large, international, collaborative study to develop new classification criteria for psoriatic arthritis, and that group wanted to carry on the great work and expand that into much broader aspects of psoriasis and psoriatic arthritis. So we're a nonprofit organization with both educational and research aims, and we aim to share information around psoriasis and psoriatic arthritis. One of our key missions is to provide up-to-date treatment recommendations that can be used by clinicians and patients worldwide.

Dr Liebowitz:

Thank you so much. That's a wonderful discussion and summary. Now, let's dive into the GRAPPA guidelines. Can you compare the recommendations from 2015 to the recommendations from 2021, regarding the treatment of peripheral arthritis and psoriatic arthritis?

Dr Coates:

So obviously, 6 years is a short time in lifetimes, but a long time in treatment recommendations, and we've seen a lot of new evidence around peripheral psoriatic arthritis during that time point. But we still have old medications that have strong evidence as well. So we have recommendations for anti-inflammatories and both intraarticular or oral steroids, particularly for relieving symptoms in the short

term. Based on observational data, we have a strong recommendation for the use of conventional DMARDs in treatment-naive patients, but we've seen new data particularly supporting the superiority of TNF inhibitors over and above conventional DMARDs in trials during that 6-year period, so there is a strong recommendation for the early use of TNF inhibitors based on those studies.

And then obviously, over that 6-year period, we've seen an expansion in the different treatment options that we have for peripheral psoriatic arthritis. So we have very high-quality RCTs which support the use of TNF inhibitors, IL-17 inhibitors, IL-23 inhibitors, and JAK inhibitors, and moderate quality evidence for IL-12/23 and PDE4 inhibitors as being efficacious in the treatment of peripheral psoriatic arthritis.

Dr Liebowitz:

Wonderful, thank you so much. And can you now compare the recommendations regarding the treatment of axial disease in psoriatic arthritis from 2015 to 2021?

Dr Coates:

So again, we've seen big changes particularly in the biologic and targeted synthetic DMARD space. So we still have good evidence around anti-inflammatories, physiotherapy, and local steroid injections. But just as in 2015, typically targeted therapies are required for the majority of our patients and is obviously strongly recommended.

In the 2015 recommendations, we already had TNF and IL-17 inhibition demonstrating efficacy. But there has been, obviously, a lot of controversy in this space. So we've seen the addition of a recommendation for JAK inhibitors, where we've had positive studies in ankylosing spondylitis, but we've also seen conflicting evidence particularly around IL-12/23, ustekinumab, and IL-23 inhibitors in the management of axial disease, and therefore, those are not recommended because we've seen negative studies in axial spondyloarthritis.

Dr Liebowitz:

It's very helpful. And now, Dr Coates, what do these 2 sets of guidelines tell us about treating the domains of skin and nail disease in psoriatic arthritis?

Dr Coates:

So obviously, GRAPPA is a group that includes both rheumatologists and dermatologists, so we always want to include good quality data for skin and nails as well. And I think this is where we see very strong data from the dermatology literature as well. So, we've got recommendations around the use of topical agents. Obviously, for a lot of dermatologists, they're jumping straight into systemic treatment but a lot of our patients in rheumatology have quite limited body surface area involvement, and so topical agents may be appropriate. For patients who have more widespread psoriasis, obviously we have very useful treatments which overlap and which show efficacy in the joint and the skin domain, including oral therapies like conventional DMARDs, apremilast, JAK inhibitors, and biologics, where we've actually got increasing differentiation between the different mode of action from the dermatology literature.

We obviously do have specific therapies that are used predominantly for skin or nail disease that don't show efficacy in the musculoskeletal domain, so phototherapy, but very useful as an adjunct for patients with severe skin and acitretin, quite commonly used in plaque psoriasis, but without evidence of efficacy for the joints. So it's trying to look at some situations where you may be able to treat multiple domains with 1 drug, which has efficacy in both skin and joints, or in some situations, you may need to have 2 different agents that are acting on those different domains, depending on that individual therapy.

And then obviously, nail disease for those with psoriatic arthritis is particularly common and troublesome. There's a little bit of evidence, although quite limited, for topical treatments or intralesional treatments, but very strong evidence now for a number of the biologics showing their efficacy in nail disease as well.

Dr Liebowitz:

That's a great discussion which is very helpful for a disease like psoriatic arthritis, which is so interesting in its multidomain manifestations. So looking to the future, is there any other data we need to incorporate to strengthen future guidelines?

Dr Coates:

So you definitely discover when you write guidelines that there's a lot of things missing, there's a lot of evidence that we don't have. We're really lucky that we have increasing evidence around different modes of actions and different numbers of drugs in these different domains. But there's still a lot of ongoing questions.

We've touched a little bit in the recommendations from 2021 around the management of related conditions and comorbidities. Because I think that's a big research area for us to think about how we manage patients with complex multi-morbidities.

There are questions around screening and early diagnosis. And obviously a research interest currently into whether effective treatment of psoriasis might be able to prevent or slow the development of PsA.

And I think where we have more and more drugs available, it's really important to think about how we use the drugs that we have. So treatment strategy, sequencing of different medications, and the potential for precision medicine to allow us to target particular individuals with the best medication for them rather than a kind of trial-and-error type approach, which tends to be what we do in the clinic at the moment.

And obviously, beyond just treatment selection, we need to be able to deal with rheumatology care more widely and think about how we optimize that in different health care settings. These particular recommendations were delayed by the COVID pandemic. That's had a massive impact on the way that we practice and has affected very different healthcare settings in different ways. And so I think there's a big gap out there to think about how we deliver optimal care for the future.

Dr Liebowitz:

That's a great way to round out our discussion. I want to thank my guest, Dr Laura Coates, for helping us better understand how the 2015 and 2021 GRAPPA treatment recommendations compare. Dr Coates, it was a great pleasure speaking with you today.

Dr Coates:

Thank you very much.

Announcer:

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