Assessing Psoriatic Arthritis in your clinic

Training manual
For Trainer
Copies of all the materials mentioned in this booklet and videos on how to conduct assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals- psa.aspx

Authored by:
Bruce Kirkham, Consultant Rheumatologist, Guy’s Hospital, London
Philip Helliwell, Consultant Rheumatologist/Senior Lecturer, Leeds University
Eleanor Korendowych, Consultant Rheumatologist, Royal National Hospital for Rheumatic Diseases, Bath
Kate Gadsby, Rheumatology Consultant Nurse, AbbVie & Honorary Rheumatology Nurse Specialist, Royal Derby Hospital, Derbyshire
Sue Oliver, Past Chair RCN Rheumatology Forum and RCN Fellow. Independent Nurse Consultant
Liz Parrish, Past Dermatology Lead Nurse/Matron, East Kent University Hospitals NHS Foundation Trust. Independent Nurse Consultant

This PsA Assessment initiative is led by the UK PsA Assessment Academy and funded by AbbVie Ltd.
# Contents

1. Introduction

- Why is assessment of psoriatic arthritis so important? ........................................... 5
- A new approach to the assessment of PsA ................................................................. 5

2. Treat to Target (T2T) PsA

- T2T Modular Approach for PsA assessment ........................................................... 7
- Outcome measures: Minimal Disease Activity (MDA) and Psoriatic Arthritis Response Criteria (PsARC) ................................................................. 8

3. Standard assessments for rheumatology clinics

- Joint count ............................................................................................................. 11
- Patient global activity VAS .................................................................................. 11
- Patient pain VAS .................................................................................................. 12
- Dermatology Quality Life Index (DLQI) ............................................................... 12
- Health Assessment Questionnaire (HAQ) ............................................................ 14

4. Intermediate assessments for rheumatology clinics

- 66/68 joint count .................................................................................................. 17
- Patient and physician global assessments ......................................................... 18

5. Advanced assessments for rheumatology clinics

- Leeds Enthesitis Index (LEI) ............................................................................. 19
- Tender dactylitis count ....................................................................................... 20
- Psoriasis Area Severity Index (PASI) ............................................................... 20
- Body Surface Area (BSA) .................................................................................. 21

6. Additional tests

- Modified Schöbers test ....................................................................................... 23
- Cervical rotation .................................................................................................. 23

7. Organising assessment training ........................................................................ 25

8. Appendices

A. 66/68 joint count poster ..................................................................................... 32
B. 66/68 joint count score sheet ............................................................................. 33
C. A quick guide to assessing PsA .......................................................................... 34
D. DLQI and score sheet ......................................................................................... 35
E. HAQ and HAQ score sheet ............................................................................... 36
F. PASI score sheet .................................................................................................. 37
G. Invitation for clinicians ....................................................................................... 38

References ............................................................................................................... 40
Introduction

Why is assessment of psoriatic arthritis so important?

Psoriatic arthritis (PsA) is a complex condition that involves many body areas: the skin, fingernails and toenails, peripheral joints, the axial skeleton (the spine, chest and sacroiliac joint), entire digits (dactylitis) and the entheses.

The prevalence of psoriasis in the general population is estimated at 2–3%, with the prevalence of inflammatory arthritis in people with psoriasis estimated at up to 30%.

At least 20% of people with psoriasis have severe psoriatic arthritis with progressive joint lesions. Psoriatic arthritis is a progressive disorder ranging from mild synovitis to severe progressive erosive arthropathy.

PsA can progress notably within the first 2 years of disease onset. It has been shown that a diagnostic delay of more than 6 months contributes to poor radiographic and functional outcomes in PsA patients. It is therefore critical to diagnose and commence treatment early.

Patients may present to either a dermatology or rheumatology clinic depending on their symptoms. To optimise best practice all patients with psoriasis should be screened for PsA to help prevent irreversible joint damage.

A new approach to the assessment of PsA

The PsA Assessment Academy has devised a Modular Approach for assessing PsA for rheumatology units. This approach details the recommended assessments of PsA at three levels: standard, intermediate and advanced.

This pack has been designed to provide rheumatology clinics with guidance on the approach recommended by the PsA Assessment Academy for the screening and assessment of PsA.

Many patients with PsA remain undiagnosed. A European study of 1,511 patients with plaque type psoriasis attending a dermatology appointment found that 20.6% had PsA; only 3% of patients had had the diagnosis of PsA established before the study.

* Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals-psa.aspx
Treat to Target (T2T) PsA

A Modular Approach has been developed for PsA assessment which lists the minimum level of assessment through to more advanced assessment for patients at rheumatology clinics. The approach supports clinics to work towards a target of Minimal Disease Activity (MDA), which can be used to support a Treat to Target approach.

**T2T Modular Approach for PsA Assessment**

As psoriatic arthritis is a complex condition that involves many body areas, in particular the joints and skin, the approach incorporates both skin and joint assessments, as well highlighting that physicians should consider the spine, nails, GI tract and eyes at all times for extra-articular manifestations.

The Modular Approach works on the basis of three levels of assessment:

1. **Standard** – the ‘bronze’ standard of assessment – outlining the minimum assessments that should be performed for each patient regardless of size of the clinic
2. **Intermediate** – the ‘silver’ standard of assessment incorporating a 66/68 joint count in addition to all the minimum assessments
3. **Advanced** – the ‘gold’ standard of assessment, incorporating assessments for dactylitis, enthesitis and the skin (psoriasis).

This training manual provides you with all the tools required to use the assessments included within the T2T Modular Approach for PsA assessment.*

* Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals-psa.aspx
As the team become experienced in performing the standard and intermediate assessments, the next level of assessment should be incorporated into the clinical practice (assuming the resources are available in the clinic), so eventually an advanced level of assessment is reached.

All together these assessments allow physicians to assess their patients for a state of minimal disease activity which defines a satisfactory state of disease activities.6

### Outcome measures: Minimal Disease Activity (MDA) and Psoriatic Arthritis Response Criteria (PsARC)

**Minimal Disease Activity (MDA): An outcome measure for advanced assessment**

Minimal disease activity (MDA) is recommended by the PsA Assessment Academy as the optimal outcome measure for the management of PsA patients. By defining a set of criteria to be met for the state of minimal disease activity encompassing all aspects of PsA, the MDA provides a target for the goal of PsA treatment which can be used to support a Treat to Target approach.6

The MDA incorporates the scores from assessments at all levels, and is the key disease activity target at the advanced assessment level; the equivalent ‘gold standard’ of outcome assessment.

A patient is classified as achieving MDA when meeting 5 of the 7 following criteria:8

- Tender joint count ≤ 1
- Swollen joint count ≤ 1
- Psoriasis Activity and Severity Index ≤ 1 or body surface area ≤ 3%
- Patient pain visual analogue score (VAS) ≤ 15
- Patient global disease activity VAS ≤ 20
- Health assessment questionnaire ≤ 0.5
- Tender entheseal points ≤ 1

The MDA criteria have been validated in two infliximab studies of PsA and a PsA observational cohort study.7,8
Psoriatic Arthritis Response Criteria (PsARC): An outcome measure for intermediate assessment

At an intermediate level the Psoriatic Arthritis Response Criteria (PsARC) is recommended as an outcome measure. The PsARC is used to assess response to treatment and is generally conducted after 12 weeks of treatment in accordance with NICE recommendations.9,10 It includes an assessment of the joints (66 swollen and 68 tender joints) and the Patient and Physician global scores (PGA). Performing the assessments recommended at an intermediate level allows you to conduct the PsARC.

PsARC defined as improvement in at least two of the following 4 criteria (one of which must be tender joint or swollen joint score) with no worsening of any criteria:11

- 20% or more improvement in physician global assessment of disease activity
- 20% or more improvement in patient global assessment of disease activity
- 30% or more improvement in tender joint count
- 30% or more improvement in swollen joint count

People whose disease has a Psoriasis Area and Severity Index (PASI) 75 response at 12 weeks but whose PsARC response does not justify continuation of treatment should be assessed by a dermatologist to determine whether continuing treatment is appropriate on the basis of skin response.

The joint count scoring sheet (page 17) provides space to record the PsARC.
Section 3

Standard assessments for rheumatology clinics

The Modular Approach recommended by the PsA Assessment Academy includes a number of assessments for patients who are managed in rheumatology units. This section provides further details on the standard (minimum) recommended assessments.

Joint count

When assessing PsA patients the joints should always be assessed for swelling and tenderness. At an intermediate level the 66 swollen and 68 tender joint count should ideally be performed, as recommended by the British Society for Rheumatology (BSR).12

At a standard level, as a minimum, an overview assessment of the joints should be carried out.

Further information on the 66/68 joint count and for recommendations on how to assess each joint for swelling or tenderness can be found in Section 4 – Intermediate assessments.*

Patient global activity VAS (visual analogue scale)

The patient global activity VAS or patient global assessment of disease activity is a simple VAS which assesses the patient’s general health and the effect of their arthritis at that point in time.

Example:
The patient is asked a question such as “Considering all the ways your arthritis affects you, how are you feeling today?”12 and asked to mark their score on the VAS line.

The VAS is scored by measuring from 0 to where the patient marks on the line. The proposed definition of low disease activity is 2.0 (scale 0 –10).13 A Likert style score may also be used such as in the PsARC.

* Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals-psa.aspx
Patient pain VAS

The patient pain VAS is a measurement of pain intensity and can be used to assess the presence or absence of arthritis-related pain and its severity. The patient is asked to place a vertical line upon the VAS line at the point that represents their pain intensity, most commonly as experienced within the last 24 hours.

The score is obtained by measuring the distance from 0 to the line drawn by the patient.

Example pain VAS:
The patient is asked a question such as “How severe was the pain you have experienced in the last 24 hours?”

Dermatology Quality Life Index (DLQI)

The DLQI is a quality of life (QoL) measure that can be used across all skin diseases and measures different aspects of psoriasis to the PASI.

The process of completing a quality of life questionnaire can encourage patients to raise issues that they see as important, but feel the doctor or nurse is not addressing. The DLQI consists of 10 simple questions relating to ways in which skin disease impairs lives. The time frame of the DLQI questions is based on quality of life over the last week.

The questionnaire is designed to be used in a busy clinical setting. The DLQI is provided with a sheet for the healthcare professional with guidance on DLQI calculation and a double sided questionnaire for the patient. The patient completes it without assistance, usually in about two minutes.

The DLQI is calculated by summing the score of each question, resulting in a maximum of 30 and a minimum of 0. The higher the score, the more quality of life is impaired.

The DLQI can also be expressed as a percentage of the maximum possible score of 30.

Meaning of DLQI Scores

- 0-1 = no effect at all on patient’s life
- 2-5 = small effect on patient’s life
- 6-10 = moderate effect on patient’s life
- 11-20 = very large effect on patient’s life
- 21-30 = extremely large effect on patient’s life
**Healthcare professional pages**

**Dermatology Life Quality Index**

1. For each box ticked assign a score as below:
   - Very much = 3
   - A lot = 2
   - A little = 1
   - No = 0
   - Not at all = 0
   - Not relevant = 0

2. Add all the scores together to give a DLQI score.

The impact on quality of life can be classified as below:
- 0–5 = No effect
- 6–10 = Small effect
- 11–20 = Moderate effect
- 21–30 = Large effect

Dermatology Life Quality Index

**Diagnosis:** ____________________

**Date:** ______________________

**Address:** ____________________________________________________________

**Name:** ____________________________

**Hospital No:** ______________________

*Please check you have answered EVERY question. Thank you.*

**Section 3**

**Patient pages**

**Dermatology Life Quality Index**

1. Have you had psoriasis for longer than 1 week? Yes ___ No ___
2. Have you never had psoriasis? Yes ___ No ___
3. Over the last week, how much has your psoriasis affected your physical appearance? Very much ___ A lot ___ A little ___ Not at all ___ Not relevant ___
4. Over the last week, have your friends or family noticed your psoriasis? Yes ___ No ___
5. Over the last week, have your relatives noticed your psoriasis? Yes ___ No ___
6. Over the last week, have your psoriasis caused you to change your clothes? Yes ___ No ___
7. Over the last week, has your psoriasis prevented you from going shopping or visiting friends? Yes ___ No ___
8. Over the last week, has your psoriasis prevented you from going out? Yes ___ No ___
9. Over the last week, has your psoriasis prevented you from going out for a drink? Yes ___ No ___
10. Over the last week, has your psoriasis interfered with your work? Yes ___ No ___
11. Over the last week, has your psoriasis interfered with your leisure activities? Yes ___ No ___
12. Over the last week, has your psoriasis interfered with your gardening or home activities? Yes ___ No ___
13. Over the last week, how much has your psoriasis interfered with your sex life? Very much ___ A lot ___ A little ___ Not at all ___ Not relevant ___
14. Over the last week, has your psoriasis interfered with your sexual relationships? Yes ___ No ___
15. Over the last week, how much has your psoriasis affected your self-esteem? Very much ___ A lot ___ A little ___ Not at all ___ Not relevant ___
16. Over the last week, how much has your psoriasis interfered with your activities? Very much ___ A lot ___ A little ___ Not at all ___ Not relevant ___
17. Over the last week, has your psoriasis interfered with your clothes? Yes ___ No ___
18. Over the last week, how much has your psoriasis affected your confidence? Very much ___ A lot ___ A little ___ Not at all ___ Not relevant ___

**Score:** ____________________

*Please send your completed DLQI® questionnaire to: *

*Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals-osa.aspx*
Health Assessment Questionnaire (HAQ)

The HAQ is patient-oriented outcome assessment tool for measuring overall health status. It was developed as a comprehensive measure of outcome for patients with a wide variety of rheumatic diseases, and is designed to capture the long term influence of multiple chronic illnesses. The HAQ is available as a short 2 page version and a full 5 page version; the most frequently used and cited version is the 2 page version which assesses the extent of a patient’s functional ability.\textsuperscript{15,16}

The 2-page HAQ contains the:

- **HAQ Disability Index (HAQ-DI)** – assessing a patient’s level of functional ability
- **HAQ visual analogue (VAS) pain scale** – assessing the presence or absence of arthritis-related pain and its severity
- **HAQ VAS patient global health scale** – assessing overall quality of life

![HAQ Disability Index](image1)

![HAQ VAS Pain Scale](image2)

The HAQ is usually self-administered, but can also be asked by a trained receptionist or a healthcare professional in a clinical setting. The 2-page HAQ takes around five minutes to complete.
### Scoring of the HAQ

There are two disability indices that can be calculated from the HAQ-DI:  

1. The Standard HAQ-DI, the preferred method, which takes into account the use of aids/devices.  
2. The Alternative Disability Index, which does not.

For either indices the patient must have a score for at least six of the eight categories (e.g. dressing and grooming, eating, walking) to calculate the score.

**Calculating the Standard HAQ-DI Score (with aids/devices):**

1. The four response options ‘Without any difficulty’, ‘With some difficulty’, ‘With much difficulty’ and ‘Unable to do’ are scored 0-3 respectively.  
2. A score for each category is calculated by using the highest sub-category score from the category. For example, in the category ‘Arising’ there are three sub-category items. If a patient responds with a 1, 2 and 0, respectively; the category score is 2.  
3. The scores are then adjusted for use of aids/devices and/or help from another person when indicated. The table below identifies the aid/device companion variable for each HAQ-DI category.

#### Companion Aids/Devices Items for HAQ-DI Categories

<table>
<thead>
<tr>
<th>HAQ-DI Category</th>
<th>Companion Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing &amp; Grooming</td>
<td>Devices used for dressing (button hook, zipper pull, long handled shoe horn etc.)</td>
</tr>
<tr>
<td>Arising</td>
<td>Built up or special chair</td>
</tr>
<tr>
<td>Eating</td>
<td>Built up or special utensils</td>
</tr>
<tr>
<td>Walking</td>
<td>Cane walker, crutches</td>
</tr>
<tr>
<td>Hygiene</td>
<td>Raised toilet seat, bathtub seat, bathtub bar, long handled appliances in bathroom</td>
</tr>
<tr>
<td>Research</td>
<td>Long handled appliances for reach</td>
</tr>
<tr>
<td>Grip</td>
<td>Jar opener (for jars previously opened)</td>
</tr>
</tbody>
</table>

When an aid/device is indicated the scores are adjusted as follows:  

- For a category score of zero or one – increase to a two  
- For a category score of two or three – no increase

4. Divide the total category scores by the number of categories answered (must be a minimum of 6) to obtain a HAQ-DI score of 0-3 (3=worst functioning).

The HAQ VAS pain scale and HAQ VAS patient global health scale are scored by asking the patient to score their pain and health from 0-100 on a 100mm horizontal VAS line. Zero represents the lowest score e.g. no pain and 100 the highest e.g. severe pain. The score is obtained by measuring the distance from 0 to the line drawn by the patient.

Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals-psa.aspx
Intermediate assessments for rheumatology clinics

In addition to all the assessments performed as a minimum level of assessment, a full 66/68 joint count and patient and physician global assessment should be performed at the intermediate level.

66/68 joint count

When assessing PsA, the British Society for Rheumatology (BSR) recommends the use of a 66 swollen and 68 tender joint count.\(^\text{12}\) Research suggests that using anything less than a 66/68 joint count may result in the patient’s disease severity being underestimated and, as a consequence, the patient not being treated appropriately.\(^\text{17}\) Once experience is gained in using the 66/68 joint count it can be performed in 3 minutes, so this doesn’t need to be time consuming.

Recommendations on how to assess each joint for swelling or tenderness can be found on the next page.

The accompanying joint count scoring sheet* can be used to record the joint count scores; the joint count scoring sheet also provides space to calculate the PsARC as discussed earlier in this manual.

* Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals- psa.aspx
The ‘A quick guide to PsA Assessment’ provides information on how to assess each of the joints in the 66/68 joint count. Also available as the joint scoring poster.*

**Patient and physician global assessment**

As within the PsARC, the patient and physician global assessments are recommended at an intermediate level to assess the patient’s general health.

The following questions are recommended for the patient and physician using a 0–5-point Likert scale.

**Patient (PtGA)**

“Considering all the ways your arthritis affects you, how are you feeling today?” (Patient)

**Physician (PGA)**

“Considering all the ways the arthritis affects your patient, how is your patient feeling today?”

The accompanying joint count scoring sheet* also allows to capture this information (as recommended in the minimum assessments).
Advanced assessments for rheumatology clinics

Assessing enthesitis and dactylitis

Enthesal inflammation and dactylitis are common in patients with PsA. Enthesal inflammation is a typical feature of PsA and is one of the features which distinguishes it from RA. Dactylitis occurs in 16–24% of patients and is characterised by diffuse swelling of a digit which can become painful.

Leeds Enthesitis Index (LEI)*

The LEI examines tenderness at six sites: 2 sites at each of the lateral epicondyles of the humerus, medial condyles of the femur and the insertion of the Achilles tendon.

**LEI examination points:**

- **Lateral epicondyle, left and right**
  - This examination is performed with the patient’s arm flexed at 90°
  - The thumb is pressed on the lateral epicondyle with the fingers underneath for support. Pressure, sufficient to blanch the nail is exerted and the enthesis examined for tenderness

- **Medial femoral condyle, left and right**
  - Find the joint line of the knee. Move the fingers approximately 2.5 cm (1 inch) proximal to this to locate the bony diffuse swelling on the medial femoral condyle
  - The thumb is pressed on the medial femoral condyle, sufficient to blanch the nail and the enthesis examined for tenderness

- **Achilles tendon insertion, left and right**
  - The Achilles tendon insertion can be located by following the Achilles tendon down until it inserts
  - Place the thumb on the insertion site with pressure sufficient to blanch the nail and assessed for tenderness.

When examining the entheses, pressure should be exerted at the enthesis sufficient to blanch the finger nail of the examiner. In addition the presence of soft-tissue swelling at the enthesis should also be assessed. For each enthesal site, assessment is made of the adjacent joint in terms of tenderness and soft-tissue swelling.

Careful attention should be made to try and distinguish swelling and tenderness separately at the joint and the juxta-articular enthesis.

The LEI score range is 0-6.

* Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals-psa.aspx
**Tender dactylitis count**

The tender dactylitis count is a simple count based on the presence or absence of tender joints. 20 digits are assessed as entire digits, looking for signs of tender dactylitis (the joints of any digits with dactylitis are not scored separately for the purposes of the 66/68 joint count). Dactylitis is defined as a uniform swelling of the digits where the joints cannot be defined.

The hands and feet should be visually assessed side by side.

**Psoriasis Area Severity Index (PASI)**

Assessing the skin is an important part of managing patients with PsA. Although the Psoriasis Area Severity Index (PASI) is generally performed by a dermatologist or in a dermatology clinic it is an important part of the assessment for PsA, and forms part of the assessment for minimal disease activity for psoriatic arthritis.

The PASI is an index used to express the severity of psoriasis. It combines the severity (erythema, induration and desquamation) and percentage of affected area. The PASI is the main test used in the clinic to assess total body area affected by psoriasis and to monitor both the patient’s psoriasis and their progression and response to treatment over time. The PASI is used to help decide the most appropriate treatment.

The body is assessed in four regions:

- Head and neck
- Arms
- Trunk (includes groin and axillae)
- Legs (includes buttocks).

Each is assigned a score to reflect extent of affected area, (see appendix F for extent score gradings on the PASI score sheet) with 0 indicating no skin affected and 6 indicating all skin affected. Severity of psoriasis is assessed with scores assigned to each of redness, thickness and scale (0 = least severe, 4 = most severe).

For each body section (head, arms, trunk and legs) specify:

- The percentage of area of skin involved
- The severity of three clinical signs (erythema, induration and desquamation) on a scale from 0 to 4 (from none to maximum).

The scores are then used to calculate the PASI.
Example of a PASI calculation

On examining the patient’s arms the percentage of the area affected was estimated to be 35% which gives an extent score 3. The total extent for the arms is 3 x 0.2 = 0.6.

The severity of the plaques on the arms was calculated as 3 for erythema (the plaques were dark red in colour), 2 for scaling (moderate scaling) and induration as 2 (moderate elevation with rough or sloped edges).

The severity for the arms was calculated as 3+2+2 = 7
The total extent multiplied by total severity for the arms is 0.6 x 7 = 4.2

The calculation of the PASI for this patient is shown below. There was no psoriasis on the head and neck, trunk or legs.

<table>
<thead>
<tr>
<th>Area</th>
<th>Extent score (0-6)</th>
<th>Total extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head &amp; Neck</td>
<td>--</td>
<td>x 0.1</td>
</tr>
<tr>
<td>Arms</td>
<td>3</td>
<td>x 0.2</td>
</tr>
<tr>
<td>Trunk</td>
<td></td>
<td>x 0.3</td>
</tr>
<tr>
<td>Legs</td>
<td></td>
<td>x 0.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Erythema (0-4)</th>
<th>Scaling (0-4)</th>
<th>Induration (0-4)</th>
<th>Total severity</th>
<th>Total severity x total extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head &amp; Neck</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arms</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Trunk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PASI = severity x extent 4.2/72

A PASI meter is available from your AbbVie representative. The PASI stick provides guidance in assessing the extent and the severity of erythema, scaling and induration.

Body surface area (BSA)

The body surface area (BSA) is an estimation of the percentage of the body affected by psoriasis. The surface of palm plus five digits is generally assumed to be approximately equivalent to 1% allowing calculation of the BSA. It should be noted that the palm has been found to be slightly less than 1% in some studies, and for the most accurate estimation, the patient’s hand should be used as a measure.

Scoring:
- <3% mild case of psoriasis
- 3-10% moderate case of psoriasis
- >10% severe case of psoriasis

* Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals-psa.aspx
Additional tests

Modified Schöbers test*

The modified Schöbers test assesses the amount of lumbar flexion. To perform this assessment:

1. Mark the lumbosacral junction by locating the dimples of Venus and mark on each side and then mark a line between the two points
2. Measure upwards from this line 10cm (superior) and also below this line 5cm (inferior) and mark each point
3. Ask the patient to lean forward to touch their toes holding the tape measure close to the skin. As the patient flexes the spine as far as possible, measure and record the distance between the superior and inferior marks
4. A normal modified Schöbers is 5cm or above.

Cervical rotation*

Cervical rotation can be measured using a goniometer. To perform this assessment:

1. With the patient seated, place the goniometer on the top of the patient’s head and line up with the patient’s nose
2. Ask the patient to turn their head to the right. Move the arm of the goniometer and align the arm with the patient’s nose. Measure the angle of the goniometer
3. Ask the patient to turn their head to the front, neutral position. Align the arms of the goniometer with the patient’s nose
4. Ask the patient to turn their head to the left. Move the arm of the goniometer to align with the patient’s nose and measure the angle of the goniometer
5. Take the average of the two readings
6. A normal cervical rotation is 70° or above.

* Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals- psa.aspx
Organising assessment training

This document contains guidance on how to conduct a training session on assessing PsA in your clinic and the role of the multidisciplinary team in your unit.

This quick and easy training module is designed to give an overview and provide guidance on carrying out the assessments used to evaluate PsA. The lack of assessment of PsA in patients can have a detrimental impact on patient outcomes. This training aims to enable participants to recognise how they should be assessing for PsA and to have confidence in conducting the assessments.

This should also ensure standardised assessment across the clinic.

The training session proposed is divided into the following parts:
- Part 1 – Presentation on PsA assessment. Overview of PsA and description of key assessments
- Part 2 – Demonstration of assessment techniques
- Part 3 – Practical session for participants
- Part 4 – Discussion.

What is required for the training session:

Time:
- Allow 2-2.5 hours for the whole session (if it is the first training session you may want to allow more time)

Participants:
- All members of the multidisciplinary team who see patients with PsA
- It is recommended there are no more than 6-8 participants per trainer

Materials:
- Assessing PsA rheumatology poster (a copy can be ordered from an AbbVie representative)
- Assessing PsA training presentation
- Assessment scoring sheets
  - 66/68 joint count score sheet*
  - DLQI score sheet*
  - HAQ score sheet
  - PASI score sheet*

* Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals-psa.aspx
Organising the training session

There are a number of ways to run the training session. The training session below involves performing and practising the assessments for both skin and joints.

Please find below the recommended steps to be taken in order to organise and hold the training session.

**Before the training session**

- Coordinate a date and time for the training session
- Circulate an agenda/training plan to attendees
- Reserve an appropriate room/venue for the session and organise the correct number of chairs
- Invite the relevant multidisciplinary team members from your clinic
- Check attendees’ availabilities, transport and funding
- Organise refreshments
- Check availability of projector or print slides

*If you would like support to organise the meeting, please contact your local AbbVie representative.*

**Key considerations**

Depending on the size of the group it may be advisable to split the group into pairs or a few small groups, so one person performs the tests while the rest of the group observes. While the assessments are being performed the group can discuss whether they agree or disagree with the way the assessment is being conducted.

If you split the group into pairs or small groups, you might want to consider whether you want to split up the more experienced members of the group or to keep similar levels together so they feel less inhibited to express their opinion.
On the day

Introductions and welcome

1. Gather the attendees in the reserved room and ask all attendees to introduce themselves if necessary
2. Introduce the aims and objectives of the training session
   a. To introduce techniques for conducting joint and skin assessments
   b. To familiarise the group with the different assessments and build confidence in using them
   c. To ensure all members of the multidisciplinary team are conducting the assessment appropriate to them in the same way.

(It might be helpful to emphasise that often different techniques are not wrong but if everyone is using a different technique it can distort the scores and therefore impact on the treatment decisions for an individual person with PsA).

Part 1 – Presentation on PsA assessment. Overview of PsA and description of key assessments (allow 15 mins)

Presentation
- Overview of PsA
- Introduction to the PsA Assessment Academy and the PsA T2T Modular Approach for PsA assessment
- MDA and PsARC as disease outcome measures
- Assessments recommended to assess PsA in the PsA T2T Modular Approach

Part 2 – Demonstration of assessments (allow 45 mins)

We would recommend that prior to the day you:
- Select which of the assessments below you would like to focus on (you will not have time to go into detail for all of them)
- Decide prior to the presentation if you would like to demonstrate the PASI, BSA or both.

A training presentation is provided to support your training/provide further details.

Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals-psa.aspx
Section 7

Assessments:

Standard:
- Joint count
  - Provide an overview on how to assess joints for swelling/tenderness
  - Patient global activity VAS and patient pain VAS
  - Agree standardised questions
- Dermatology Quality Life Index (DLQI) and Health Assessment Questionnaire (HAQ)
  - Data collection and scoring

Intermediate:
- 66/68 joint count
  - Demonstrate how to perform the 66/68 joint count (using the A1 poster Assessing Psoriatic Arthritis and training videos)
  - Split the group into pairs and discuss the different aspects of the 66/68 joint count focussing on the location of each joint and the technique
- Patient and physician global assessments
  - Highlight the standardised question

Advanced:
- Tender dactylitis count
  - Demonstrate how to perform the tender dactylitis count
- Leeds Enthesitis Index (LEI)
  - Demonstrate how to perform the LEI
- Psoriasis Area Severity Index (PASI) or BSA
  - Demonstrate how to do a skin assessment using PASI/BSA

Part 3 – Practical session for participants to carry out the assessments on each other (allow 30-60 mins)
- Split the group into pairs
- Practice assessing the joints for the 66/68 joint count (depending on the level of experience of the group you may want to also include other assessments in this section)

Part 4 – Discussion (allow 30 mins)
- Depending on the experience of the group this time may be used for any questions related to the Modular Approach
- There is an accompanying training presentation if you want to go through each assessment in more detail
Conclusion

- Informal practice sessions with colleagues are an ideal way to improve assessment skills
- We would recommend aiming to perform this training every 12-18 months, depending on the number of new starters you have in your clinic, to ensure assessment techniques remain standardised within your clinic.

Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals-psa.aspx
Section 8

Appendices

A. 66/68 joint count poster*
B. 66/68 joint count score sheet*
C. A quick guide to assessing PsA*
D. DLQI and score sheet*
E. HAQ and HAQ score sheet
F. PASI score sheet*
G. Invitation for clinicians*

* Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals- psa.aspx
Appendix A – 66/68 joint count poster

Joint Assessment

Assessing Tender Joints
Joint tenderness should be assessed by pressing on the joint using the thumb and index finger. A general guide to the amount of pressure required is press until it causes ‘whitening’ of the examiner’s nail bed.

Assessing Joint Swelling
Joint swelling is typically soft and boggy and not hard or bony.

Joint Count 66/68

Pale green dots represent joints also assessed in DAS28. For additional information on scoring these joints, please refer to the Standardising DAS28 poster.
Appendix B – 66/68 joint count score sheet

**Joint Count Scoring Sheet**

**Tender and swollen measurements**

Patient number: _________

<table>
<thead>
<tr>
<th>Tender Joints: Number ___/68</th>
<th>Swollen Joints: Number ___/66</th>
</tr>
</thead>
</table>

**Global PsARC Assessment**

<table>
<thead>
<tr>
<th>Patient (PtGA)</th>
<th>Physician (PGA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Considering all the ways the arthritis affects you, how are you feeling today?</td>
<td></td>
</tr>
</tbody>
</table>

- 0 = very good, no symptoms, no limitations on normal activities
- 1 = very good, no symptoms
- 2 = mild, very few symptoms
- 3 = mild, very few symptoms which are tolerable, no limitation on normal activities
- 4 = mild, very few symptoms which are tolerable, no limitation on normal activities

**PsARC criteria (pre-treatment)**

<table>
<thead>
<tr>
<th>Tender (0-68)</th>
<th>Swollen (0-66)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PtGA</td>
<td>PGA</td>
</tr>
</tbody>
</table>

**PsARC criteria (post-treatment)**

<table>
<thead>
<tr>
<th>Tender (0-68)</th>
<th>Swollen (0-66)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PtGA</td>
<td>PGA</td>
</tr>
</tbody>
</table>

**Definition of the criteria:**

Response = improvement in ≥ 2 of the 4 tests:

- One of which must be the joint tenderness or swelling score
- No worsening in any of the four measures
- Improvement is defined as a decrease ≥ 30% in the swollen or tender joint score and a decrease ≥ 1 in either of the global assessments

**Date of preparation:** July 2015  Job Code: AXHUR151220f
Appendix C – A quick guide to assessing PsA

Psoriatic arthritis is a complex condition that involves many body areas, in particular the joints and skin.

A modular approach has been developed that includes the minimum level of assessment through to more advanced assessment for each patient at every visit. The advanced assessment is performed for all visits to support the Targeted Disease Activity – which can be used to support a Treat to Target approach.

PsARC Outcome Assessment

An additional outcome assessment for the patient has not undergone any of the assessments within the MDA assessment in the PsARC (PsA Response Criteria) Module. This assessment is only needed if the patient continues anti-TNF treatment. This assessment is only needed at 12 weeks and once at 3 months.

PsA Assessment

SASD – PsA

T2T PsA

PsARC Outcome Assessment

PsA Assessment

SASD – PsA

T2T PsA

PsARC Outcome Assessment

PsA Assessment

SASD – PsA

T2T PsA

PsARC Outcome Assessment

PsA Assessment

SASD – PsA

T2T PsA
Appendix D – DLQI and score sheet

Dermatology Life Quality Index

1. For each box below assign a score on the basis of

   Very much = 3
   A lot = 2
   A little = 1
   No = 0
   Not relevant = 0

2. Add all the scores together

   The score on quality of life can be classified as below:

   0-4 = No effect
   5-9 = Small effect
   10-16 = Moderate effect
   17-23 = Large effect
   24+ = Extremely large effect

3. If you answer ‘No’ to any questions, please answer ‘Not relevant’ to the next question.

Do you have any psoriasis at the moment?

Yes ☐ No ☐

If you answered Yes, please complete the questions on the right side of this page.

Please hand this page to your doctor or nurse when you have finished.

Dermatology Life Quality Index

Please email us if you have any remaining questions. Thank you.

www.psoriatic-arthritis.co.uk/healthcare-professionals-psa.aspx
Appendix E – HAQ and HAQ score sheet
Appendix F – PASI score sheet

**About PASI**

PASI is derived from skin assessment of the body in four regions: head and neck, arms, trunk (including groin and axillae) and legs (including buttocks). The assessment of the severity of the symptoms erythema, scaling and induration is performed separately for each region. The extent to which each of the four regions of the body is affected by psoriasis is also assessed.

<table>
<thead>
<tr>
<th>Extent score</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>1</td>
<td>1% to 9%</td>
</tr>
<tr>
<td>2</td>
<td>10% to 29%</td>
</tr>
<tr>
<td>3</td>
<td>30% to 49%</td>
</tr>
<tr>
<td>4</td>
<td>50% to 69%</td>
</tr>
<tr>
<td>5</td>
<td>70% to 89%</td>
</tr>
<tr>
<td>6</td>
<td>90% to 100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extent</th>
<th>Total extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head &amp; Neck</td>
<td>x 0.1</td>
</tr>
<tr>
<td>Arms</td>
<td>x 0.2</td>
</tr>
<tr>
<td>Trunk</td>
<td>x 0.3</td>
</tr>
<tr>
<td>Legs</td>
<td>x 0.5</td>
</tr>
</tbody>
</table>

**Severity Score**

- **Erythema**
  - 0: No redness
  - 1: Pink but not dark red
  - 2: Dark red
  - 3: Very dark red
- **Scaling**
  - 0: No scaling
  - 1: Fine to rough scaling
  - 2: Rough, thick scaling
  - 3: Very rough, very thick
- **Induration**
  - 0: No induration
  - 1: Slight, indistinct
  - 2: Sharp edges
  - 3: Sloped edges

**PASI = severity x extent / 72**

<table>
<thead>
<tr>
<th>Erythema</th>
<th>Scaling</th>
<th>Induration</th>
<th>Total severity</th>
<th>Total extent</th>
<th>PASI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Don't forget signs of PsA on nails

Reference:
Appendix G – Invitation for clinicians

[Insert hospital name]
[Insert hospital address]
[Insert hospital address]
[Insert hospital address]

[Insert date]

Dear [Insert name],

PsA Assessment Training

I would like to invite you to join the Psoriatic Arthritis (PsA) assessment training taking place on [Insert date] at [Insert time] in [Insert room].

PsA is a complex condition involving the joints and the skin, and many patients remain undiagnosed.\(^1\) PsA can progress notably within the first 2 years of disease onset.\(^1\) Symptoms of PsA can place a considerable burden on patients and negatively affect a patient’s quality of life.\(^2\)

To optimise best practice and patient outcome, all appropriate patients should be screened for PsA to help prevent irreversible joint damage.

It is, therefore, essential that all members of the team are familiar and are confident in conducting all components of the PsA assessment.

For this training to be a success it relies on all members of the clinic who conduct PsA assessments to participate, so I would be grateful if you could make the PsA assessment training a priority in your diary.

I look forward to seeing you at the training.

Kind regards

[Insert name]

This PsA Assessment initiative is led by the UK PsA Assessment Academy and funded by AbbVie Ltd.

References

10. SIGN Guideline 121: Diagnosis and management of psoriasis and psoriatic arthritis in adults October 2010.

Copies of all the materials mentioned in this booklet and videos on how to conduct the assessments are available for download from the Outside In website: www.psoriatic-arthritis.co.uk/healthcare-professionals-psa.aspx