

Diagnosis and management of psoriatic arthropathy in primary care

EXTENT OF THE UNDERDIAGNOSIS

Psoriasis arthritis (PsA) is a chronic, inflammatory disease, affecting predominantly skin and joints (Figure 1). Skin psoriasis develops before arthritis in the majority of cases, with a typical time lag of 5 to 10 years. However, around 20% of PsA patients never develop psoriasis.¹ The prevalence of psoriasis in the UK is approximately 2% of the adult population.²

Epidemiological studies indicate that between 10% and 30% of people with psoriasis will go on to develop PsA, giving a population prevalence for PsA of 0.4%. Out of 40 million adults in England, around 160 000 would be expected to have PsA. According to the National Institute for Health and Care Excellence (NICE), only 6200 people in England are currently registered to receive biological therapies for PsA, representing 4% of this population. Of the 350 000 people in the UK who have rheumatoid arthritis (RA), 35 000 (10%) are on biological therapies.

PsA appears to be underdiagnosed not

only in the UK but also abroad. According to the American Psoriasis Foundation, there are over 7 million adults in the US who have psoriasis but only 520 000 (7.4%) of these patients have a PsA diagnosis.³ These statistics support the theory that more than half of those suffering from PsA are not being recognised.

RECOGNITION

The patient journey invariably begins with a visit to their GP, therefore early recognition of PsA in primary care is paramount. Recent evidence shows that a short duration between the onset of symptoms and diagnosis is an important predictor of better clinical outcomes at 5-year follow-up.⁴

Diagnosis of PsA may be difficult, and should be based on clinical rather than radiological and immunological evidence. The most common subtypes of joint disease in PsA are: oligoarticular asymmetric (fewer than five joints on one side of the body) and polyarticular (more than five joints, resembling RA in that it is usually symmetric). The key differences with RA are the involvement of distal interphalangeal (DIP) joints and nail pitting.

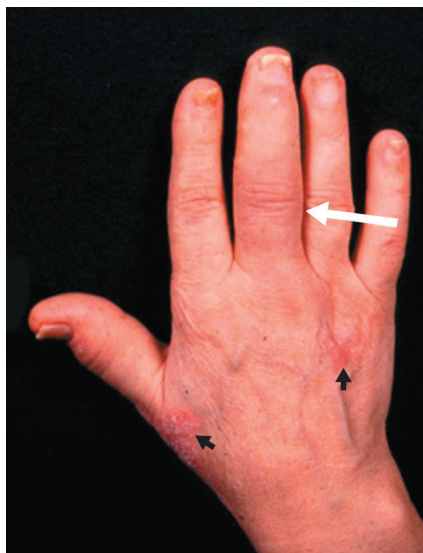
Psoriasis can be subtle, consisting only of small areas of skin change around the hairline, umbilicus, or natal cleft. Usually, a suggestive clinical pattern of psoriasis and/or peripheral arthritis is then supported by distinctive features such as negativity for rheumatoid factor (90%) and nail pitting (80%).¹

THE PEST SCREENING QUESTIONNAIRE

With such a wide variety of presentations, a brief but effective screening tool is essential. The PEST questionnaire, developed in 2009, only involves five questions, making it ideal for use in primary care (Box 1). It is limited, however, to patients with skin psoriasis.⁵

All psoriasis patients should have an annual PEST score recorded and a score of 3 or more should trigger a rheumatology referral (Box 2).

Figure 1. Typical clinical presentation of psoriasis arthritis. The white arrow denotes dactylitis and the black arrows denote psoriasis.



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Submitted: 16 January 2014; **Editor's response:** 29 January 2014; **final acceptance:** 10 March 2014.

©British Journal of General Practice 2014; 64: 424–425.

DOI: 10.3399/bjgp14X681181

Box 1. The PEST screening questionnaire

Each 'Yes' answer scores 1 point. A score of ≥ 3 is indicative of PsA. (Sensitivity = 0.92, specificity = 0.78)

1. Have you ever had a swollen joint (or joints)?
2. Has a doctor ever told you that you have arthritis?
3. Do your finger nails or toe nails have holes or pits?
4. Have you had pain in your heel?
5. Have you had a finger or toe that was completely swollen and painful for no obvious reason?

Box 2. CASPAR criteria for diagnosing PsA^a

		Points
1	Psoriasis	
	Current on examination	Skin or plaque disease
	Personal history	
	Family history	1 ^o or 2 ^o relative
2	Nail dystrophy	
	Current on examination	Onycholysis, pitting, hyperkeratosis
3	Negative test for RF	
4	Dactylitis	
	Current on examination	Swelling of an entire digit
	Personal history	
5	Radiographical evidence	
		X-rays of hands and feet show juxta-articular new bone formation

^aSensitivity = 0.91, specificity = 0.98. RF = rheumatoid factor

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PsA DIAGNOSIS

Psoriatic arthritis was first described as a clinical entity in 1973 by Moll and Wright, and originally required the presence of three diagnostic criteria:

- an inflammatory arthritis;
- the presence of psoriasis; and
- seronegativity for rheumatoid factor (RF).

In 2006, a new classification system was developed following the CASPAR study.⁶ The biggest difference was that skin disease was no longer necessary for the diagnosis. To meet the CASPAR criteria, a patient must first have inflammatory articular disease (arthritis, dactylitis, or enthesitis) and then score 3 from the list of criteria [Box 2].

GPs therefore need to be alert to patients who present with a swollen heel, digit, or joint, and also be aware of PsA as a differential diagnosis. The new criteria allow the diagnosis of PsA where RF is positive, or skin psoriasis is absent. To capture those patients with PsA without skin disease, it is important to check for a personal or family history of psoriasis.

MANAGEMENT

Although psoriasis may be effectively treated in primary care, patients with suspected inflammatory arthritis should be referred for specialist review. The 2012 guideline from the British Society for Rheumatology includes the following pharmacological treatments

for PsA: non-steroidal anti-inflammatory drugs (useful for pain management prior to referral), injected steroids, disease-modifying anti-rheumatic drugs (DMARDs), and anti-TNF agents.⁷

Although intra-articular steroid injections may be beneficial, GPs should not prescribe systemic steroids due to the risk of a psoriasis rebound flare. Methotrexate is the most commonly used DMARD for PsA and works well on skin and joints. Others, such as sulfasalazine, work only on the joints. GPs may have a role in prescribing and monitoring these medications depending on local arrangements. As well as regular blood tests, those on DMARDs or anti-TNF therapy should receive influenza and pneumococcal vaccinations. Contraceptive advice for women on methotrexate or leflunomide (known teratogens) is also important.

Dual referrals can result in multiple appointments, high costs, and a lack of integrated management. In general, GPs should refer to a rheumatologist if PsA is suspected. Patients with severe psoriasis, already under the care of a dermatologist, should be automatically screened for PsA in clinic.

As most psoriasis is managed in primary care, the typical PsA patient would experience joint care from their GP and rheumatologist.

It is becoming increasingly recognised that patients with inflammatory arthritis, including PsA, have a higher risk of cardiovascular disease, and that GPs have a lead role in managing this.⁸

CONCLUSION

There is an enormous contribution that GPs could make to provide better care for PsA patients. Key areas where primary care physicians could make a difference are:

- recognition of the condition to reduce the current level of underdiagnosis;
- use of screening and diagnostic tools to guide referrals to rheumatology;
- management of cardiovascular risk and psychological wellbeing; and
- awareness and monitoring of PsA treatments and their side effects.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

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