Dermatologists' Management of Psoriatic Arthritis: A Report from the 2014 GRAPPA Meeting

Wolf-Henning Boehncke

ABSTRACT. The presence of concomitant psoriatic arthritis (PsA) directly affects the treatment decisions dermatologists may make as they manage their patients' psoriasis (PsO). Because the prevalence of PsA increases with PsO duration, it is important to regularly screen for signs and symptoms of PsA. Dermatologists and rheumatologists agree that they need to cooperate in the management of skin and musculoskeletal manifestations of PsA. However, the respective healthcare systems substantially influence how this cooperation is achieved in different countries and possibly even within regions. Some models exist that address how this crucial cooperation can be achieved. (J Rheumatol 2015;42:1029–31; doi:10.3899/jrheum.150125)

Key Indexing Terms:
PSORIASIS PREVALENCE DERMATOLOGIST RHEUMATOLOGIST

According to current guidelines, mild psoriasis (PsO) can potentially be managed using topical therapies, while moderate-to-severe PsO necessitates phototherapy or systemic therapy in combination with topicals[1]. If the patient has coexisting psoriatic arthritis (PsA), a systemic therapy may be needed even if the patient exhibits only mild PsO[2]. Further, PsA may involve peripheral joints, the axial skeleton, tendons, and entheses[3], all of which respond differently to drugs currently available[4]. The presence and type of PsA, therefore, may directly influence the dermatologist's treatment decision. This is true from a medical as well as from a regulatory point of view, as not every drug available to treat PsO is approved for the treatment of both PsO and PsA, and vice versa.

The Role of Dermatologists in Screening for PsA

Along with the difficulties described above, dermatologists need to screen for PsA symptoms for at least 3 additional reasons[5]:

1. PsA is more common than previously thought. While older textbooks cite PsA in 6–8% of patients with PsO, more recent epidemiologic and clinical studies suggest numbers on the order of 15–30%.
2. PsA is more serious than previously thought. Although it has sometimes been nicknamed "the little sister of rheumatoid arthritis," it is now clear that about 50% of patients with PsA have a chronic-progressive disease course.
3. Even a relatively short delay in diagnosis and adequate treatment of PsA is associated with a worse longterm outcome[6].

From the Department of Dermatology, Geneva University Hospital, Geneva, Switzerland.

W.H. Boehncke, MD, Department of Dermatology, Geneva University Hospital, and Department of Pathology and Immunology, University of Geneva.

Address correspondence to Prof. W.H. Boehncke, Department of Dermatology, Geneva University Hospital, Rue Gabrielle-Perret-Gentil 4, CH–12 11, Geneva 14, Switzerland.
E-mail: wolf-henning.boehncke@hcuge.ch

Thus, screening for PsA to ensure early diagnosis and treatment is a high priority. And dermatologists are in a position to be "sentinels," because in the majority of cases, PsA symptoms manifest after the onset of PsO[3].

Who and How to Screen

Although there is a trend toward a higher prevalence of PsA among patients with severe PsO, the prevalence of PsA among patients with mild PsO is still high, thus necessitating inclusion of every patient with PsO in the dermatologists' screening efforts. The likelihood of PsA is particularly high if the patient has PsO of the scalp or nails, or has perianal or intertriginous manifestations[7].

Given the clinical heterogeneity of PsA, it is difficult for nonrheumatologists to establish this diagnosis. Numerous groups have developed screening questionnaires as potential tools for this purpose, e.g., the Psoriatic Arthritis Screening and Evaluation (PASE) questionnaire, the Toronto Psoriatic Arthritis Screening (ToPAS) questionnaire, and the Psoriasis Epidemiology Screening Tool (PEST). While initial reports of these questionnaires suggested good sensitivities, a subsequent publication reported much lower ones[8]. In a recent head-to-head comparison study, sensitivity values of about 75% were found[9]. Such questionnaires — with reasonably good but not excellent sensitivity — might therefore be considered helpful for screening purposes, but should not replace careful physical examination and additional questions.

How to Organize the Cooperation Between Dermatologists and Rheumatologists

It is evident that screening for PsA is an important task for dermatologists, but it might quickly become time-consuming once actions beyond the evaluation of questionnaires are involved. The need to effectively and efficiently identify potential PsA patients for referral to a rheumatologist for

diagnosis where required and to organize cooperation between dermatologists and rheumatologists for patients with PsA becomes even more urgent to ensure these patients are appropriately treated and monitored to improve longterm outcomes. Achieving this cooperation depends to a large extent on the resources made available by the respective healthcare system, as highlighted by a comparison between Germany and Switzerland.

Cooperation Between Dermatologists and Rheumatologists in Germany and Switzerland

The German and Swiss healthcare systems are comparable with regard to many key criteria including availability of drugs and strategies for reimbursement. To date, however, German and Swiss dermatologists and rheumatologists have not determined how to cooperate best with regard to managing patients with PsA.

In Germany, numerous initiatives over the last decade were meant to enable dermatologists to screen for and to a certain extent, to treat PsA. These included joint symposia of dermatologists and rheumatologists on the management of PsA as well as workshops focusing on the early diagnosis of PsA by dermatologists.

In Switzerland, a recent Delphi exercise in a group of 8 dermatologists and 8 rheumatologists from secondary and tertiary care centers yielded different answers from the 2 professions (Table 1)[10]. The group did agree on the importance of screening patients with PsO for signs and symptoms of PsA, as well as the potential for dermatologists to serve as sentinels in this regard. Moreover, they agreed on the goal to initiate an effective early treatment to prevent structural damage and functional loss.

On the other hand, the rheumatologists discouraged a more active role for dermatologists. For example, the group agreed that nonrheumatologists should not order imaging as part of the diagnostic investigations, and initiation of a therapy with disease-modifying antirheumatic drugs such as methotrexate or biologics should be discussed with a rheumatologist.

With regard to the envisioned cooperative models, these differences may be explained at least in part by the differences in the respective healthcare systems despite numerous similarities[11]. In Germany, there are about 4000 dermatologists and 400 rheumatologists for 80 million people; in Switzerland, the respective numbers are 400, 400, and 8 million. Thus, German dermatologists need to serve as "filters" to protect the time of rheumatologists, while rheumatologists in Switzerland probably have time to see patients with PsA, those with other inflammatory joint diseases, and those with noninflammatory disorders such as osteoarthritis. Hence, the respective roles of dermatologists might be labeled "gatekeeper" in Germany, but "pilot" in Switzerland.

Perspectives

While the importance of PsO as a global health problem has been widely accepted and underlined by a recent resolution of the World Health Organization, awareness of the importance and effect of PsA must still be fully established. Routine screening for PsA among patients with PsO is not widely practiced, and the available tools must be optimized further. Even in developed countries, there is a shortage of resources dedicated to the adequate care of patients with PsA.

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Table 1. Summary of key statements resulting from a recent interdisciplinary Delphi exercise conducted in Switzerland (summarized from Boehncke, *et al*, Dermatology 2015;230:75-81[10]).

Domain	Statement	% Participants Voting "strongly agree" or "agree" (3rd round)
Significance of PsA	The prevalence of PsA has been underestimated in the past	91
	PsA contributes significantly to the morbidity of PsO patients	100
Strategic goal in managing PsA	The diagnosis of PsA needs to be established as early as possible	92
	Dermatologists are in a position to identify patients with PsA early	100
	Presence or absence of PsA substantially influences the choice of treatment	100
Establishing the diagnosis of PsA	Nonrheumatologists should ask PsO patients about joint and back pain	100
	Nonrheumatologists need to know the clinical manifestations of PsA	83
	Nonrheumatologists should not perform imaging	92
Management of PsA	Rheumatologists should confirm the diagnosis of PsA suspected by nonrheumatologists	92
	Introduction of DMARD treatment by dermatologists needs to be discussed with the rheumatologist	83
	Dermatologists and rheumatologists need to jointly follow PsA patients	100
	Proven efficacy in PsO and PsA is a substantial advantage for a drug to be used in treating patients with PsO and/or PsA	84
	The treatment goal should be "minimal residual disease"	100
	Treatment response must be assessed regularly (about every 3 months) and treatment must be adapted accordingly	100

DMARD: disease-modifying antirheumatic drug; PsA: psoriatic arthritis; PsO: psoriasis.

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