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Uncovering Hidden Clues in Diagnosing Psoriatic Arthritis

Announcer Open:
This is ReachMD. Welcome to Spotlight on: Rheumatic Diseases. This episode titled, “Uncovering Hidden Clues in Diagnosing Psoriatic Arthritis” is sponsored by Lilly. The views and/or opinions expressed are of the medical expert and not necessarily by Eli Lilly & Company.

Here’s your host, Dr. Matt Birnholz.

Dr. Birnholz:
Coming to you from the Annual Rheumatology Meeting in Atlanta, Georgia. This is ReachMD. I am Dr. Matt Birnholz. Joining me today is Dr. Roger Kornu, a rheumatologist from Tustin, California. Dr. Kornu earned this distinction of top doctor in Orange County by Castle Connolly in 2016 and most recently, he has been named by the Orange County Medical Association as a Physician of Excellence for both 2018 and 2019, and today we are going to center our discussion on Psoriatic Arthritis and Uncovering Hidden Clues in Diagnosing This Condition. So, Dr. Kornu, welcome to you.

Dr. Kornu:
Oh, thank you so much for having me out here.

Dr. Birnholz:
Yeah, pleasure to have you. So, this is one of my favorite parts of the interview is right off at the get go, I get to ask you a little bit about how you came into psoriatic arthritis, specifically, as a disease state. From an educational sense, you’ve developed a real passion for it and from your academic to your multispecialty to your single specialty practice arenas, you’ve tried to spread the word about psoriatic arthritis. Can you tell us how you came into that passion?

Dr. Kornu:
Well, thanks a lot. That’s exactly right. You know it’s been a journey. I think in all rheumatology cases, you always think about the journey of a patient, the journey about the education of the patients through medicine, and right, I’ve been through pretty much every practice possible. I started at single specialty, multispecialty group, academics at UC Irvine, and now in solo practice for the past two years, and just realizing that psoriatic arthritis is, as one of our inflammatory diseases, is it’s been really under-diagnosed. There is no test for it like we would think in say, rheumatoid arthritis, and just trying to educate folks on different domains of disease. Call it the classic noggin disease. We have to really think about what the person has, not just use a test. You have to use your physical exam skills, your history taking skills. Classic medicine, if you will.

Dr. Birnholz:
Right. That’s a great backdrop and getting right into psoriatic arthritis then, we know that there are studies that suggest around 10-30% of psoriasis patients will develop psoriatic arthritis over their lifetime, but what’s the significance of this risk from your vantage point?

Dr. Kornu:
Oh, it’s huge. I mean, it’s one of the clues that we do have and I think, to say, well if you have psoriasis throughout your body, that that’s a pretty obvious case, but really, at the end of the day, there’s a lot of cases where it’s really subtle, and in fact, a lot of our patients in our clinic are basically at fairly 1-2% of BSA, which is basic body surface area of psoriasis and really areas that we don’t really think about as much. And you think about the nails, you think about the skin, you think about the risk for this arthritis condition, which people don’t know about. I mean, it may take 8 to 10 years to actually have any arthritis manifestations. Actually, I had a patient I saw in clinic the other day basically had psoriasis about age 10 to 12, had it for a few years, some topicals. She is 50 now, and she developed these

joint pains that no one could figure out and at a more typical, asymmetrical disease, not in the classic symmetrical that we think in say a rheumatoid patient., No one bothered to take the history of the psoriasis when she was a kid, but that still applies.

Dr. Birnholz:
Interesting. So there really is an awareness gap in the broader field as a whole regarding the development of psoriatic arthritis. Look for the history of psoriasis and oftentimes, that's not done, it sounds like.

Dr. Kornu:
That's right and, in fact, even the CASPAR criteria actually has family history of psoriasis as a criteria. So, you ask not just about the patient's pertinent history, but also the parents, their siblings. People don't ask that as often as they probably should.

Dr. Birnholz:
Well, let's stick with that theme of the awareness gap and move towards plaque psoriasis. Many clinicians are familiar with the more typical manifestations of plaque psoriasis on the scalp, the elbows, the knees, but you've also been helping train others on some of these hidden areas that shouldn't be missed. Can you just speak to that for our audience?

Dr. Kornu:
Actually behind the ear is a very common place that we see. On the gluteal cleft as well. So, you have to usually ask the patient that. It's a little sensitive question, but to say, "Do you have any psoriasis there as well?" The other thing is also the nails and people will have, especially in the toes. I challenge everyone to actually take the shoes off the patient. Sounds pretty obvious, but it doesn't always happen

Dr. Birnholz:
So, coming back to the feet, this idea of, for instance, the presence of dactylitis. How often is that missed in general practice and maybe even rheumatology practice.

Dr. Kornu:
Oh, I think it is missed quite a bit. I think it is because, again, people don't take their shoes off, and you don't really ask. In fact, you have to even like, take their shoes, socks off and look. And you look at their toes and say "Gosh, what about that fifth toe?" especially is a very common place, that is larger. They are like, "Oh yeah, that's been there for a while" and it doesn't necessarily hurt in all cases. It actually maybe asymptomatic to them. This is a sign that we have to think about disease because we are all pretty much good about saying "Oh, I have this big red toe for gout," but don't think about the other toes. They kind of get a shaft a little bit. So, we really want to look at that very closely.

Dr. Birnholz:
And you bring up a really good point about signs versus symptoms. Are we lacking in the ability to really look after the signs when symptoms are not necessarily forthcoming?

Dr. Kornu:
Oh, I think so. It is education, right? You can say "I don't have time to think about these things," but if you start thinking about a spondy-type patient, then you start really narrowing it down and say, "Well I've got to think about their feet, and I've got to think about things like enthesitis. Think about plantar fasciitis," which people say, "Yeah, I've had this plantar fasciitis for on and off over the past, but podiatry said just wear these inserts and I'm good," right? And maybe it is the case in some of those, but bilateral involvement, just chronic involvement, you've got to think about some other process besides just the typical mechanical type cause.

Dr. Birnholz:
And you mentioned enthesitis. I understand that that, or the recognition thereof, is becoming more and more important as a domain. Can you describe the areas that are most commonly affected by enthesitis in a psoriatic arthritis patient?

Dr. Kornu:
Right. So, I mean, it is a great point. I think you look at Achilles tendinitis as very common because it's the largest tendon that we have, of course. The plantar area is very common. You look at the biceps tendinitis as well is there. And you really ask like "Well how long have you had this for? Is it bilateral? Is it unilateral?" And it's really quick to ask the patient this. You have to just think about it because remember patients just will minimize things. I mean, they will, as much as they complain about certain things, they will minimize others and say, "Oh, yeah, that's related? Okay maybe that's, what is that doctor?" So, you have to encourage the patient by asking them the right questions.

Dr. Birnholz:
And I find that fascinating because, especially enthesitis where that's concerned. We often pass that off in our own experience without

thinking of the patient's special risk factors. Can you speak to that in terms of trying to separate – as you said, it's a noggin disease – separating our own experience and the things that happen commonly from the things that actually might represent a risk factor or might represent a red flag for somebody who might be developing psoriatic arthritis?

Dr. Kornu:
Oh, that's a great question. I mean, you think about things like how long it has been going on for? Have you tried some conservative therapies? Maybe go by PCP or podiatrist if it is the feet, and they're not responding. If people don't respond, you don't say "Well, sorry." You have to think about what else? Of course, you start thinking about the other domain.

Dr. Birnholz:
If we come back to the dermatological manifestations, what would you say is the dermatological manifestation or manifestations that represent the greatest risk factors for the development of psoriatic arthritis?

Dr. Kornu:
You usually have nails with other skin areas, but you can also have it in isolation, which I think is huge. Obviously on their fingers, people may complain more, but again, that is not as common as their feet. You got to look at it if you have several toes that are involved, not just one, it's like having a fungal infection in every toe is not common. What is actually more common? Something else. I would encourage, though, folks to test for fungal. That is easy. Just do a KOH prep or a nail clipping to make sure it is not, because you actually can have both. You can have a psoriatic nail and you have a fungal infection. It is possible.

Dr. Birnholz:
Not mutually exclusive.

Dr. Kornu:
Correct. It's like having osteoarthritis and rheumatoid arthritis. You can have both, unfortunately. It can happen, but you have to be discerning and figure out how you treat this or how I treat that. There is different rabbit holes of considerations, as we call it.

Dr. Birnholz:
Interesting. Have any cases come to you recently that were a real throw off in a sense that they came off looking a certain way. And you looked at it and said, "No, hold on a second. Looking at the domains, I am seeing something very different here."

Dr. Kornu:
I saw a patient recently in my clinic, who was referred for rheumatoid arthritis and said "I think you have RA," and they had maybe a kind of borderline rheumatoid factor. That's a good referral for a rheumatologist, right? But then you go and you're like thinking this is not symmetrical disease. So, I think you have to think about you can have PSA that's symmetrical, but usually it is asymmetrical. This wrist, this finger, this toe, and the patient's like, "doctor I have RA, right? This is RA." I went, well, and you start asking other questions and you say, oh he has maybe some inflammatory bowel-type symptoms. He has enthesitis that he just kind of blew off because he is an athlete. He plays on a softball team.

Dr. Birnholz:
So, they think that soreness must be a Thursday kind of thing.

Dr. Kornu:
Right, exactly. So again, there could be that too, but you put it all together and you think there is something else. Of course, then we do other testing. He was at sero positive, which of course, a lot of people can be, but again another clue. There is no one test, but you have to take all the different aspects and say, well this is not going to be RA, I don't think. And so, his mom has psoriasis. so that was another aspect to it and then, of course, the last clues before we took his shoes off and they're all yellow nails, and he goes, "Well gosh, I have athlete's foot." I'm like, well that's not athlete's foot. And so, the key thing, I guess, for, as far as a rheumatologist, if you have an inflammatory suspicion of anything, refer to us because we can help folks decide that. I have a patient where he had this asymmetrical arthritis and I said, "Do you have a skin rash and where is it?" He basically takes his shirt and he unbuttons the shirt and I saw this huge plaque psoriasis he had for 10 years that really no one really bothered it. I mean, it wasn't a big deal. He used a little over-the-counter topicals fine, but no one put it together. Some of that I think the last few years we've been better about, but hopefully we can continue to tell that story of not just joints, not just skin, but you think about the enthesitis. You think about inflammatory bowel disease symptoms as well. You think about the other nail involvements. A lot of different areas that we have to think about.

Dr. Birnholz:
I have a feeling many of our listeners will have heard the case representations you just talked about and think, "I saw a patient just like that. I don't think I took off their shoes" and other such ideas that really could represent a change in their management going forward. I really want to thank you for joining us and talking about these hidden clues. It feels like a mystery being solved. Thanks again for your

time.

Dr. Kornu:
Thank you very much for having me.

Announcer Close:
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