Training on the new modular approach on the assessment and management of psoriatic arthritis (PsA) for rheumatology units
Overview of PsA
Psoriatic arthritis (PsA) is a progressive disorder ranging from mild synovitis to severe progressive erosive arthropathy\(^1\)

PsA is a complex condition that involves many body areas:

- Skin
- Fingernails and toenails
- Peripheral joints
- The axial skeleton (the spine, chest and sacroiliac joint)
- Entire digits (dactylitis)
- Entheses

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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%\(^1\)

At least 20% of people with psoriasis have severe psoriatic arthritis with progressive joint lesions\(^1\)

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1. NICE Technology appraisals.TA199, August 2010. Slide template developed as part of the Outside in Materials
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\(^1\)

Without treatment, PsA can progress notably within the first 2 years of disease onset\(^2\)

Dual skin and joint involvement can have a negative impact on a patient’s quality of life\(^3\)

It is, therefore, critical to diagnose and commence treatment early

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Diagnosis

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.
PsA Assessment Academy
Objectives of Training

- To provide background information on PsA
- To explain the new modular approach on the assessment of PsA
- To ensure all practitioners are proficient in using the assessment tools
- To agree a standardised assessment protocol for each clinic
A group of physician and nurse experts in rheumatology and dermatology met to discuss the assessment of PsA based on the available evidence:

- **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**, Lead Rheumatology Educator, Royal Derby Hospital, Derby
- **Sue Oliver**, Past Chair RCN Rheumatology Forum and RCN Fellow. Independent Nurse Consultant
- **Liz Parrish**, Dermatology Lead Nurse/Matron, East Kent University Hospitals NHS Foundation Trust
Academy recommendations

Practical recommendations were put forward that could:

• Optimise initial assessment and monitoring of PsA by recommending a standardised approach to assessment
• Improve coordination between rheumatology and dermatology services
Aligning with existing guidelines

The recommendations were developed to build on and align with existing guidelines issued by the:

- British Society of Rheumatology (BSR)
- Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA)
- National Institute for Clinical Excellence (NICE)
- Scottish Intercollegiate Guidelines Network (SIGN)
A modular approach
A modular approach was recommended that encourages sharing of knowledge and information, efficient use of time, and prompt referral and treatment of patients.

As a minimum, it has been suggested that:

- **Rheumatology clinics** perform the **66/68 joint count**, DLQI and **PASI** if staff are trained in skin assessment.
- **Dermatology clinics** should perform the **PASI** and the **PEST**.

Over time the components of the modular approach can be added to clinic practice.
Modular approach for PsA managed in rheumatology units

ASSESSMENT AND SCREENING OF PSORIATIC DISEASE IN RHEUMATOLOGY CLINICS
The recommended approach for assessing and screening patients is outlined below. A training manual including short videos on how to conduct the assessments shown on this poster and other recommended assessments is available.

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

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

If neck or back pain is thought to be inflammatory, then practitioner to conduct:
- modified Schöber's test
- cervical rotation

Patient to have PsA assessments by a practitioner:
- **66/68 joint count**
- Leeds enthesitis index
- Tender dactylitis count

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

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

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Apply the modular approach to daily clinical practice

- Agree a **standardised approach** for each test in your clinic
- At initial consultation it is recommended that patients receive the following:
  - Undergo the 66/68 joint count
  - DLQI
  - PASI (if staff are trained in skin assessment)
Clinical questionnaires
Clinical questionnaires

Clinical questionnaires are useful for the continued management of patients who have PsA.

A receptionist or nurse can give the patient the questionnaire when the patient first arrives.

Clinical questionnaires should be completed periodically by the patient, or as required.
Clinical questionnaires

ASSESSMENT AND SCREENING OF PSORIATIC DISEASE IN RHEUMATOLOGY CLINICS

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

**Back and neck:** Have you been suffering from any neck or back pain recently?

**Skin:** Do you have any psoriasis at the moment?

Yes | No
--- | ---
Patient to be given the BASDAI** to complete in the waiting area

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

- modified Schöbers test**
- cervical rotation**

66/68 joint count

Leeds enthesitis index**

Tender dactylitis count**

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

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

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

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

**Guidance on these assessment tasks is provided in the training manual and on the video.
Clinical questionnaires

Have you been suffering from any neck or back pain recently?
  • If patients respond ‘yes’ they should be asked to complete a BASDAI questionnaire before their examination

Do you have any psoriasis at the moment?
  • If a patient responds ‘yes’ they should be asked to complete a DLQI before their examination
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 DLQI consists of 10 simple questions relating to ways in which skin disease impairs lives.

The DLQI is calculated by summing the score of each question. The higher the score, the more quality of life is impaired.

- If the DLQI >5 the patient should be referred to the dermatology clinic.
Dermatology Life Quality Index (DLQI)

Do you have any psoriasis at the moment?

Yes ☐ No ☐

If you answered Yes, please continue to the other side of the page.

Please hand this page to your dermatologist once you have finished.

Dermatology Life Quality Index

1. Over the last week, have daily tasks, physical or social activities been affected by your skin condition?
   - How much?
   - A lot
   - A little
   - Not at all

2. Over the last week, has your skin been irritable?
   - Why much?
   - A lot
   - A little
   - Not at all

3. Over the last week, how much has your skin affected you in your social activities?
   - Why much?
   - A lot
   - A little
   - Not at all

4. Over the last week, how much has your skin affected your self-esteem?
   - Why much?
   - A lot
   - A little
   - Not at all

5. Over the last week, how much has your skin affected your personal relationships?
   - Why much?
   - A lot
   - A little
   - Not at all

6. Over the last week, has your skin affected your ability to work or study?
   - Why much?
   - A lot
   - A little
   - Not at all

7. Over the last week, has your skin affected your ability to carry out activities at home or in the house?
   - Why much?
   - A lot
   - A little
   - Not at all

8. Over the last week, how much has your skin affected your personal appearance?
   - Why much?
   - A lot
   - A little
   - Not at all

9. Over the last week, has your skin affected your personal hygiene or grooming?
   - Why much?
   - A lot
   - A little
   - Not at all

10. Over the last week, how much has your skin affected your ability to take care of your face or body?
    - Why much?
    - A lot
    - A little
    - Not at all

Please check you have answered EVERY question. Thank you.

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Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)

The BASDAI was developed as a composite index to measure the severity of:

- Fatigue
- Spinal and peripheral joint pain
- Localised tenderness and morning stiffness (both qualitative and quantitative)

The BASDAI is user friendly (taking under 2 minutes to complete), highly reliable and is sensitive to clinical change.
Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)

- Patients are asked to complete a series of 6 questions rating them 0-10 (0 = none, 10 = very severe), relating to the last week.

- The **higher the BASDAI score**, the more severe the patient's disability due to their inflammatory arthritis.
Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)

Have you been suffering from any neck or back pain?

Yes ☐ No ☐

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

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

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BASDAI - Bath Ankylosing Spondylitis Disease Activity Index

1. How would you describe the worst back pain you have experienced?
   - None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Anywhere

2. How would you describe the worst neck pain you have experienced?
   - None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Anywhere

3. How would you describe the worst neck pain you have experienced this week?
   - None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Anywhere

4. How would you describe the worst hip pain you have experienced this week?
   - None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Anywhere

5. How would you describe the worst pain you have experienced this week?
   - None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Anywhere

6. How long were you suffering from your worst pain this week?
   - Less than 3 days ☐ 3 to 5 days ☐ 5 to 7 days ☐ 7 to 10 days ☐ More than 10 days ☐

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BASDAI Score Calculation:

1. Add the score of question 1 (Worst back pain)
2. Add the score of question 2 (Worst neck pain)
3. Add the score of question 3 (Worst neck pain this week)
4. Add the score of question 4 (Worst hip pain)
5. Add the score of question 5 (Worst pain)
6. Add the score of question 6 (Duration of worst pain)

Total score: BASDAI score = 1 + 2 + 3 + 4 + 5 + 6

The higher the BASDAI score, the more severe the patient's disability due to their AS.

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Assessing the joints
Assessing the joints

ASSESSMENT AND SCREENING OF PSORIATIC DISEASE IN RHEUMATOLOGY CLINICS

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

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

**Yes**

**No**

**Yes**

Patient to have PsA assessments by a practitioner

- **66/68 joint count**
- **Leeds enthesitis index**
- **Tender dactylitis count**

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

**Yes**

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

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

*Outside in Materials*

**AbbVie**
In order to assess and manage PsA, the **66/68 joint count** should be conducted and recorded on each patient at **every** clinic visit.

- **66 joints** are assessed for **swelling**
  - Hip joints are too deep to palpate so are only assessed for tenderness

- **68 joints** are assessed for **tenderness**
Assessing the joints

- Patients with PsA can present with disease primarily in:
  - The small joints of the feet
  - The distal interphalangeal joints of the hands and feet

- These affected joints would be missed when calculating DAS28 and the patient's disease severity underestimated

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Assessing the joints

The British Society for Rheumatology (BSR) recommends the use of a 66 swollen and 68 tender joint count.
Measuring 66/68 tender joints\(^1\)

All joints should be assessed separately for tenderness and swelling

**Assessing joint tenderness:**
- Press on the joint using the thumb and index
- A general guide to the amount of pressure required is press until it causes ‘whitening’ of the examiner’s nail beds
- The joints are scored for tenderness on a 0-1 scale
  - 0 = no tenderness
  - 1 = tenderness

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Measuring 66/68 swollen joints

All joints should be assessed separately for tenderness and swelling

Assessing joint swelling:

- Joint swelling in inflammatory arthritis is typically soft and boggy and not hard or bony
- Fluctuation is a characteristic feature and joint swelling may influence the range of joint movement.
- The joints are scored for swelling on a 0-1 scale
  - 0 = no swelling
  - 1 = swelling

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66/68 scoring sheet
Temporomandibular joint

- The line of the temporomandibular joint can easily be found by placing the tips of two fingers immediately in front of the tragus of the ear.
- As the patient opens their jaw, the mandibular condyle moves forwards and a depression can be felt.
Sternoclavicular joint (SCJ)

- To palpate the SCJ find the manubrial notch at the top of the sternum
- Move the fingers laterally to the medial end of the clavicle
- To check position ask the patient to shrug their shoulders upwards

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Acromioclavicular joint

- Move the fingers laterally along the clavicle until where the end of the clavicle meets the acromion
- The position of the joint line can be checked by asking the patient to shrug their shoulders
- This is usually the site that the bra strap sits in women
Shoulder joint

- Examiner holds slightly flexed arm and place the 4 fingers in the anterior aspect of shoulder joint.
- Ensure no pressure on other joints when moving the arm, e.g. holding the wrist or elbow when moving shoulder joint.
- Passive abduction movement of patient’s shoulder through from zero to 50°. Observe carefully for swelling.
- Note: If shoulder is damaged, pain is inevitable on excessive movement.


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Elbow joint

- Flex elbow between 70° and 80° (examine not on full flexion)
- Examine with both hands
- Place thumb between olecranon and lateral epicondyle
- Place index fingers in ante-cubital fossa
Wrist joint

- Examine extended wrist in neutral position
- Use both hands to examine with thumbs on dorsal surface of patient’s wrist and fingers on palmar surface of patient’s wrist
- Gently move wrist through 10° and 20° dorsiflexion and palmar flexion whilst exerting mild pressure from both examining hands

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Metacarpophalangeal (MCP) joint

- Use supporting hand to keep the patient’s hand extended with MCP joints flexed to about 50°
- Examine each joint in turn with patient’s hand extended
- Feel right and left posterior joint margins using both thumbs while the fingers are supporting patient’s hand


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Examine each joint in turn with patient’s hand extended

Feel lateral and medial joint margins with examining hand using thumb and index finger (With index finger and thumb on each hand make a “C” shape)

Position the other hand to exert pressure alternately on anterior and posterior aspect of joint using thumb and index finger (Forming another “C” shape)

Distal interphalangeal joints

- With index finger and thumb on each hand make a “C” shape
- Position one C anteriorly/posteriorly over the joint line and the other one laterally
- Then in turn squeeze the fingers over the joint line
- If there is an effusion within the joint you will feel the fluid moving below your fingers
- This technique is called “ballotting”
The hip joint is too deep seated to palpate, hence 66 swollen versus 68 tender. Therefore only tenderness is assessed.

Tenderness of the hip is classified as pain on movement when flexing and rotating the hip.
Ideally patient should be assessed on a trolley; where this isn’t practical, and the patient is examined sitting in a chair, avoid raising the knee too high.

**Step 1:** Place thumb and index finger of examining hand along mid-points of medial and lateral tibio-femoral joint margins. This detects tenderness and swelling. With a large joint it may need both hands.

**Step 2:** Subsequently, use second hand to evacuate suprapatellar pouch while examining hand has thumb and middle finger along medial and lateral margins of patello-femoral joint and index finger or thumb superiorly on patella. This detects synovial effusion. If present, the joint is swollen.
Ankle joint

- Place both index fingers on the medial and lateral malleoli and place both thumbs on the midline of the ankle joint.
- Ask the patient to plantar flex and dorsiflex the ankle to ensure you are on the joint line.
Metatarsophalangeal joints

- Squeeze both thumbs on the plantar aspect and both thumbs on the dorsal aspect of the foot
- Palpate each metatarsophalangeal joint in turn, both for tenderness and swelling
Proximal interphalangeal joints

- These are done in the same way as assessing distal interphalangeal joints of the hand
- Position one C anteriorly/posteriorly over the joint line and the other one laterally
- Then in turn squeeze the fingers over the joint line
- Care should be taken when assessing proximal interphalangeal joints as there is less space between the toes


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Assessing the Skin
Assessing the skin

ASSESSMENT AND SCREENING OF PSORIATIC DISEASE IN RHEUMATOLOGY CLINICS

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- **Skin**: Do you have any psoriasis at the moment?

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

66/68 joint count

- modified Schöbers test**
- cervical rotation**

Leeds enthesitis index**

Tender dactylitis count**

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

Patient to have PsA assessments by a practitioner

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

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

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

Yes

No

Yes

No
Psoriasis Area Severity Index (PASI)

PASI is an index used to express the severity of psoriasis considering the following:
  • Severity (erythema, induration and desquamation)
  • Percentage of affected area

The body is assessed in four regions:
  • Head and neck
  • Arms
  • Trunk (includes groin and axillae)
  • Legs (includes buttocks)
Psoriasis Area Severity Index (PASI)

- Each is assigned a score to reflect extent of affected area, (0 = no skin affected, 6 = 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)
Psoriasis Area Severity Index (PASI)

- The PASI is the main test used in the clinic to assess total body area affected by psoriasis.
- It can be used to monitor both the patient’s psoriasis and their disease progression and response to treatment over time.
- The test is used to help decide the most appropriate treatment.
Psoriasis Area Severity Index (PASI)

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

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

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

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

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

- **Yes**
  - Patient to be given the BASDAI** to complete in the waiting area
  - If neck or back pain is thought to be inflammatory, then practitioner to conduct:
    - modified Schöbers test**
    - cervical rotation**
  - 66/68 joint count
  - Leeds enthesitis index**
  - Tender dactylitis count**
- **No**
  - Patient to have PsA assessments by a practitioner
  - Patient to be given the DLQI** to complete in the waiting area
  - If the patient has any psoriasis a PASI* should be conducted.
  - If the rheumatology clinic is unable to do a PASI or if DLQI >5 then the patient should be referred to the dermatology clinic. Nails should be visually assessed for pitting.

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

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Over time practitioners can be trained in the additional components of the modular approach:

- Leeds enthesitis index
- Tender dactylitis count
- Modified Schöbers test
- Cervical rotation

Assessments are available in the training manual or as videos on the CD-Rom.
The LEI examines **tenderness** at six sites and scores 0-6 depending on severity:

- 2 sites at each of the **lateral epicondyles of the humerus**
- 2 sites at each medial **condyles of the femur**
- 2 sites at each insertion of the **Achilles tendon**

For **each** entheséal site, **assessment is made of the adjacent joint** in terms of tenderness and soft-tissue swelling.
Lateral epicondyle

- 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 condyle of the femur

- Identify the medial joint line of the knee then move the thumb by about 2-3cm over the femoral condyle to feel for tenderness.
- Pressure, sufficient to blanch the nail is exerted and the enthesis examined for tenderness.
Achilles tendon

- Place thumb over posterior aspect of the foot and move up from the calcaneus to feel for tenderness at the site where the Achilles tendon inserts into the calcaneus.

- Pressure, sufficient to blanch the nail is exerted and the enthesis examined for tenderness.
Tender dactylitis count

Dactylitis is the uniform swelling of a whole digit such that the joints cannot be identified. It is commonly known as a sausage finger or a sausage toe.

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.
Tender dactylitis count

- 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

Dactylitis of the big toe (above)
Modified Schöbers test

- The modified Schöber test assesses the **amount of lumbar flexion**

- To perform this assessment:
  - Mark the lumbosacral junction by locating the dimples of Venus and mark on each side and then mark a line between the two points
  - Measure upwards from this line 10cm (superior) and also below this line 5cm (inferior) and mark each point
  - 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**
  - A normal modified Schöbers is an increase of 5 cm or more between the two points
Cervical rotation can be measured using a goniometer. To perform this assessment:

- With the patient seated, place the goniometer on the top of the patient’s head and line up with the patient’s nose.
- 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.
- Ask the patient to turn their head to the front, neutral position. Align the arms of the goniometer with the patient’s nose.
- 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.
- Take the average of the two readings, a normal cervical rotation is ≥70°.
Assessing treatment response
Psoriatic Arthritis Response Criteria (PsARC)

PsARC is used to assess **response to treatment** and is generally conducted after **12 weeks of treatment**\(^1,2,3\)

As part of the PsARC assessment, the patient’s general health is assessed by **both** the patient and physician.

Global assessment: Recommended questions:
As part of the PsARC assessment, the patient’s general health is assessed by both the patient and physician. Below are recommended questions for your patient and the physician using a 5-point Likert scale.

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

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0  1  2  3  4  5
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Very good, no symptoms, no limitations on normal activities
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“Considering all the ways the arthritis affects your patient, how is your patient feeling today?" (Physician)
An adequate response is defined as an **improvement in at least two of the four PsARC criteria**, (one of which has to be joint tenderness or swelling score) with no worsening in any of the four criteria.

**Improvement in at least 2 of 4 criteria, including:**

- Physician global assessment (0-5)
- Patient global assessment (0-5)
- 66 Swollen joint score (≥ 30%)
- 68 Tender joint score (≥ 30%)
Psoriatic Arthritis Response Criteria (PsARC)

According to NICE guidance Anti–TNF treatment should be discontinued in people whose psoriatic arthritis has not shown an adequate response using the PsARC at 12 weeks.

An adequate response is defined as:

- An improvement in at least two of the four PsARC criteria, (one of which has to be joint tenderness or swelling score) with no worsening in any of the four criteria.
- 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.
Training materials
A selection of training materials are available on the CDROM
Summary

To optimise best practice **all patients with psoriasis** should be screened for PsA

Agree a **standardised approach** for each test in your clinic

As a minimum, it has been suggested that:

- **Rheumatology clinics** perform the **66/68 joint count, DLQI** and **PASI** if staff are trained in skin assessment
- Patients with a **DLQI >5** should be referred to a dermatology clinic