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OPINION ARTICLE

Psoriasis-Arthritis Units: Three Years On[☆]



Unidades psoriasis-artritis: 3 años después

A. López-Ferrer,^{a,*} A. Láiz-Alonso^b

^a Servicio de Dermatología, Hospital de la Santa Creu i Sant Pau, Barcelona, Spain

^b Servicio de Reumatología, Hospital de la Santa Creu i Sant Pau, Barcelona, Spain

Since the inclusion of psoriasis as one of the Caspar classification criteria¹ for psoriatic arthritis in 2006, a confirmed diagnosis of psoriasis by a dermatologist has become an almost essential requirement for the confirmation of a diagnosis of psoriatic arthritis by a rheumatologist in a patient in whom an arthritic condition is being investigated. The dermatologist's intervention is particularly important when the presentation of the skin disease is not one of the common forms—such as plaque psoriasis—that can be easily recognized by a rheumatologist experienced in diagnosing and treating psoriatic arthritis. When a patient has one of the rarer and more difficult-to-diagnose forms of the skin disease (for example, flexural psoriasis, scalp psoriasis, pustular psoriasis, or nail psoriasis), confirmation by a dermatologist specialized in the management of psoriasis becomes essential.

The emergence of a wide range of new treatments in both specialties also means that rheumatologists and dermatologists must collaborate to identify the best treatment for each patient. However, the chief motivation for the creation of units where rheumatologists and dermatologists in the same hospital can work together is the need to increase early detection of arthritis in patients with psoriasis.

Joint consultations are motivated by a need to confirm the diagnosis of psoriasis in patients with joint symptoms or to diagnose arthritis in patients with psoriasis. Given that

psoriasis precedes psoriatic arthritis in as many as 80% of patients, it is very likely that patients with psoriasis requiring the care of a dermatologist will develop joint symptoms at some point in the course of their lives. This means that dermatologists play a key role in screening patients with psoriasis for psoriatic arthritis and in diagnosing the joint disease when the presentation is typical. With this in mind, dermatologists who specialize in the treatment of psoriasis should always obtain a targeted medical history and perform a basic physical examination when there is any suspicion of psoriatic arthritis. If the joint disease is more difficult to diagnose, the patient should be referred to a rheumatologist promptly.^{2,3} In recent years, dermatologists who work with psoriatic patients have become increasingly aware of the need to screen for joint symptoms because of the high suspicion of arthritis in these patients. Likewise, greater involvement on both sides has facilitated collaboration between dermatologists and rheumatologists in joint units or consultations. However, while those of us who work closely with rheumatologists are very aware of the need for early detection of arthritis in patients with psoriasis, several studies have reported that specialist dermatologists in general have a low capacity for detecting arthritis,^{4,5} a task that requires close collaboration between the two specialties to ensure prompt diagnosis of joint disease in a patient with psoriasis.

Furthermore, the questionnaires developed to detect psoriatic arthritis in patients with psoriasis (PASE, TOPAs, PEST, EARP) have now been shown not to be as effective as expected,⁶ and their use has now been relegated to a second-line position, making close collaboration between the two specialties even more essential.

Another incentive for rheumatologists and dermatologists to work together is the need to identify and agree on

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* Corresponding author.

E-mail address: alopezfe@santpau.cat (A. López-Ferrer).

the best treatment for patients who have both psoriasis and arthritis and whose disease is uncontrolled in some area.

The first dermatology-rheumatology units were created in the USA based on a very different model from the one later used in Spain. According to Vélez et al, the goal of those units was to ensure the diagnosis and follow-up of patients with psoriatic arthritis and to deal with all aspects of their disease. As a result, they included clinicians from all of the relevant specialty areas, and not just dermatologists and rheumatologists. These pioneering initiatives were conceived of as multidisciplinary units for the management of a specific disease: psoriatic arthritis.⁷

Although there is no descriptive study of a representative sample of hospitals in Spain that can provide sufficient data to support conclusions about the current situation of dermatology-rheumatology units in this country, articles have been published on some of the units set up in recent years.⁸⁻¹⁰ The first clinics were based on a high-efficiency model, with a high number of first visits compared to follow-up visits; in one or very few consultations the problem was resolved and the patient was referred back to the referring consultant (dermatologist or rheumatologist). These units are particularly useful for the early diagnosis of joint disease in patients with psoriasis, for confirming a diagnosis of psoriasis in a patient with arthritis, and also for starting the patient on the most appropriate treatment. However, they are not a good model for the care of complex cases or patients with a poor response to several different types of treatment.

Consequently, these units have evolved naturally towards the management of complex cases, irrespective of whether the complexity is related to the course of the psoriasis or of the joint disease. These include cases that fail to respond to conventional treatments, either because of the nature of the disease or due to comorbidities. Such cases require management by experts in both specialties to bring the disease under control and this may take several visits.

In many cases, the complexity arises from the severity of the psoriasis or the joint disease and involves patients who respond only partially to the treatment prescribed for one or the other disease. They require a therapeutic approach designed through close collaboration between the two specialists, who can tailor the regimen to control both the skin and joint disease at the same time for the longest period possible.

The management and follow-up of complex cases highlights the clear correlation between the complexity of the case and the severity of the comorbidities. Patients with psoriasis, and particularly those with moderate to severe forms of the disease, tend to have comorbidities, in particular cardiovascular conditions.¹¹⁻¹⁴ It is well known that patients with psoriasis and psoriatic arthritis have a higher risk of cardiovascular disease and metabolic syndrome. As their doctors and as the people responsible for coordinating the overall management of their condition, we must refer them to the appropriate specialist in each case. Also well-known is the influence of obesity and metabolic syndrome on psoriasis and psoriatic arthritis and, even more important, the poorer response to conventional systemic and biologic treatments observed in patients with those conditions.¹⁵

As psoriasis is an independent cardiovascular risk factor, our multidisciplinary clinics should perhaps also incorporate

physicians from other specialties, such as internal medicine, endocrinology, and cardiology. Likewise, we should establish closer communication with the primary care team working with our hospital. Dermatologists are well positioned to improve the care of psoriasis, and we also have the opportunity of detecting unhealthy blood lipid levels, persistently high glycemic values, and elevated waist circumference measurements, all of which are factors that exponentially increase the cardiovascular risk associated with psoriasis. In view of the high prevalence of psoriasis and psoriatic arthritis, collaboration between dermatologists and rheumatologists could significantly reduce cardiovascular risk in Spain.

Another medical specialty closely related to rheumatology and dermatology is hepatology because many of our patients have liver comorbidities, due mainly to fatty liver disease.¹⁶ Therefore, a digestive specialist is required to monitor and control their liver disease.

The involvement of a digestive specialist is also warranted for patients who have inflammatory bowel disease (IBD) in addition to psoriasis and psoriatic arthritis.¹⁷ In such cases, all 3 specialist areas must be involved. Since the disease is often more severe and the range of treatments more limited in patients with IBD, coordination between the 3 specialists is needed to ensure that the therapeutic options available to these patients are not exhausted. Furthermore, paradoxical reactions, and particularly psoriasis-like skin reactions, occur relatively often patients with IBD in response to the biologic drugs indicated for the treatment of their intestinal disease.¹⁸ While these skin reactions are generally mild and self-limiting, in some cases treatment with an additional systemic drug or a switch to another biologic agent is necessary to control the paradoxical reaction—which often takes the form of generalized pustular psoriasis. In such cases, better results are achieved when the different specialists work together, bearing in mind the need to avoid exhausting available treatments unnecessarily.

Today, our improved knowledge of the physiopathogenesis of psoriatic arthritis and its comorbidities underscores the need to create real multidisciplinary units, possibly coordinated by the existing dermatology-rheumatology units, and to involve other specialists depending on the needs of each hospital.

We currently have no evidence related to the collaboration between dermatologists and rheumatologists in Spain because the data available comes from a very small number of hospitals. Moreover, that study included initiatives in which the two specialists did not conduct joint consultations and which cannot, therefore, be classified as true dermatology-rheumatology units.

This is not to say that the dermatology-rheumatology unit is the only possible model of collaboration between the two specialist areas. In small hospitals, where only a small number of patients are treated for complex psoriatic arthritis, consultations between these specialists can take place in other more simple ways, such as parallel consultations or a rapid pathway for such patients to access the other consultant. In all these cases, protocols developed jointly by the two specialists are needed to define the process and the pathways patients must follow between the two specialist areas until they have been diagnosed and are in treatment.

Another important consideration that must be discussed in relation to joint dermatology-rheumatology units is the cost arising from the participation of two specialists in a single consultation. As yet, there are no studies that allow us to quantify the economic viability of this option. It would, therefore, be of interest to assess the results obtained in such joint consultations.

In view of the above, we believe that it is essential to obtain a more realistic overview of the current status of dermatology-rheumatology units in Spain as a whole, including the largest number of hospitals possible. This would open the way for the creation of standardized protocols and joint patient registries, two measures that would make it possible to draw much more evidence from our work with patients in daily practice.

Conflict of interests

Dr. Anna López-Ferrer has received fees as a consultant and speaker from Abbvie, Janssen, MSD, UCB, Pfizer, Lilly, and Celgene.

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References

1. Taylor W, Gladman D, Helliwell P, Marchesoni A, Mease P, Mielants H, CASPA Study Group. Classification criteria for psoriatic arthritis: Development of new criteria from a large international study. *Arthritis Rheum.* 2006;54:2665–73.
2. Taylor SL, Petrie M, O'Rourke KS, Feldman SR. Rheumatologists' recommendations on what to do in the dermatology office to evaluate and manage psoriasis patients' joint symptoms. *J Dermatol Treatment.* 2009;20:1–4.
3. Cañete JD, Daudén E, Queiro R, Aguilar MD, Sánchez-Carazo JL, Carrascosa JM, et al. Elaboración mediante el método Delphi de recomendaciones para el manejo coordinado (reumatólogo/dermatólogo) de la artritis psoriásica. *Actas Dermosifiliogr.* 2014;105:216–32.
4. Mease PJ, Gladman DD, Papp KA, Khraishi MM, Thaçi D, Behrens F, et al. Prevalence of rheumatologist-diagnosed psoriatic arthritis in patients with psoriasis in European/North American dermatology clinics. *J Am Acad Dermatol.* 2013;69:729–35.
5. Villani AP, Rouzaud M, Sevrain M, Barnetche T, Paul C, Richard MA, et al. Prevalence of undiagnosed psoriatic arthritis among psoriasis patients: Systematic review and meta-analysis. *J Am Acad Dermatol.* 2015;73:242–8.
6. Walsh JA, Callis Duffin K, Krueger GG, Clegg DO. Limitations in screening instruments for psoriatic arthritis: A comparison of instruments in patients with psoriasis. *J Rheumatol.* 2013;40:287–93.
7. Velez NF, Wei-Passanese EX, Husni ME, Mody EA, Qureshi AA. Management of psoriasis and psoriatic arthritis in a combined dermatology and rheumatology clinic. *Arch Dermatol Res.* 2012;304:7–13.
8. Luelmo J, Gratacós J, Moreno Martínez-Losa M, Ribera M, Román J, Calvet J, et al. Experiencia de 4 años de funcionamiento de una unidad multidisciplinar de psoriasis y artritis psoriásica. *Actas Dermosifiliogr.* 2014;105:371–7.
9. Queiro R, Coto P, Rodríguez J, Notario J, Navío Marco T, de la Cueva P, et al. Modelos de atención multidisciplinar en pacientes con artritis psoriásica en España. *Reumatol Clin.* 2017;13:85–90.
10. Cañete JD, Puig L. Unidades multidisciplinarias de artritis psoriásica: sobre objetivos y modelos. *Actas Dermosifiliogr.* 2014;105:325–7.
11. Haque N, Lories RJ, de Vlam K. Comorbidities associated with psoriatic arthritis compared with non-psoriatic spondyloarthritis: A cross-sectional study. *J Rheumatol.* 2016;43:376–82.
12. Husni ME. Comorbidities in psoriatic arthritis. *Rheum Dis Clin North Am.* 2015;41:677–98.
13. Sundararajan S, Arumugam M. Comorbidities of psoriasis - Exploring the links by network approach. *PLoS One.* 2016;11:e0149175.
14. Ogdie A, Yu Y, Haynes K, Love TJ, Maliha S, Jiang Y, et al. Risk of major cardiovascular events in patients with psoriatic arthritis, psoriasis and rheumatoid arthritis: A population-based cohort study. *Ann Rheum Dis.* 2015;74:326–32.
15. Batalla A, González-Fernández D, González-Lara L, Abalde T, Salgado-Boquete L, Queiro-Silva R, et al. Cardiovascular risk factors influence response to biological therapies in psoriasis. *J Am Acad Dermatol.* 2015;73:327–9.
16. Abedini R, Salehi M, Lajevardi V, Beygi S. Patients with psoriasis are at a higher risk of developing nonalcoholic fatty liver disease. *Clin Exp Dermatol.* 2015;40:722–7.
17. Lolli E, Saraceno R, Calabrese E, Ascolani M, Scarozza P, Chiricozzi A, et al. Psoriasis phenotype in inflammatory bowel disease: A case-control prospective study. *J Crohns Colitis.* 2015;9:699–707.
18. Fiorino G, Danese S, Pariente B, Allez M. Paradoxical immune-mediated inflammation in inflammatory bowel disease patients receiving anti-TNF- α agents. *Autoimmun Rev.* 2014;13:15–9.