JOINT ADVANCES IN RHEUMATOLOGY AND DERMATOLOGY

A best practice guidance document for the care of people with Psoriatic Arthritis (PsA)
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Foreword

The British Health Professionals in Rheumatology (BHPR) welcomes this comprehensive document concerning the identification and management of psoriatic arthritis, a condition which may present in many different ways and go unrecognised and undertreated. This guide contains useful tools for health care professionals who may come across the condition in the course of their work and will help to raise awareness of psoriatic arthritis. It also highlights the need for a multidisciplinary approach to the management of the condition, with good communication between health professionals and with the needs of the patient, both physical and psychosocial at the very heart of the care that is delivered.

I thank all those involved for their hard work in producing this publication and am sure that many health professionals will find it a useful reference document.

Lindsey Hawley
President
BHPR

At a time when resources, both time and money, are precious for patients and the health service alike, it is essential that patients with long-term conditions like psoriasis and psoriatic arthritis are diagnosed and treated swiftly and appropriately.

Many people with psoriasis also have arthritis, but this is currently unrecognised, and whilst the Psoriasis Association provides information on both conditions, patients may find that one facet of these conditions is not treated adequately.

Outside In provides key guidance for diagnosing and treating psoriatic arthritis, promoting the collaborative care between dermatologists and rheumatologists, which not only has the patients’ needs at the heart, but includes them as a member of the multidisciplinary team, involved in the decision making process.

By highlighting key points from existing Guidelines such as SIGN 121 and NICE, Outside In advises the use of disease severity and Quality of Life measures that should be available in all clinical settings. Once a diagnosis has been made, it is vital to record ongoing assessments not only to see if a treatment is working, but to detect any issues the patient may be experiencing psychologically in living with the conditions.

Patients are the expert at how living with the conditions affects them, whilst the other members of the MDT, Rheumatologists, Dermatologists, Specialist Nurses, Physiotherapists, Podiatrists etc are experts in their field – only by a combined approach, using examples such as those included in Outside In, can the patient receive the best care, enabling them to be fulfilled in work and life.

The working group have produced a set of recommendations that are not only achievable, but will make a difference to the lives of those affected by psoriasis and psoriatic arthritis.

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What are the objectives of this document?

- Raise awareness of the current challenges in the identification and management of PsA
- Prevent misdiagnosis and delays in diagnosis of PsA
- Provide recommendations and consensus on the assessment of patients with PsA
- Raise awareness of the multidisciplinary team and improve patient access to appropriate specialists
- Ensure patients with PsA receive appropriate and timely access to the right treatments
- Highlight the main goals of treatment:
  - Prevent disease progression and/or further degeneration
  - Reduce symptoms
  - Improve quality of life (QoL)
  - Restore functional ability
- Ensure each individual is optimally managed – by treating to guidelines and to personal goals
- Promote collaborative care between dermatologists and rheumatologists to ensure the best care possible for this unique group of patients
1. Awareness, screening, and referral from community practitioners

As with other inflammatory arthritis, it is important to refer to specialist care early to prevent progressive joint damage

- Any swollen joint or inflammatory back pain in the presence of psoriasis is an indication for referral
- A PEST questionnaire should be completed annually for any patients with psoriasis who have not been diagnosed with PsA
  - Patients with a PEST score ≥3 and in whom there is any suspicion of PsA should be referred to a rheumatologist for specialist care
- Patients with psoriasis of sufficient impact, DLQI >5, should be referred to a dermatologist for specialist care
- All patients should have an annual assessment of co-morbidities and risk factors

2. Diagnosis and assessment

All patients with PsA attending a dermatology or rheumatology clinic should have a minimum of standardised assessment by a competent practitioner.

- Practitioners within one unit should maintain a consistent assessment process.
  - Training should be provided to achieve this
- Support from other services should be used where necessary to complete assessments

3. Treatment

- Treat psoriatic disease according to national guidelines
- Offer appropriate symptom control
- It is good practice to assess patients’ ongoing treatment response throughout the course of the disease to identify those who may be sub-optimally treated
- Pathways should consider enabling direct access to specialist care for when flares or exacerbation present

4. The multidisciplinary team and patient pathways

- Patient care should be integrated to optimise cost and care
  - Specialist teams should work together with agreed outcomes
  - Maximise each practitioner’s expertise to offer an efficient service
  - Training must be provided to achieve this.
Psoriatic arthritis (PsA) is an inflammatory arthritis that is associated with psoriasis. Symptoms range from mild to severe – the typical rheumatic symptoms being joint stiffness, pain and swelling, and tenderness of ligament and tendon insertions.\textsuperscript{1} Patients may present via a variety of routes including (but not limited to) dermatology, rheumatology, podiatry, physiotherapy, and community practice. In addition to joint disease, dactylitis (inflammation of the whole digit) occurs in nearly half of all patients over the course of their disease, and enthesitis (inflammation of the insertion of tendons or ligaments into bone) occurs in at least a third. Axial disease also occurs in approximately half of all patients with PsA over the course of their disease. The majority of patients have nail signs, which occasionally may precede the development of skin psoriasis.\textsuperscript{2} PsA can present solely with inflammation in peripheral joints and may appear similar to rheumatoid arthritis (RA). However, PsA is linked to the spondyloarthritides due to similar clinical and pathophysiologic features.\textsuperscript{3}

Most people with PsA develop skin symptoms before joint symptoms (approximately 70% of cases) although joint symptoms may appear first or simultaneously (each occurring in approximately 15% of cases).\textsuperscript{1, 4-7} PsA typically develops within 10 years of a diagnosis of psoriasis.\textsuperscript{1} The prevalence of PsA in the general population has been estimated at 0.04–0.9\%\textsuperscript{1, 6, 8, 9} with an equal distribution between men and women.\textsuperscript{10}

Although traditionally perceived as a rare and mild disease, increased interest in PsA and cohort studies have revealed that PsA is more severe than originally thought.\textsuperscript{2} Around two-thirds of people with PsA have progressive, damaging arthritis.\textsuperscript{11}

The progressive nature of the joint damage highlights the importance of effective screening and treatment.\textsuperscript{12} Untreated PsA can lead to long-term damage and disability with profound impairment of patient quality of life (QoL).\textsuperscript{11, 13}

Despite this knowledge, PsA is often unrecognised.
Psoriasis is a relatively common disease, with an estimated prevalence in the UK of approximately 2–3%. Many people with psoriasis also have psoriatic arthritis but this may be currently unrecognised in many patients. A European survey of 1,511 patients with psoriasis attending a dermatology clinic revealed that 21% of them had PsA, yet only 3% of them were already diagnosed.\textsuperscript{14}

The awareness of PsA among community practitioners and dermatologists should be addressed, as their regular contact with patients with psoriasis places them in the best position for screening for PsA. Currently, many patients with psoriasis seen in general clinics will not have an objective assessment of severity with a Psoriasis Area and Severity Index (PASI) or complete a Dermatology Life Quality Index (DLQI) questionnaire, let alone a Psoriasis Epidemiology Screening Tool (PEST), or any other test suitable for PsA screening. The group also acknowledged that, in dermatology clinics, a PEST or formal screening for arthritis is not regularly carried out, and the impact of psoriasis is often neglected in rheumatology clinics.

There is also the need to raise awareness of PsA across the full multidisciplinary team (MDT) as undiagnosed patients may present via a variety of routes including, but not limited to, dermatology, rheumatology, podiatry, physiotherapy, and community practice.

A patient with undiagnosed PsA may, for example, chose to go direct to a podiatrist with foot complaints, giving the podiatrist a unique opportunity to diagnose PsA.

Foot involvement in patients with PsA is common and associated with clinically important levels of impairment and disability, yet only a small proportion receive any intervention for their foot problems. Peripheral enthesitis is a hallmark feature of PsA, with entheses of the lower extremities (in particular the foot) more frequently involved than those of the upper limbs. The heel is reported to be the most common site.\textsuperscript{16,17} A common reason for referral into podiatry and physiotherapy services is for the management of plantar heel pain and Achilles tendon problems and so it is important that PsA is included as a potential differential diagnosis in all these cases.
Nail changes (nail pitting, discolouration, thickening, and separation of nail from the free edge) are common amongst people with psoriasis and are commonly mistaken for fungal nail infections. It is reported to be more common in patients with PsA. Recognition of this factor is important when screening for PsA by all healthcare professionals.

In current clinical practice, patients may not be followed up after their initial consultation and there is no record of their disease severity. This problem may be exacerbated by the difficulty patients with psoriasis may have in describing the impact the disease has on their lives and feeling stigmatised and therefore easily dismissed. They may not initiate returning to their GP as they do not realise that they are entitled to standardised care for their condition, nor do they realise that their aches may be arthritis. They generally believe that they can and should manage their condition without support.

Patients should be motivated on the need for assessments and it should be accepted as standard care in the same way as for patients with diabetes, for example, who expect to have their weight, blood pressure, and blood glucose measurements taken at regular intervals.

This working group supports the Scottish Intercollegiate Guidelines Network (SIGN) recommendation that patients with psoriasis or PsA should have an annual review with their GP involving the following:

- Documentation of severity using DLQI
- Screening for depression
- Assessment of cardiovascular risk (in patients with severe disease)
- Assessment of articular symptoms
- Optimisation of topical therapy
- Consideration for referral to secondary care
- Screening for PsA using PEST

Although the list may initially seem daunting, many assessments should already be carried out as part of good clinical practice, management of long-term conditions, and screening for co-morbidities (which may be relevant for reimbursement purposed). To minimise impact on appointment times, the questionnaires can be handed out to patients on arrival for them to complete in the waiting room.
Regular screening of patients can be used to reassure patients and, in those who are not diagnosed with PsA, it may provide the opportunity to identify other conditions that can then be treated.

A call to administer an annual screening questionnaire is of additional value in raising awareness of PsA. Currently, many physicians are not aware of the risk of musculoskeletal disease in patients with psoriasis.

**PEST as a screening tool for referral to rheumatology**

In addition to the patient’s annual review, any patient in whom there is any suspicion of PsA (i.e., swollen joints or inflammatory back pain) should complete a PEST questionnaire. There are a number of available screening tools, each with their own imperfections, but the PEST is recommended as it is simple and quick to complete and the mannequin is helpful both to the patient and the physician. In addition, it is highly sensitive, thus ensuring potential cases are not missed. The SIGN guidelines recognise PEST as an appropriate screening tool for a high volume clinical setting.8

In patients in whom there is a suspicion of PsA, a **PEST score ≥3 is an indication for referral to a rheumatologist.**

The **PEST tool is available at the end of this document.**

It is also worth noting that patients with psoriasis or PsA may present with back pain due to inflammation. Back pain is common in the general population but if the pain has the clinical characteristics of inflammatory back pain (IBP) further investigation may be required. Characteristics of IBP include:25

- Age at onset <40 years
- Back pain >3 months
- Insidious onset
- Improvement with exercise
- No improvement with rest
- Pain at night (with improvement upon getting up)
- Morning stiffness
The DLQI as a screening tool

The DLQI is a patient-administered questionnaire that is used to determine the impact of patient’s skin disease on their QoL. If the patient’s psoriasis is of sufficient impact, they should be referred to a dermatology clinic for specialist care. **A DLQI score >5 is an indication for referral to a dermatologist.**

The DLQI tool is available at the end of this document.

Referral pathways

Referral to both a dermatologist and a rheumatologist may be indicated for some patients. In these cases, the community practitioner should use their judgement and knowledge of local services to decide upon the best route. In some cases, and where local services permit, referral to both services may be warranted as consultant to consultant referrals are often hampered by local hospital algorithms.

The group acknowledges that referral pathways vary depending on local services, but call for frameworks that identify this unique group of patients and set out appropriate pathways.

Currently there are no studies to support the hypothesis that early diagnosis and treatment of PsA can improve long-term joint damage and disability, a paradigm widely accepted for RA; however, it has been shown in a cohort of patients with PsA that the rate of peripheral joint involvement is the highest in the first year of arthritis. There is evidence that psoriasis can have a progressive negative impact on the decisions patients make throughout their life, resulting in them being in relationships and jobs that they perhaps would not have chosen otherwise – a concept known as cumulative life impact. Therefore, it is important to refer any patients with psoriasis of sufficient severity (DLQI >5) to specialist care.

Regardless of whether screening results in a referral or not, it is good clinical practice to record and monitor patients’ scores, as the results will affect the choice of management.
RECOMMENDATION 1

- As with other inflammatory arthritis, it is important to refer to specialist care early to prevent progressive joint damage
  - Any swollen joint or inflammatory back pain in the presence of psoriasis is an indication for referral
  - A PEST questionnaire should be completed annually for any patients with psoriasis who have not been diagnosed with PsA
    - Patients with a PEST score ≥3 and in whom there is any suspicion of PsA should be referred to a rheumatologist for specialist care
  - Patients with psoriasis of sufficient impact, DLQI >5, should be referred to a dermatologist for specialist care
  - All patients should have an annual assessment of co-morbidities and risk factors
The diagnosis of PsA is made on clinical, radiological and immunological grounds. Diagnosis is suggested by a distinct clinical pattern of peripheral arthritis and psoriasis together with distinctive features such as enthesitis, dactylitis and spondylitis. Rheumatoid factor is usually negative.

The CASPAR (ClASsification criteria for Psoriatic ARthitis) criteria (shown in table 1) list the potential features of patients with PsA. A patient must have inflammatory articular disease (joint, spine, or entheseal) with ≥3 points based on points assigned to each feature.\textsuperscript{26} It should be noted that these criteria were designed for classification, not diagnosis, and should be applied to people with established inflammatory musculoskeletal disease.

Table 1: The CASPAR criteria for PsA\textsuperscript{26}

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current psoriasis (assigned a score of 2)</td>
<td>2</td>
</tr>
<tr>
<td>A history of psoriasis (unless current psoriasis was present)</td>
<td>1</td>
</tr>
<tr>
<td>A family history of psoriasis (unless current psoriasis was present or there was a history of psoriasis)</td>
<td>1</td>
</tr>
<tr>
<td>Dactylitis</td>
<td>1</td>
</tr>
<tr>
<td>Juxtaarticular new bone formation</td>
<td>1</td>
</tr>
<tr>
<td>Rheumatoid factor negativity</td>
<td>1</td>
</tr>
<tr>
<td>Nail dystrophy (e.g., nail pitting, thickening, and separation of nail from the free edge)</td>
<td>1</td>
</tr>
</tbody>
</table>

There are currently no uniformly understood or implemented methods of best practice for assessing psoriasis and PsA. A group of physician and nurse experts in rheumatology and dermatology (the PsA Assessment Academy) met in March 2011 to discuss assessment of PsA based on the available evidence. They put forward practical recommendations that could optimise initial assessment and monitoring of PsA by improving coordination between rheumatology and dermatology services.
The recommendations were developed to build on and align with existing guidelines issued by the British Society for Rheumatology (BSR), Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA), National Institute for Health and Clinical Excellence (NICE) and SIGN.

The group recommend a modular approach that encourages sharing of knowledge and information, efficient use of time, and prompt referral and treatment of patients. As a minimum, it has been suggested that rheumatology clinics perform the 66/68 joint count, DLQI and PASI if staff are trained in skin assessment. Dermatology clinics should perform the PASI and the PEST.

**Assessment in rheumatology units: a modular approach (Fig. 1)**

The modular approach to assessment in rheumatology focuses on assessments for joints and axial skeleton with a simple assessment of skin involvement. When patients first present to clinic it is recommended that they are asked two screening questions to facilitate appropriate assessments:

1. Have you been suffering from any neck or back pain recently?
2. Do you have any psoriasis at the moment?

If the patient answers no to these questions, a 66/68 joint count, Leeds enthesitis index (LEI) and tender dactylitis count are recommended.
Figure 1: Assessment and screening of psoriatic disease in rheumatology clinics.

**ASSESSMENT AND SCREENING OF PSORIATIC DISEASE IN RHEUMATOLOGY CLINICS**

The recommended approach for assessing and screening patients is outlined below. A training manual including short videos on how to conduct the assessments shown on this poster and other recommended assessments is available.

At first contact in the rheumatology clinic a patient with PsA should be asked two questions:

- **Back and neck:** Have you been suffering from any neck or back pain recently?
- **Skin:** Do you have any psoriasis at the moment?

Yes

Patient to be given the BASDAI** to complete in the waiting area.

If neck or back pain is thought to be inflammatory, then practitioner to conduct:

- modified Schöber's test**
- cervical rotation**
- cervical lateral flexion

No

Patient to have PsA assessments by a practitioner.

66/68 joint count

Leeds enthesis index**

Tender dactylitis count**

Yes

Patient to be given the DLQI*** to complete in the waiting area.

If the patient has any psoriasis a PASI* should be conducted.

If the rheumatology clinic is unable to do a PASI or if DLQI >5 then the patient should be referred to the dermatology clinic. Nails should be visually assessed for pitting.

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*A PASI should be conducted in all patients who are being considered for biologic treatment or who are already on biologic treatment.

**Guidance on these assessment tests is provided in the training manual and on the video.

66/68 tender and swollen joint counts

Although the number of joints to be counted initially appears high, it is important that patients suspected of having PsA have a 66/68 joint count due to the high proportion who present with oligoarthropathy,10 and the presence of foot involvement. In line with the new BSR guidelines, the use of the 66/68 joint count is recommended as a minimum when assessing patients with PsA.

The PsA Assessment Academy discourages the use of the 28 joint count (as used for DAS28 scores) when assessing patients with PsA because of its potential to overlook patients who would be deemed suitable for anti-TNF-α therapy by other methods.
Dactylitis

Dactylitis is defined as uniform swelling of a digit. Usually there is no problem in identifying dactylitis as it is often a painful and disabling manifestation of PsA. However, there are a number of pitfalls:

- The little toe(s) can cause confusion as they usually appear short and fat, rather like a cocktail sausage.
- Comparison between sides is recommended.
- Sometimes a bulbous proximal inter-phalangeal joint will be mistaken for dactylitis – remember that uniform swelling of the entire digit is the feature of dactylitis
- Sometimes subtle swelling of the digit causes doubt – in these cases a validated method such as the Leeds dactylitis index (LDI)\(^27\) is recommended to clearly define and measure dactylitis.\(^27\)

Entheses

The LEI is the only measure specifically developed and validated for PsA\(^28\) and should be considered the tool of choice for assessing the entheses. Only six entheseal sites (right and left Achilles insertions, medial femoral condyles, and lateral epicondyles of the humerus) are assessed, which makes it quick and easy to administer.\(^28\)

Since the Achilles tendon insertion is most frequently involved in PsA and is easy to find during assessment, it is recommended that this site could be assessed alone to save time, as long as fibromyalgia has been excluded.\(^23\)
Axial Skeleton

As inflammatory back pain is a feature of PsA, the spine should be considered for assessment in all patients who answer positively to the screening question ‘Have you been suffering from any neck or back pain recently?’ For those patients, the Academy suggests the Bath Ankylosing Spondylitis Activity Index (BASDAI) screening questionnaire be given to patients to complete when they first present at clinic.

For those in whom the neck or back pain may be inflammatory, the group recommends the following tests as practical options:

- Test for cervical spine involvement by observing rotation of the head and estimating the degree of rotation possible (cervical rotation), and observing a tilt of the head towards the shoulder and estimating the degree possible (lateral flexion). Use a goniometer for both measurements
- Assess lumbar flexion using the modified Schöber test.

Further spine assessments should be carried out in those with suspected inflammatory back pain.25

Psoriasis

In addition to assessments of the joint, axial skeleton and peripheral features of PsA, any psoriasis should be assessed when a patient presents at a rheumatology clinic. For those presenting with skin disease, the DLQI should be given at the same time as the BASDAI. The DLQI is used to determine whether the psoriasis is of sufficient impact (>5) to require referral to dermatology. A PASI should also be conducted in patients with any psoriasis. If necessary, a patient may be referred to dermatology for these assessments or, alternatively, dermatology colleagues consulted.

Assessment in dermatology units: a modular approach

PASI

Although the PASI has some limitations, the assessment is widely used and well understood, and so the group recommend this as the primary assessment used in evaluating skin involvement. The PASI should be used in all patients presenting to dermatology clinics, in monitoring response to treatment, and in patients who respond positively to the screening question in rheumatology (support from dermatology may be required to perform the assessment).
PEST

The PEST is recommended for initial assessment of patients in dermatology. It is simple to complete, and the mannequin is helpful to both patients and physicians. As the PEST can assess both skin and joint involvement, it has the ability to identify joint pain where other assessments may not. For patients with (or with any suspicion of) PsA, a PEST score of \( \geq 3 \) is an indication for referral to a rheumatologist.

DLQI

It is also recommended that patients presenting in dermatology clinics also complete a DLQI at each visit (again, the patient may complete this while in the waiting room). A DLQI score of >5 is considered to be significant.

Figure 2: Assessment and screening of psoriatic disease in the dermatology unit.

The algorithm for assessment and referral of PsA is aimed at encouraging prompt referral to a rheumatology service.
Quality of Life and Psychosocial Assessments

PsA provides a unique challenge for patients. Patients with PsA have often endured a disfiguring and stigmatising skin condition for many years prior to developing painful, disabling joint disease. This dual combination provides a considerable psychological and physical burden for individuals. Objective, regular assessment of the social, psychological and physical impact of the disease enables the effect of treatments to be monitored and appropriate intervention instituted.

There are several validated measures of function and disability including the Health Assessment Questionnaire (HAQ), the SF-36, and EQ-5D. Only the Psoriatic Arthropathy Quality of Life Index (PsAQoL) has been validated specifically in PsA, but is yet to be widely used. The BASDAI and spinal pain visual analogue score (VAS) can be used in the assessment of patients with psoriatic spondyloarthropathy. A reduction of BASDAI of 50% or ≥ 2 units and a reduction in spinal pain VAS by ≥ 2 cm suggests an adequate response to treatment.

There is guidance from NICE on screening for depression. They recommend asking two questions:

During the last month, have you often been bothered by:

- feeling down, depressed or hopeless?
- having little interest or pleasure in doing things?

A ‘yes’ to either question should result in further assessment or referral.

Assessment Academy tools

The Assessment Academy have developed a set of tools to assist with the assessment and screening of psoriatic disease in dermatology and rheumatology clinics, in particular to ensure that assessment methods are consistent across units.

These tools are available freely from Abbott UK. To obtain a pack please contact your local Abbott representative, or Abbott Medical Information on 01628 774920.
RECOMMENDATION 2

- All patients with PsA attending a dermatology or rheumatology clinic should have a minimum of standardised assessment by a competent practitioner.

- Practitioners within one unit should maintain a consistent assessment process.
  - Training should be provided to achieve this

- Support from other services should be used where necessary to complete assessments
Section 3: Treatment

This section refers to UK and international evidence-based guidelines. Healthcare professionals should follow local guidelines and their clinical judgement to make decisions appropriate for individual patients.

The goal of treatment is to slow disease progression, to relieve symptoms, to improve QoL, and to restore functional ability. A variety of treatments are available for psoriatic diseases, ranging from topical treatments to injected drugs, and patients may be managed in community practice or in specialist care. The ideal treatment will help both the skin and joint manifestations. In addition, as PsA has many manifestations and can affect the whole of a patient’s health and well-being, a holistic approach to treatment is necessary. Successful patient management should include patient education and support with psychosocial adjustment, as necessary. Please see Section 4 for more information on the support available from the MDT.

This group advocates the SIGN Psoriasis and PsA Care Pathway (Figure 3) as a useful resource for healthcare professionals to refer to. The pathway shows the patient journey between primary and secondary care, featuring both dermatology and rheumatology routes, and the appropriate treatments at each stage. Of particular importance for a disease with various manifestations, physician judgement should always play an important role in treatment decisions for patients with PsA. Co-morbidities should be taken into consideration when selecting appropriate treatments.
**Figure 3:** The SIGN Psoriasis and PsA Care Pathway.* Symptomatic relief should be offered. NSAIDs are recommended for short term symptom relief in patients with PsA where not contraindicated.
This group also supports the GRAPPA recommendations on appropriate therapies based on disease characteristics [Figure 4;37].

**Figure 4:** [Anti-TNF, anti-tumour necrosis factor; CsA, ciclosporin A; DMARD, disease-modifying antirheumatic drug; IA, intra-articular; LEF, leflunomide; MTX, methotrexate; NSAID, non-steroidal anti-inflammatory drug; PT, physiotherapy; PUVA, psoralen–ultraviolet light A; SSZ, sulfasalazine; UVB, ultraviolet light B.].37 **NICE do not recommend biologics for dactylitis alone but may be permitted on a named-patient basis.**

Treatment recommendations are traditionally based around the classification of disease severity, which can be mild, moderate, or severe based on selected criteria,13 although physician judgement plays an important role in treatment decisions for patients with PsA.

Non-steroidal anti-inflammatory drugs (NSAIDs) and local corticosteroid injections are widely used. Patients who are unresponsive to NSAIDs are treated with DMARDs to reduce joint damage and prevent disability.1
The BSR Guidelines note that while NSAIDs and corticosteroid injections are an important initial intervention, current practice is aimed at early diagnosis and early use of potential DMARDs to suppress persistent inflammation. The anti-TNF-α medications have shown the greatest efficacy of any treatment to date in the various clinical aspects of PsA, although they are only recommended for patients who have failed to respond to at least two traditional DMARDs.

NICE recommends anti-TNF-α agents for the treatment of active and progressive PsA, based on specific criteria (also summarised in Figure 5):

- The person has peripheral arthritis with three or more tender joints and three or more swollen joints, and
- The PsA has not responded to adequate trials of at least two DMARDs, administered either individually or in combination.

SIGN make a similar recommendation, for the use of anti-TNF-α agents for the treatment of active PsA in patients who have failed to respond to, are intolerant of, or have had contraindications to, at least two disease-modifying therapies.

NICE recommends that treatment choice should be started with the least expensive drug (taking into account drug administration costs, required dose and product price per dose). This may need to be varied for individual patients because of differences in the method of administration and treatment schedules.
Figure 5: NICE PsA algorithm – based on their guidance on biologic drugs for the treatment of PsA.\textsuperscript{1, 29}

- **Use standard treatment for psoriatic arthritis including DMARDs**
  - **YES**
  - **NO**

- **Does the Patient have peripheral arthritis, with 3 or more tender joints and 3 or more swollen joints?**
  - **YES**
  - **NO**

- **Is the psoriatic arthritis responding to adequate trials of at least 2 standard DMARDs (administered either individually or in combination)?**
  - **YES**
  - **NO**

- **Use the least expensive licensed TNF inhibitor, taking into account drug administration costs, required dose and product price per dose.**

- **Is there an adequate response to treatment, defined as:**
  - improvement in at least 2 of the 4 PsARC criteria (1 of which has to be the joint tenderness and swelling score) and
  - no worsening in any of the 4 criteria?
  - **YES**
  - **NO**

- **Response to be first measured at 12 weeks**

- **At 12 weeks does the patient have a PASI 75 response?**
  - **YES**
  - **NO**

- **Discontinue the treatment with the TNF inhibitor used**

- **Refer to a dermatologist to assess whether it is appropriate to continue treatment on the basis of skin response**

**Key**

- **DMARD**: disease-modifying anti-rheumatic drug
- **PASI**: psoriasis area severity index (PASI) score
- **PsARC**: psoriatic arthritis response criteria
- **TNF**: tumour necrosis factor

**TA**: NICE technology appraisal
Treatment response

It is good practice to assess patients’ ongoing treatment response throughout the course of the disease to identify those who may be sub-optimally treated. Setting a target – for example, in the dermatology clinic, a PASI 75 (75% reduction in PASI), or a PASI 50 (50% reduction in PASI) plus a 5-point reduction in DLQI – can be helpful to determine if patients are responding to a therapy.

NICE guidance support the use of the Psoriatic Arthritis Response Criteria (PsARC) for assessing treatment response to biologics. It is recommended that treatment is discontinued if disease does not show an adequate response to biologics on the PsARC at 12 weeks. In the absence of an adequate PsARC response, treatment may be continued if the patient’s skin disease has a PASI 75 response at 12 weeks (this treatment response assessment should be carried out by a dermatologist). A disadvantage of the PsARC is that it is a measure of response and does not give an absolute disease state.

The Assessment Academy recommends that outcomes indicating effectiveness of therapy should provide a wider picture of the patient’s disease activity and QoL. Although the PsARC is quick and easy to perform, it has the limitation in that it provides a snapshot overview of disease status rather than measurement of disease activity. Therefore, in addition to regular use of QoL measures to assess patients’ overall well-being (as mentioned earlier), this group supports their use as part of assessing treatment response.

Open access services

This group recommends that, where services permit, pathways should consider enabling direct access to specialist care for when flares or exacerbations present. This is supported by SIGN Guidelines.

A nurse-led telephone advice line service is also recommended as way to offer timely access to information and support.
RECOMMENDATION 3

- Treat psoriatic disease according to national guidelines
  - Offer appropriate symptom control
  - It is good practice to assess patients’ ongoing treatment response throughout the course of the disease to identify those who may be sub-optimally treated
  - Pathways should consider enabling direct access to specialist care for when flares or exacerbation present
A multidisciplinary approach

Appropriate care from a MDT can provide adequate support to a patient and help them stay in their community. There are limited recommendations and evidence on the organisation of care for patients with PsA, although it is acknowledged that patients should have access to appropriate multidisciplinary care.8

It is unlikely that a patient with PsA will require access to every possible specialty; however, they may benefit from access to any number of the following: specialist nurses, specialist doctors, community practitioners, pharmacists, physiotherapists, occupational therapists, podiatrists, patient groups, psychologists, othotists, dieticians, family and carers, social services, and employers (figure 6). Referral to, or opinion of, other specialists such as gastroenterologists may be necessary for some patients if symptoms present. Support from each specialty should be readily available if needed, but the actual pathway the patient takes should be tailored to the individual and their disease characteristics.

Effective use of the MDT can help run an efficient service by streamlining a patient ‘through the system’ and potentially reducing the number of appointments. It is essential that members of the MDT communicate well and complement each other. For example, test results should be shared across the MDT to avoid duplication and unnecessary costs and inconvenience for the patient.
Figure 6: Support from the full MDT should be available to patients, as required.
As mentioned earlier, the MDT should be aware of the signs and symptoms of PsA as undiagnosed patients may present via a variety of routes.

Patients with PsA are at increased risk for a number of comorbidities including diabetes, depression, hypertension, inflammatory bowel disease, and lymphoma. These common co-morbidities can and should be managed by a community practitioner. As patients with PsA are also at increased risk of cardiovascular morbidities compared with the general population, community practitioners should be educated on the association so that they can take an active role in managing the patient’s cardiovascular (CV) profile. An annual CV risk assessment using national guidelines should be considered for all patients with PsA.

Appropriate management of co-morbidities by a community practitioner or an appropriate healthcare professional (e.g. a clinical biochemist or a nutritionist) is good clinical practice and is of benefit to the patient’s overall well-being. In turn, the patient should take an active role in the management of their co-morbidities. A simple example is taking part in a smoking cessation or weight-loss programme. The SIGN guidelines note it may be worth considering advising patients that they may be at increased risk of cardiovascular disease and diabetes.

Patients should be actively involved in the decision-making process, which includes discussing treatment options, risks and benefits. Patients themselves are important members of the MDT and, if informed correctly, can help to manage their own care. A successful patient education initiative may also help to alleviate resources elsewhere. Two examples are given below.

1. An educational coffee morning attended by a combination practice or specialist nurses, occupational therapists and/or physiotherapists could be offered to patients and their partner, family, or carers. This represents an opportunity for them to be educated on the self-management of their condition, to offer peer support, and to answer any questions they may have. A coffee morning hosted once every 3 months could save several unnecessary appointments.

2. A specialist nurse could give suitable patients education on skin surveillance (with or without a partner, family member, or carer, as appropriate). Patients could then have open access (dependent on local services) to return to the clinic only if they notice any suspicious lesions or have another reason for concern. This model can therefore create additional appointment times for new or high-risk patients.
Patient support

In addition to involving patients in the decision-making process and encouraging them to take an active role in managing their disease, patients should be directed to additional resources to help them understand and manage their condition.

As many patients will now seek information online, it is advisable to direct patients to reputable websites of patient organisations. There are currently limited resources specifically for PsA, and so this group recommends a wider selection of rheumatology and arthritis associations:

Arthritis Care: http://www.arthritiscare.org.uk/Home
Arthritis Research UK: http://www.arthritisresearchuk.org/
The British Society for Rheumatology (BSR): http://www.rheumatology.org.uk/
National Rheumatoid Arthritis Society (NRAS): http://www.nras.org.uk/
The Psoriasis Association: http://www.psoriasis-association.org.uk/

Patients may also benefit from Expert Patient Programmes, which are free courses run in the community to help people to manage their long-term condition on a daily basis. They aim to support patients by increasing their confidence, improving their QoL, and helping them manage their condition more effectively. More information is available at: http://www.expertpatients.co.uk/.
An integrated approach

The management of PsA may be significantly enhanced by making efforts to combine and co-ordinate care between rheumatology and dermatology teams, ensuring patients have access to the right specialists at the right time and that the disease is treated and managed as a whole.

Good collaborative models or ‘joint clinics’ for PsA management may demonstrate the NHS QIPP (Quality, Innovation, Productivity, Prevention) framework of quality of care. Clinics – particularly in the current NHS climate – need to demonstrate that they are implementing cost-effective changes that do not compromise patient outcomes, but actually improve management and optimise treatment for patients. Such models enable a MDT to provide quality and tailored care, financial savings, innovative practice and better prevention of disease progression.

Moving towards a collaborative model could involve minimal adjustments such as making the rheumatology team more ‘skin aware’ and vice versa, or it could involve a whole new approach to the management of patients with PsA.

The following examples of collaborative care highlight the fact that there are a number of different routes you may wish to take depending on your capacity, available resources and local services.

Key considerations:

• Think about what you can realistically manage within your budget and resources
• Carefully plan which patients should be seen at the clinic
• Create a workable referral infrastructure
**Parallel-run PsA clinic**

A PsA clinic runs on the same day as a routine rheumatology clinic and a psoriasis clinic, which allows for a co-ordinated and flexible management model. The PsA clinic runs weekly and takes place as a 30 minute session just before the regular Inflammatory Arthritis Clinic and whilst running in parallel to a psoriasis clinic – this skin clinic takes place at the same time in the same building, on the floor above. The PsA clinic can see two to three patients a week. The majority of PsA patients are seen initially at the psoriasis clinic and then routinely referred to the rheumatology clinic for joint assessment. Patients are only referred to the PsA clinic if there are any significant joint or skin concerns or treatment issues that cannot be addressed during routine follow up.

**Potential benefits:**

- **Convenience** – patients can attend the PsA clinic on the same day as one of their regular follow up appointments
- **Rapid referral** – if a patient presents with a severe concern in their regular arthritis or psoriasis clinic that cannot be addressed at that routine follow up, they are referred for assessment at the PsA clinic that very day, eliminating the need for waiting lists or additional appointments
- **Smooth information exchange** – patient notes and follow up information can be easily transferred from the regular clinics to the PsA clinic
- **Efficiency** – running the PsA clinic as a session just ahead of a regular follow up clinic requires less resourcing and is more time effective
Case 2

**Combined consultant-led PsA clinic**

This consultant-led combined clinic runs twice a year with each clinic held alternately at the rheumatology and then the dermatology department. Both a consultant rheumatologist and a consultant dermatologist take the clinic alongside a nurse specialist from the ‘home side’ (i.e. the department the clinic is taking place at), with support from staff nurses. Each clinic runs for 3 ½ hours with appointment slots of 20 minutes, which is double the appointment time dedicated to patients in the departmental follow-up clinics.

For the rheumatology consultant, the combined clinics run in addition to her work plan. For the dermatology consultant, the clinic replaced an already existing psoriasis follow up clinic in the dermatology department. Patients are referred to the combined clinic from the individual rheumatology or dermatology clinics under a number of criteria developed by the clinic:

- If there is a borderline score for joint assessment but no visible skin concern
- If there is a problem assessing the patient appropriately on anti-TNF therapy
- If the patient is not responding to anti-TNF therapy
- If the patient has any other problems with anti-TNF therapy

**Potential benefits:**

- Joined-up, multidisciplinary care and review of patients
- Quicker decision-making on patient management
- Avoidance of interruptions to treatment regimens
- Fewer cross-referrals
- Enhanced learning for staff
- Meeting NICE guidance regarding dermatology supervision for patients on anti-TNF therapy for PsA
Case 3

Combined nurse-led clinic for PsA patients on anti-TNF therapy

This clinic’s remit is to see every patient with moderate to severe PsA, on anti-TNF, once a year for PASI and joint assessment scores, as well as skin surveillance to detect and prevent any skin malignancy. Patients with problematic skin or joint disease can be seen more frequently, or fast-tracked into the conventional rheumatology or dermatology clinic. The clinic is held once a month, running for three and a half hours with appointment slots of 30 minutes.

Originally patients were seen by both a dermatology nurse specialist (DNS) and a rheumatology nurse specialist (RNS) in one room so that both nurses learned and standardised PASI together. Patients are now seen in tandem in two separate rooms with one room equipped for the RNS to carry out 66/68 joint scores and the other room for the DNS to carry out PASI and skin surveillance and skin education. Patients are seen by the RNS first and then the DNS.

Potential benefits:
The combined clinics offer patients a more tailored and efficient management option. An audit carried out in 2008 showed that 21 of the 45 patients seen in the clinic had never previously seen a dermatologist about their PsA. These patients highly valued the advice given on their psoriasis. Overall, patient satisfaction was rated as high with patients preferring to be seen in a combined clinic. As well as measured results, the nurse specialists have perceived an overall improved quality of patient care and speed of access by the department.
Efficient services

Training the workforce at every level is an important step in running an efficient service. Fully trained specialist nurses can successfully take many of the ‘regular’ patient appointments, allowing a consultant to spend more time on complex cases. Staff who are competent in following protocols can also help make the service more efficient by, for example, only offering appointments every 6 months for stable, low-risk patients.

In line with the recommendation on assessment, training should be provided to maximise each practitioner’s expertise. The greatest potential lies with specialist nurses. In areas where resources are challenged, it is advisable to develop a business case around this model to demonstrate the need (and high value) of specialist nurses and associated training.
RECOMMENDATION 4

Patient care should be integrated to optimise cost and care

- Specialist teams should work together with agreed outcomes
- Maximise each practitioner’s expertise to offer an efficient service
  - Training must be provided to achieve this
The Psoriasis Epidemiology Screening Tool (PEST).

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Dermatology Life Quality Index

Hospital No: ___________________ Date: ___________________ Score: _______________
Name: ___________________ Diagnosis: ___________________
Address: ___________________

The aim of this questionnaire is to measure how much your skin problem has affected your life OVER THE LAST WEEK. Please tick one box for each question.

1. Over the last week, how itchy, sore, painful or stinging has your skin been? Very much ☐
A lot ☐
A little ☐
Not at all ☐

2. Over the last week, how embarrassed or self-conscious have you been about your skin? Very much ☐
A lot ☐
A little ☐
Not at all ☐

3. Over the last week, how much has your skin interfered with you going shopping or looking after your home or garden? Very much ☐
A lot ☐
A little ☐
Not at all ☐

4. Over the last week, how much has your skin influenced the clothes you wear? Very much ☐
A lot ☐
A little ☐
Not at all ☐

5. Over the last week, how much has your skin affected any social or leisure activities? Very much ☐
A lot ☐
A little ☐
Not at all ☐

6. Over the last week, how much has your skin made it difficult for you to do any sport? Very much ☐
A lot ☐
A little ☐
Not at all ☐

7. Over the last week, has your skin prevented you from working or studying? Yes ☐
No ☐

If ‘No’, over the last week how much has your skin been a problem at work or studying? A lot ☐
A little ☐
Not at all ☐

8. Over the last week, how much has your skin created problems with your partner or any of your close friends or relatives? Very much ☐
A lot ☐
A little ☐
Not at all ☐

9. Over the last week, how much has your skin caused any sexual difficulties? Very much ☐
A lot ☐
A little ☐
Not at all ☐

10. Over the last week, how much of a problem has the treatment for your skin been, for example, by making your home messy, or by taking up time? Very much ☐
A lot ☐
A little ☐
Not at all ☐

Please check you have answered EVERY question. Thank you.

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References
