Psoriasis and Psoriatic Arthritis: Providing Bidirectional Care

Transcript

Alexis Ogdie, MD (Guest): I totally think it's so important to identify your "derm-rheum" buddy.

Joel Gelfand, MD (Guest): We're fortunate to be in this position to really help our patients in a profound way.

Meghna Rao (Host): Welcome to Rheum Advisor on Air, the official podcast of *Rheumatology Advisor*, one of Haymarket Media's leading publications that focuses on the latest news and research in rheumatology to inform clinical practices. I'm your host, Meghna Rao, the editor of *Rheumatology Advisor*. In this podcast series, we will be looking at emerging topics in the field of rheumatology from various experts. These perspectives may be related to the diagnosis and treatment of rheumatic diseases, current guidelines, practice management, patient care, and much, much more. So let's dive in!

Today is a very special episode. I'm joined by my colleague, and the editor of *Dermatology Advisor*, Heidi Moore. Welcome aboard, Heidi.

Heidi Moore (Host): Thank you, Meghna.

Meghna: Our conversation today promises to be very interesting and insightful because we have a dermatologist and rheumatologist joining us on this episode to talk more about the different aspects in overlap and transition of care between patients with psoriasis and psoriatic arthritis.

Our guests today are Dr Joel Gelfand, the vice chair of Clinical Research, medical director at the Dermatology Clinical Studies Unit, and professor of dermatology at Penn Medicine, and Dr Alexis Ogdie, an associate professor of medicine at the Hospital of the University of Pennsylvania, associate professor of epidemiology in biostatistics and epidemiology, and also a Penn Medicine physician.

It's an absolute pleasure; thank you both for joining me today.

Dr Ogdie: Thanks so much for having us.

Dr Gelfand: Yeah, it's great to be with you.

Meghna: Let's start right at the beginning with psoriasis that occurs either preceding or concurrently with psoriatic arthritis or PsA.

Heidi: Dr Gelfand, after a patient presents to you with symptoms of psoriasis, one of the biggest challenges remains identifying risk factors for progression to PsA. Also, recent population-based studies have shown a delay in

transition from psoriasis to PsA. So, my first question to you is, in what percentage of patients with psoriasis are you able to predict progression to PsA, and can you tell us about the reliability and sensitivity of the current screening methods?

Dr Gelfand: Heidi, that's a great question, and it's really a critical point of research. At this point, we really can't reliably predict which patient with psoriasis will go on develop psoriatic arthritis, when they will develop psoriatic arthritis, and how significant this psoriatic arthritis will be. What we've learned over the last decade of the research, that's been really important for our listeners to be aware of, is that, one is, the old dogma was that, "Oh, patients develop psoriatic arthritis within 8 to 10 years of having psoriasis." That turned out to be not correct based on longitudinal, well-done epidemiological studies, which really showed the risk of developing psoriatic arthritis remains present as long as you have psoriasis. That risk continues to be there for patients. So, for someone who's had the disease for 15 [or] 20 years, they are still at risk of developing psoriatic arthritis.

Other risk factors are important for people to think about, and I would be certainly interested to hear Dr. Ogdie's thoughts on this, are body surface area psoriasis; the more significant body surface area psoriasis involved, the more likely someone is to develop psoriatic arthritis eventually. Although, the severity of skin diseases correlates very weakly with the severity of joint disease, and so, that's important be aware of. People who are obese are more likely to develop psoriatic arthritis over time. Then finally, family history. Psoriasis is one of the most heritable of the complex, multigenic traits, and psoriatic arthritis has an even stronger heritable component as a multigenic disease than psoriasis.

Heidi: So, what you're saying is, there really is no “safety zone” for a patient with psoriasis, and if they encounter any other comorbidities, such as they gain weight [or] they become morbidly obese, they then put themselves at a higher risk than they had been?

Dr Gelfand: We think that's a correct assumption, Heidi, and interpretation where the data [are] currently.

I do want to say, taking a step back, certainly psoriasis itself is a big marker of someone's risk of developing psoriatic arthritis. You know, we think of other inflammatory diseases like rheumatoid arthritis [(RA)] or Crohn disease, you really don't know who in the general population is at risk of developing those diseases, beyond having a family history. So, having the clinical disease of psoriasis, we know puts you in a much different risk category, of developing another inflammatory disease, in this case, psoriatic arthritis.

It’s important that patients be aware of this condition, so they know what to look for and they bring it to our attention to developing new symptoms, because this disease can present in a multitude of different ways. Oftentimes,

it can be hard for the patient's primary care doctor to really hone in on a diagnosis of psoriatic arthritis because they may not be as familiar with the various presentations of this disease state.

Dr Ogdie: I was going to say exactly the same thing. I think when we talk about all of these different risk factors, one of the strongest risk factors for developing or getting a new diagnosis of psoriatic arthritis is having symptoms. And many patients have these symptoms a year or more before they're actually diagnosed. So, referring early when the patient has symptoms is ideal.

Dr Gelfand: In clinic, when I talk to my patients about their joint symptoms, the decision I have to make as a clinician is, am I worried about their joint symptoms and I feel that they need to see rheumatology, or I need to initiate a laboratory work up, or maybe an imaging work up, or do we want to just watch it. I'll have that discussion with a patient, and someone who has some mild joint symptoms that go away very quickly upon waking in the morning, and aren't really affecting their activities in daily living, I'll say, all this is a little suspicious for psoriatic arthritis; I'll say we need to watch this, and if the symptoms are persisting and getting worse, then you let me know. Whereas other patients who have swelling on exam, or tenderness on exam, or have a half an hour or more of morning stiffness in the joints, those are [the] people I tend to be much more aggressive in terms of initiating a workup and making sure they see you and our colleagues in rheumatology.

Heidi: Dr Gelfand, the average patient with psoriasis, how familiar are they with the possibility that their disorder may progress to PsA?

Dr Gelfand: Yeah, I think this is very challenging for patients because, you know, it's a complicated disease [psoriasis], and when someone comes to see me as a dermatologist, they tend to be mainly focused on the manifestation of the disease in the skin itself. That's what their main concern may be.

So oftentimes, it's pretty important for us to educate them about the natural history that psoriasis and other conditions that can occur over time. Certainly, I've had many patients over the years [who] have developed arthritis and just weren't aware that [that] could be part of their psoriatic disease. So it's something that I always counsel my patients on; it’s part of the educating of the patient.

Meghna: I want to jump in quickly here. I heard the term pre-PsA recently – the terminology is definitely getting more attention, which is great since both psoriasis and PsA are such challenging conditions to study. But Dr Ogdie, you may be better positioned to answer this. What are the chances of a patient presenting to a rheumatologist with signs and symptoms of psoriasis or PsA before receiving care from a dermatologist, and what's the standard of care here, and are dermatologists often consulted in such cases because of the obvious skin involvement?

Dr Ogdie: That's a great question. So actually, if you look at the overall population of patients with PsA, on average, the majority have mild psoriasis. [M]any of our patients come to us without having seen a dermatologist or without having a regular dermatologist and we often will send them to a dermatologist to confirm the diagnosis of psoriasis. We see a fair number of people who don't have a dermatologist or at least aren't seeing them first.

Dr Gelfand: Yeah, this is something that causes a lot of confusion, I think, in the literature, and among people thinking about these issues. But this phenomenon is basically based on the distribution of severity of psoriasis in the general population. Of the 8 million people who have psoriasis in the United States, roughly 7 million of them have pretty mild disease. So what that means is that the largest number of people at risk of developing psoriatic arthritis are those who have mild disease, and they're the largest number of people in the general population. That's why when patients present to a rheumatologist, they're likely to have mild psoriasis.

Meghna: Yeah, that's interesting. [I]'d imagine this makes following up with patients also that much more demanding, right?

[To] make matters a bit more challenging, there's axial PsA and then there's axial spondyloarthritis or ankylosing [spondylitis] along with skin psoriasis. This was discussed at some length at [the American College of Rheumatology] (ACR) 2020 [annual meeting] and definitely warrants more dialogue. I wanted to ask, how can these patients be differentiated and care provided accordingly. Is the dermatologist or rheumatologist sought after here?

Dr Gelfand: Certainly as a dermatologist, we have to be aware of the different symptoms that could be a sign of inflammatory arthritis, and then our job is really to educate the patient and, unless it's a straightforward case, to refer to our colleagues in rheumatology. Some presentations are extremely challenging, especially axial disease. So I wanted to first question Dr Ogdie, I'm really curious to hear her thoughts on how to differentiate the myriad of common joint symptoms that patients can present with that may mimic or be comorbid with psoriatic arthritis.

Dr Ogdie: That's a great question. So, we see a lot of patients with joint pain who have osteoarthritis or fibromyalgia, both common in the general population as well as the patient with psoriasis. Some of the things we think about in terms of differentiation are swelling; so [if] a patient has never had swelling, it's really hard to say that they have psoriatic arthritis. Morning stiffness is helpful, although patients with fibromyalgia also have prolonged morning stiffness and it's noninflammatory, so that creates [a] difficulty in distinguishing between those two. Fibromyalgia can also overlap with psoriatic arthritis, so that makes it even more complicated, and patients with psoriatic arthritis can have osteoarthritis as well. Or, if [patients] have axial disease – [m]orning stiffness in the spine, having difficulty moving in the morning when they first get up, gets better with activity, a lot of those patients prefer to stand rather than sit – there are some criteria that can help

differentiate inflammatory back pain. But then again, even with the inflammatory back pain, there are other causes of inflammatory back pain, including degenerative disease in the fibromyalgia. So, it can be tricky and that's where imaging can help especially for the spine.

Dr Gelfand: Dr Ogdie, I'm curious. Help us understand, [w]hat type of imaging you do for axial disease. To me as a dermatologist, I often feel comfortable ordering x-rays in the hands and feet because it's an inexpensive test, low risk intervention, and if [patients] have any signs of joint damage or erosions, then that obviously makes me discuss with [them] their risk of progressively developing disabling psoriatic arthritis and really ensure they see you in rheumatology. But what type of imaging you think about for axial disease and what makes you decide to image someone vs not image them?

Dr Ogdie: Yeah. That's a really important question and actually difficult for rheumatologists sometimes, too.

So, we always want to focus on the pelvis. Sacroiliac [(SI)] joints are most commonly still where it starts. There [are] some data that the cervical spine can be involved outside of the SI joints in psoriatic arthritis, as opposed to just regular old axial spondyloarthritis or axSpA, but almost always, the money is on the SI joints. So, the most common mistake we see is people ordering lumbar spine films, but then you generally aren't getting the SI joint. If that's normal, then we go for a pelvis [magnetic resonance imaging] (MRI). And again, pelvis, not lumbar spine, because the lumbar spine won't cover that. We just get a pelvis MRI without contrast, but ideally, it's read by musculoskeletal radiologist, who's trained to look at SI joints. That is not always the case in the community setting, so we have to make sure that the radiologist is aware of what we're looking for. There's a high variability in reading the SI joints.

Dr Gelfand: Yeah, this is why I think it's so important for dermatologists who manage [patients] with psoriasis to identify the rheumatologist or rheumatologists in their community they can partner with to manage this disease. Because if you take care of psoriasis, you will have plenty of patients who fall into these sort of diagnostic conundrums in terms of the musculoskeletal symptoms.

I wanted to ask you, Alexis, earlier you mentioned about swelling as being one of the important signs of inflammatory arthritis; psoriatic arthritis. But from my point of view, as a dermatologist, what does swelling mean to you? I know this counts as *[sic]* synovitis, which as an untrained person, me not being trained rheumatologist, I don't feel that confident I could pick up synovitis on my own joint exam. I could pick up joint pain, if they are tender, but I don't know if I could pick up joint synovitis. I feel like I could observe swelling, like if the joint looks swollen, that's pretty obvious, but my sense is that you guys are looking for more subtle changes of swelling. Am I right?

Dr Odgie: Yeah it's a really good point. I totally think it's so important to identify your "derm-rheum" buddy because it's been even really helpful for rheumatology perspective to say, I don't know if this is psoriasis.

[I]n terms of swelling, if a patient tells me, on history, that they've never had joint swelling, I think it has a pretty high negative predictive value. On the other hand, if they're sitting in front of you [and] there's no joint swelling today, but they can tell you that they had swelling, that's still helpful that they know that there was swelling. On exam, one of the most helpful things is symmetry – as dermatologists, you're really good at that part – but looking at the joint compared to the other; now, you can tell this is how we learn to do things from telemedicine, to have your partner or someone at home take a picture of your hand next to the other hand to show us the difference, so that we can see if there's actually a swelling there.

But you also mentioned synovitis and it's true that a lot of patients think they have joint swelling when what they have is osteophytes. Hand osteoarthritis, at the [distal interphalangeal] (DIP) or [proximal interphalangeal] (PIP) joints, you get bony enlargement there, and if you push on it, it just feels like bone, like if you're pushing on your own knuckle, but when it's actually swollen, it does feel a little soft and I call it "squishy;" a truly swollen joint is squishy. If you can't feel the joint line, that's probably a good sign that it's probably swollen. It is a subtle characteristic, but I would say that even the patient's history of joint swelling is really important.

Heidi: It sounds as though the transition of care is not as linear as you might think. It doesn't necessarily start with a patient at the dermatologist's office, then progressing to the rheumatologist. It sounds as though they can start at the rheumatologist, then work backwards to the dermatologist. Is that accurate?

Dr Ogdie: Yeah, that's definitely true.

Dr Gelfand: The arrow definitely goes both ways. One of my goals is to hopefully minimize the patient's need to see a rheumatologist by using effective therapies. So, if the patient is presenting with symptoms that are concerning for psoriatic arthritis, but they're fairly mild and maybe I do a simple workup – like I'll get a sedimentation rate, a C-reactive protein, I'll get a rheumatoid factor, [cyclic citrullinated peptide] (CCP) antibody, and a uric acid level – and if all those tests are more or less normal, and then I'm treating their psoriasis with a disease-modifying agent anyway, like an [interleukin] (IL)-17 inhibitor or [tumor necrosis factor] (TNF) inhibitor, or something along those lines, if their joint symptoms are better, I treat their skin psoriasis with an appropriate therapy, then we continue to watch things. But if my patients have persistent joint symptoms or I don't have a reason to get them a systemic agent because maybe their skin psoriasis doesn't require one, then consultation with rheumatology is really important to help influence what the next course of treatment would be for the patient.

Dr Ogdie: Yeah, exactly. I think a 1-time visit to a rheumatologist is never a bad idea. What Dr Gelfand and others do at Penn [Medicine] is, we say, can you see this person within 4 weeks, if there's a concern, or we're trying to start therapy on this patient and I need to know if this patient has axial disease, could you see that patient. That can be really helpful and having that that conversation to say, how urgent is this.

Because some of the things that might sway you one way or the other [is] the axial disease since not all therapies that treat psoriasis cover the axial disease. It's really only the TNF inhibitors or the IL-17 inhibitors, or soon, the [Janus kinase] (JAK) inhibitors, and those are not used in dermatology offices.

Dr Gelfand: Right. And then, also, we've got to be mindful of the fact that there is a disconnect between how effective our therapies are for the skin disease compared [with] the joint disease. So, we are much more likely to put a person's skin psoriasis in remission or close to remission or close to clear with current therapies than we are to get their joint symptoms under complete remission or asymptomatic. So, as a result, you will often be left with patients who may be on an excellent systemic agent and their skin is completely clear but they may have residual joint symptoms and then you'll need input from our colleagues in rheumatology to see how we [need to] optimize from here – do we need to increase the frequency or dosing of the disease-modifying agent or biologic that they're [receiving]; do we need to add on another therapy; or can we just add some [nonsteroidal anti-inflammatory drugs] (NSAIDs) to control symptoms and be reassured that they're on the right treatment and they won't have progression of their disease.

Dr Odgie: Exactly. We aspire to be dermatologists and we aspire to have the treatment effectiveness that dermatologists do for psoriasis. We don't yet have that for psoriatic arthritis.

Dr Gelfand: Yeah, and I think it's really important for our listeners, especially dermatologists, to recognize that of all the complicated immune-mediated diseases, [such as] RA, multiple sclerosis, Crohn disease, psoriatic arthritis, by far, we're just fortunate that the targets for psoriasis are very specific for that disease and therapies are just highly effective. You don't have this kind of response for any other chronic inflammatory multigenic disease out there, and so, we're fortunate to be in this position to really help our patients in a profound way.

Meghna: That's super interesting. Thank you, Dr Gelfand [and] Dr Ogdie.

[A]nother aspect of this is psoriasis and psoriatic arthritis in children, although I'm sure this is more positioned for a pediatric rheumatologist. But how are pediatric cases typically handled; are they any different from those in adults? This definitely seems like a tricky area to navigate since psoriasis typically starts or is diagnosed during teenage or late adolescent years when patients are on the cusp of transitioning into adult rheumatology care.

Dr Ogdie: So, psoriatic arthritis in children is really interesting because it's quite different than adult presentations in that the children will often present first with the joint symptoms and later with the skin. So, [more than] half will present with joint symptoms first, and this is particularly true in the teenage boy group because they have the joint stuff first. They may also have more axial component of the disease. They are then categorized according to [juvenile idiopathic arthritis] (JIA) categories instead of PsA because they don't have known psoriasis. It's actually that the criteria make it really complicated to sometimes recognize the psoriatic arthritis part. So, it's different from that perspective.

Dr Gelfand: Alexis, if I recall, children with psoriatic arthritis are also at fairly significant risk for uveitis.

Dr Ogdie: Yeah, exactly.

Dr Gelfand: That's an important thing to be aware of when you're interacting with these patients. You know that they have skin disease and joint disease, and if you're a dermatologist, you want to ask about eye symptoms along the way, because uveitis is quite common in that demographic.

Dr Ogdie: Exactly. Rheumatologists, they tend to check an [antinuclear antibody] (ANA), and if an ANA is positive, they follow the eyes every 6 months. So, it's more aggressive than for adults. Children can actually have asymptomatic uveitis.

Dr Gelfand: But in adults, you don't get an ANA. Correct?

Dr Ogdie: Right, and no, please no ANAs!

Heidi: Now, in light of the fact that every doctor has a different standard of care and a different decision-making process and there are so many available treatment options for patients with psoriasis and psoriatic arthritis, can you address the importance of communication between the 2 different practices, dermatology and rheumatology, and what can be done by physicians and patients to bridge the gap between your 2 specialties?

Dr Gelfand: Well, from my perspective, Heidi, and this is a really important question, the one thing I always hope my colleagues in rheumatology would keep in mind is that if they're choosing within the class of therapies to manage a patient's joints, they should choose the one that works better for the skin. Within classes of drugs, say in TNF inhibitors, etanercept dosing for psoriatic arthritis is not particularly effective for the skin disease, you're probably better off using like certolizumab or adalimumab, which get better responses in the skin and similar responses in the joints. The other thing is that the dosing in biologics for skin diseases is often higher for people with psoriasis than is for just psoriatic arthritis alone, and so, that's an important point I think for rheumatologists to be aware of.

Dr Ogdie: Yeah, exactly. I think that many rheumatologists do not know about the difference in the dosing for psoriasis and psoriatic arthritis, and I agree, I always choose the skin dose. So you could always come down on the dose, if needed, but never, kind of, short that.

Meghna: You know, just wrapping up our conversation, I'd like to ask both of you, what are the existing barriers during transition from dermatology to rheumatology and vice versa? We have spoken a little bit about this [already], but what guidance is there for clinicians and practices to better streamline this process and provide continuity of care?

Dr Ogdie: Well, I think, what Joel just mentioned, which is having someone to talk to is so critical, having that "derm-rheum" buddy. I feel like we provide so much better care when we're seeing the patient within our own system because we could so easily have conversations about these things. We also know how each other practice and I think that helps a lot to know [that] Dr Gelfand will choose this drug over this one, and to be able to talk to the patient about the fact that I can call him later. You can't say enough about how helpful that is than having to try to track down an outside rheumatologist or dermatologist who we don't really know and maybe you have to play phone tag and go back and forth. So, I think that communication piece is so huge and I think it makes a big difference for patient outcomes, but also, [p]rovider satisfaction as much as patient satisfaction.

Dr Gelfand: Yeah, you know, patients should think about who are the people I need to be part of my care team to manage this chronic disease that they're going be dealing with and it's just not curable. And I think that Alexis outlined, for those of us as clinicians, it's really incumbent upon us to know locally who the doctors [are] that I can work with to get patients in when they really need to get in. So really, the message to the listeners is go out and see in your community who really has an interest in this disease.

Rheumatologists tend not to be as subspecialized as dermatologists are; there may be some dermatologists [who] don't really treat psoriasis, for example. So, if you're a rheumatologist and you're trying to find a dermatologist to work with you, you want to make sure that the dermatologist uses all the psoriasis therapies. Then, on the flip side, as a dermatologist, I will want to confirm the rheumatologist has a particular interest in psoriatic arthritis as well because this can be a tough disease even for a general rheumatologist who doesn't see a lot of it, and so it's even more helpful if you can find and partner with someone who's really interested in inflammatory joint disease.

Meghna: Those are some wonderful insights. I speak on behalf of both Heidi and I when I say that this has been a wonderful conversation, definitely insightful for us as well as our listeners, I'm sure. Thank you both for joining us, Dr Gelfand and Dr Ogdie.

Dr Ogdie: Thanks so much.

Dr Gelfand: My pleasure.

Meghna: Please stay tuned for more episodes in this series. For more information on *Rheumatology Advisor*, and this podcast, you can reach out to us at editor@rheumatologyadvisor. We, at *Rheumatology Advisor*, look forward to delivering timely, evidence-based news to you. You can also sign up for our free e-newsletters on the site.