JOINT ADVANCES IN RHEUMATOLOGY AND DERMATOLOGY

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

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). PsA typically develops within 10 years of a diagnosis of psoriasis. The prevalence of PsA in the general population has been estimated at 0.04–0.9% with an equal distribution between men and women.

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. Around two-thirds of people with PsA have progressive, damaging arthritis.

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

Despite this knowledge, PsA is often unrecognised.
Psoriasis is a relatively common disease, with an estimated prevalence in the UK of approximately 2–3%.\textsuperscript{1} 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.\textsuperscript{15} 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.\textsuperscript{18,19} Recognising 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\textsuperscript{20} and feeling stigmatised\textsuperscript{21} 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.\textsuperscript{22}

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:\textsuperscript{8}

- 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 purposes). 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.

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

**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.

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, and that a diagnostic delay of more than 6 months contributes to poor radiographic and functional outcomes in PsA patients. 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.
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 ARthritis) criteria (shown in table1) list the potential features of patients with PsA. A patient must have inflammatory articular disease (joint, spine, or enthesial) with ≥3 points based on points assigned to each feature. 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

<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 when assessing PsA for rheumatology units. This approach details the recommended assessments of PsA at three levels: standard, intermediate, and advanced.

**Figure 1:** Modular approach for assessment of PsA in rheumatology clinics

The modular approach lists the various levels of assessment for patients at rheumatology clinics – from a minimum level through to a more advanced assessment. This approach supports clinics to work towards a target of Minimal Disease Activity (MDA), which can be used to support a Treat to Target approach. It incorporates both skin and joint assessments, as well as highlighting that physicians should consider the spine, nails, GI tract and eyes at all times for extra-articular manifestations.

As the team become experienced in performing the standard and intermediate assessments, the next level of assessment should be incorporated into clinical practice (assuming that the resources are available in the clinic), so eventually an advanced level of assessment is reached. Together, these assessments allow physicians to evaluate their patients for a state of MDA which defines a satisfactory state of disease activity.27
MDA

This 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 MDA, 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. 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.

Standard assessments (‘bronze standard’)

- **Joint count**
  - When assessing patients with PsA, the joints should always be assessed for swelling and tenderness. At a standard level, an overview assessment of the joints should be carried out as a minimum

- **Patient global activity VAS (visual analogue scale)**
  - Also known as patient global assessment of disease activity. It is a simple VAS which assesses the patient’s general health and the effect of their arthritis at that point in time

- **Patient pain VAS**
  - This 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

- **Dermatology Life Quality 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 past 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
• **Health Assessment Questionnaire (HAQ)**
  - A 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. It 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.\(^{29,30}\)

**Intermediate assessments (‘silver standard’)**

**The assessments performed at the standard level:**
- Patient global activity VAS
- Patient pain VAS
- DLQI
- HAQ

**PLUS:**

• **Full 66/68 joint count**
  - 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).\(^{31}\) The BSR recommends the use of a 66 swollen and 68 tender joint count when assessing PsA. 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.\(^{32}\) 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

• **Patient and physician global assessment**
  - 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: ‘Considering all the ways your arthritis affects you, how are you feeling today?’
    - Physician: ‘Considering all the ways the arthritis affects your patient, how is your patient feeling today?’
Advanced assessments (‘gold standard’)

The assessments performed at the intermediate level:

- Full 66/68 joint count
- Patient and physician global assessment
- Patient global activity VAS
- Patient pain VAS
- DLQI
- HAQ

PLUS:

- **Enthesitis and dactylitis assessment**

  Enthesal inflammation is a typical feature of PsA and is one of the features which distinguishes it from RA.\(^9\) Dactylitis occurs in 16–24% of patients and is characterised by diffuse swelling of a digit which can become painful.\(^{33}\)

- Leeds Enthesitis Index (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.

- Tender dactylitis count
  - Dactylitis is defined as a uniform swelling of the digits where the joints cannot be defined.
  - The tender dactylitis count is a simple count based on the presence or absence of tender joints. A total of 20 digits are assessed as entire digits; observation should be 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).
  - The hands and feet should be visually assessed side by side.
• **Psoriasis Area Severity Index (PASI)**
  - The PASI is an index used to express the severity of psoriasis. Assessing the skin is an important part of managing patients with PsA. Although the 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. It combines severity (erythema, induration and desquamation) and percentage of affected area.
  - It is assessed in four body regions – with each assigned a score to reflect extend of affected area:
    - Head and neck
    - Arms
    - Trunk (includes groin and axillae)
    - Legs (includes buttocks)

• **Body surface area (BSA)**
  - The BSA is an estimation of the percentage body area affected by psoriasis. The surface of palm plus five digits is generally held to be approximately equivalent to 1% of body area - allowing for BSA estimation. It should be noted that for the most accurate estimation, the patient’s hand should be used as a measure\(^4\)

*For more information on the various assessment methods, see the following pages.*
**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 oligoarthritis, and the presence of foot involvement.

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 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) is recommended to clearly define and measure dactylitis.

**Entheses**

The LEI is the only measure specifically developed and validated for PsA 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.

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.
Psoriasis

In addition to assessments of the joint 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. The DLQI is used to determine whether the psoriasis is of sufficient impact (>5) to require referral to dermatology. A PASI and BSA assessment should also be conducted in patients with any signs of psoriasis. If necessary, a patient may be referred to dermatology for these assessments or, alternatively, dermatology colleagues consulted.

PASI

Although the PASI has some limitations, the assessment is widely used and well understood, and the group recommend this as the gold standard assessment used in evaluating skin involvement. The PASI should be used as the gold standard in 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).

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.

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.

The HAQ is recommended by the group as one of the assessments that must be done at a standard level in patients with PsA.
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.

Copies of all materials mentioned and videos on how to conduct the various assessments are available for download from the Outside In website:

www.psoriatic-arthritis.co.uk/healthcare-professionals-psa.aspx

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
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 2) 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 2: 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 3].

**Figure 3:** [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].

*NICE do not recommend biologics for dactylitis alone.*

Treatment recommendations are traditionally based around the classification of disease severity, which can be mild, moderate, or severe based on selected criteria, 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.
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 with active PsA who have failed to respond to at least two conventional DMARDs. However, anti-TNF therapy may be considered after failure with one DMARD if the patient has adverse prognostic factors.

NICE recommends anti-TNF-α agents for the treatment of active and progressive PsA, based on specific criteria (also summarised in Figure 4):

- 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), of administration and treatment schedules.
**Figure 4:** NICE PsA algorithm – based on their guidance on biologic drugs for the treatment of PsA.1,28

Use standard treatment for psoriatic arthritis including DMARDs

Does the Patient have peripheral arthritis, with 3 or more tender joints and 3 or more swollen joints?

Is the psoriatic arthritis responding to adequate trials of at least 2 standard DMARDs (administered either individually or in combination)?

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?
  Response to be first measured at 12 weeks

At 12 weeks does the patient have a PASI 75 response?

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

Discontinue the treatment with the TNF inhibitor used

**Key To terms**

DMARD: disease-modifying anti-rheumatic drug

PsA: psoriatic arthritis

PsARC: psoriatic arthritis response criteria

TNF: tumour necrosis factor

PASI: psoriasis area severity index

PASI 75 Response: reduction in PASI score of at least 75% from baseline

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 and BSR guidance support the use of the Psoriatic Arthritis Response Criteria (PsARC) for assessing treatment response to biologics.\(^1,31\) It is recommended that treatment is discontinued if disease does not show an adequate response to biologics on the PsARC at 12 weeks.\(^1\) 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).\(^1\) 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.\(^8\)

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, otothists, dieticians, family and carers, social services, and employers (Figure 5). Referral to, or opinion of, other specialists such as gastroenterologists may be necessary for some patients if symptoms are 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 5: 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/*
- 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/.*

*These websites are not owned by AbbVie and AbbVie are not responsible for the content of these sites.
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
Case 1

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

This case study has been provided by Dr Bruce Kirkham (Consultant Rheumatologist) and Dr Catherine Smith (Consultant Dermatologist); and is not the opinion of, or endorsed by AbbVie.
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

This case study has been provided by Dr Lesley Kay (Consultant Rheumatologist) and Professor Nick Reynolds (Consultant Dermatologist); and is not the opinion of, or endorsed by AbbVie.
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.

This case study has been provided by Kate Gadsby (Rheumatology Nurse Specialist) and Sue Jordan (Dermatology Nurse Specialist); and is not the opinion of, or endorsed by AbbVie.
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
Healthcare professional pages

Dermatology Life Quality Index

Patient pages

Do you have any psoriasis at the moment?

Yes ☐ No ☐

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

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

Notes