

Spot Psoriatic Arthritis Early in Psoriasis Patients



Psoriatic arthritis (PsA) is common among patients with psoriasis. It is a destructive arthritis with bone destruction often occurring just months after presentation of symptoms. Therefore, it is important to remain vigilant to the development of joint pain. By identifying PsA early and aggressively treating it with systemic therapy, dermatologists may be able to help patients avoid long-term disabling joint destruction and pain.

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How does psoriatic arthritis present?

Psoriatic arthritis (PsA) can present in psoriasis patients with an average latency of approximately 10 years. In patients with a strong genetic predisposition, another more severe form of PsA can present earlier in life (<20 years of age). Although PsA generally is classified as a seronegative spondyloarthropathy, more than 10% of patients may in fact be rheumatoid factor–positive. Nail pitting is a feature that can suggest the possibility of PsA, present in almost 90% of patients with PsA.

Who should treat PsA?

Although involving our colleagues in rheumatology is usually beneficial for our patients, in most cases dermatologists can and should effectively manage the care of PsA. The immunology of PsA is the same as psoriasis, which contrasts with rheumatoid arthritis (RA). Although active human immunodeficiency virus infection can trigger widespread psoriasis and PsA, RA conversely improves with the depletion of CD4⁺ cells. Methotrexate, which is used cavalierly by rheumatologists for RA, has a different effect in psoriasis; liver damage is 3 times as likely in psoriasis versus RA at the same doses, while cirrhosis without transaminitis is much more likely with psoriasis patients. Thus, a dermatologist's experience with using systemic medications to treat psoriasis is paramount in successful treatment of PsA.

What medications can we use to treat PsA?

Because halting the progression of PsA is the key to limiting long-term sequelae, systemic therapy is the mainstay of treatment. Treatment options range from methotrexate

to most of the newer biologics. Acitretin tends to be ineffective. Apremilast is approved by the US Food and Drug Administration, and Janus kinase (JAK) inhibitors also have demonstrated efficacy in PsA trials. There are some biologics that are used for PsA but do not have an approval for psoriasis, such as certolizumab pegol.

What's new in PsA?

The literature is well established in the classic progression and presentation of PsA, but there is new evidence that the development of PsA in patients with psoriasis is preceded by a period of nonspecific musculoskeletal symptoms, such as joint pain, arthralgia, fatigue, heel pain, and stiffness (Eder et al). The presence of these symptoms may help guide focused questioning and examination.

Another recent study has shown that the incidence of Crohn disease and ulcerative colitis are more likely in patients with PsA (Zohar et al). It is another important consideration for our patients, especially with recent concerns regarding onset of inflammatory bowel disease with some of the newer biologics we may use to treat psoriasis.

As newer classes of biologic treatments emerge, it will be interesting to see how effective they are in treating PsA in addition to plaque psoriasis. We should be aggressive about treating our patients with psoriasis using systemic therapy if they develop joint pain.

SUGGESTED READINGS

Eder L, Polachek A, Rosen CF, et al. The development of PsA in patients with psoriasis is preceded by a period of non-specific musculoskeletal symptoms: a prospective cohort study [published online October 28, 2016]. *Arthritis Rheumatol*. doi:10.1002/art.39973.

Zohar A, Cohen AD, Bitterman H, et al. Gastrointestinal comorbidities in patients with psoriatic arthritis [published online August 17, 2016]. *Clin Rheumatol*. 2016;35:2679-2684.

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