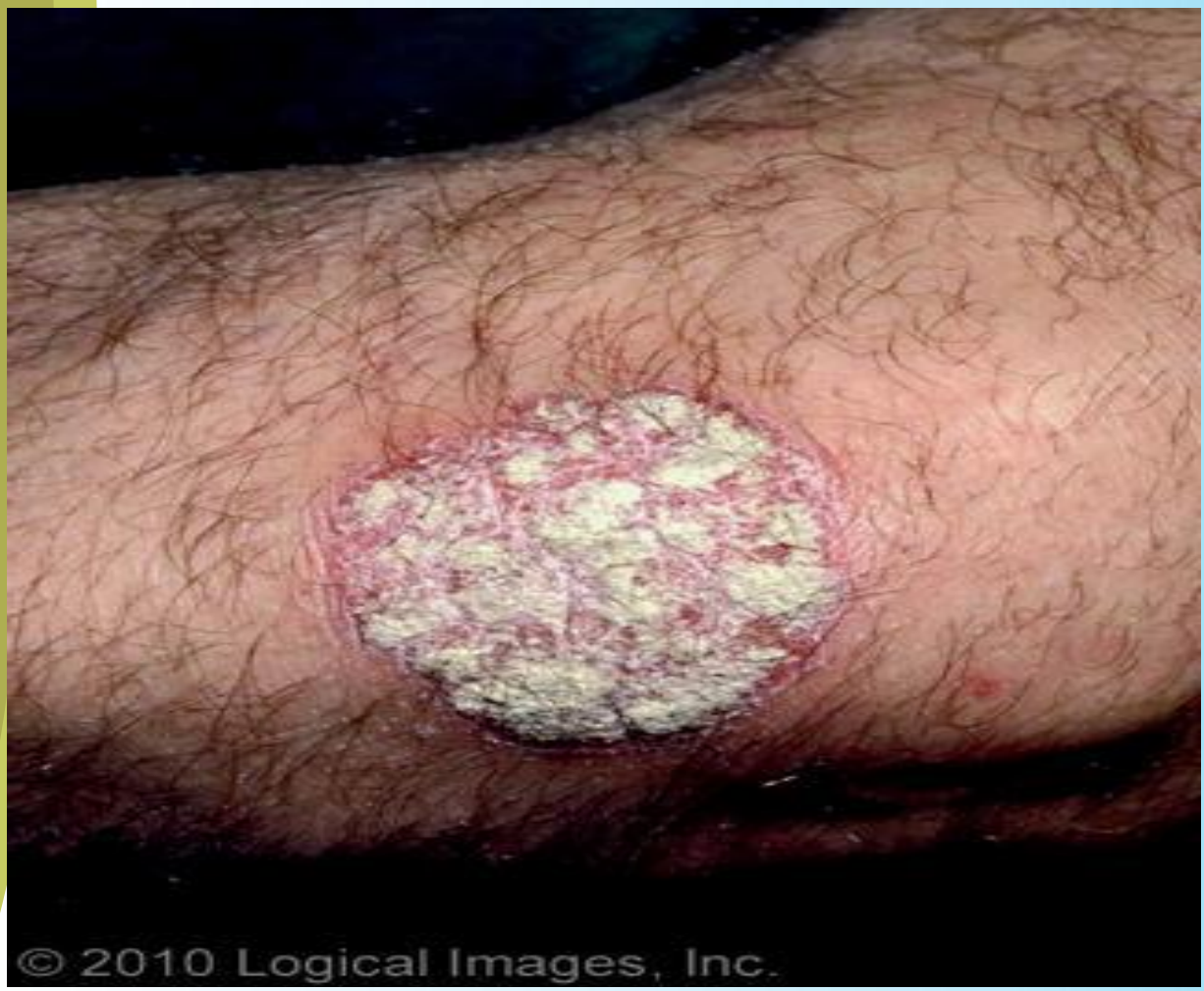
Psoriasis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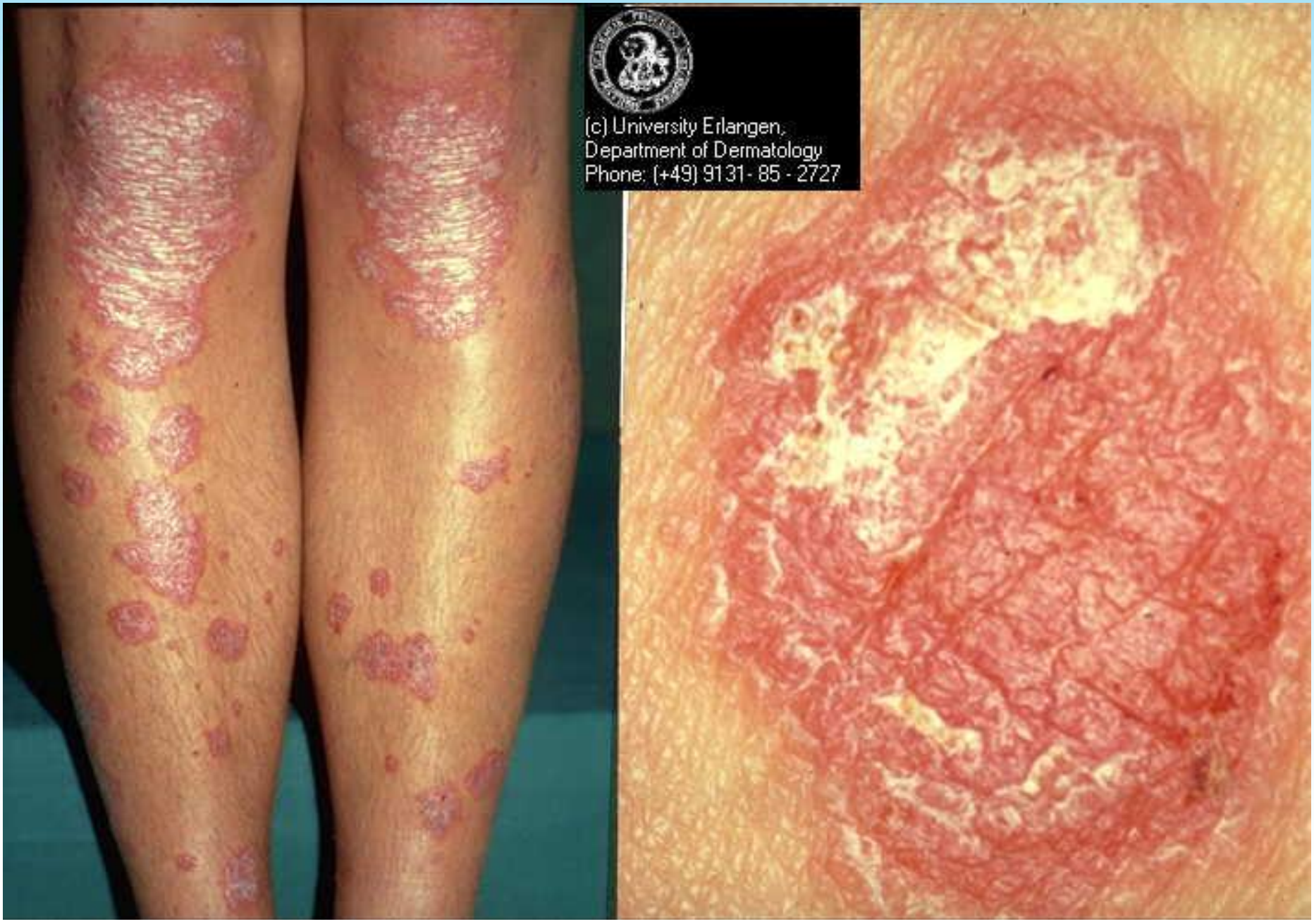
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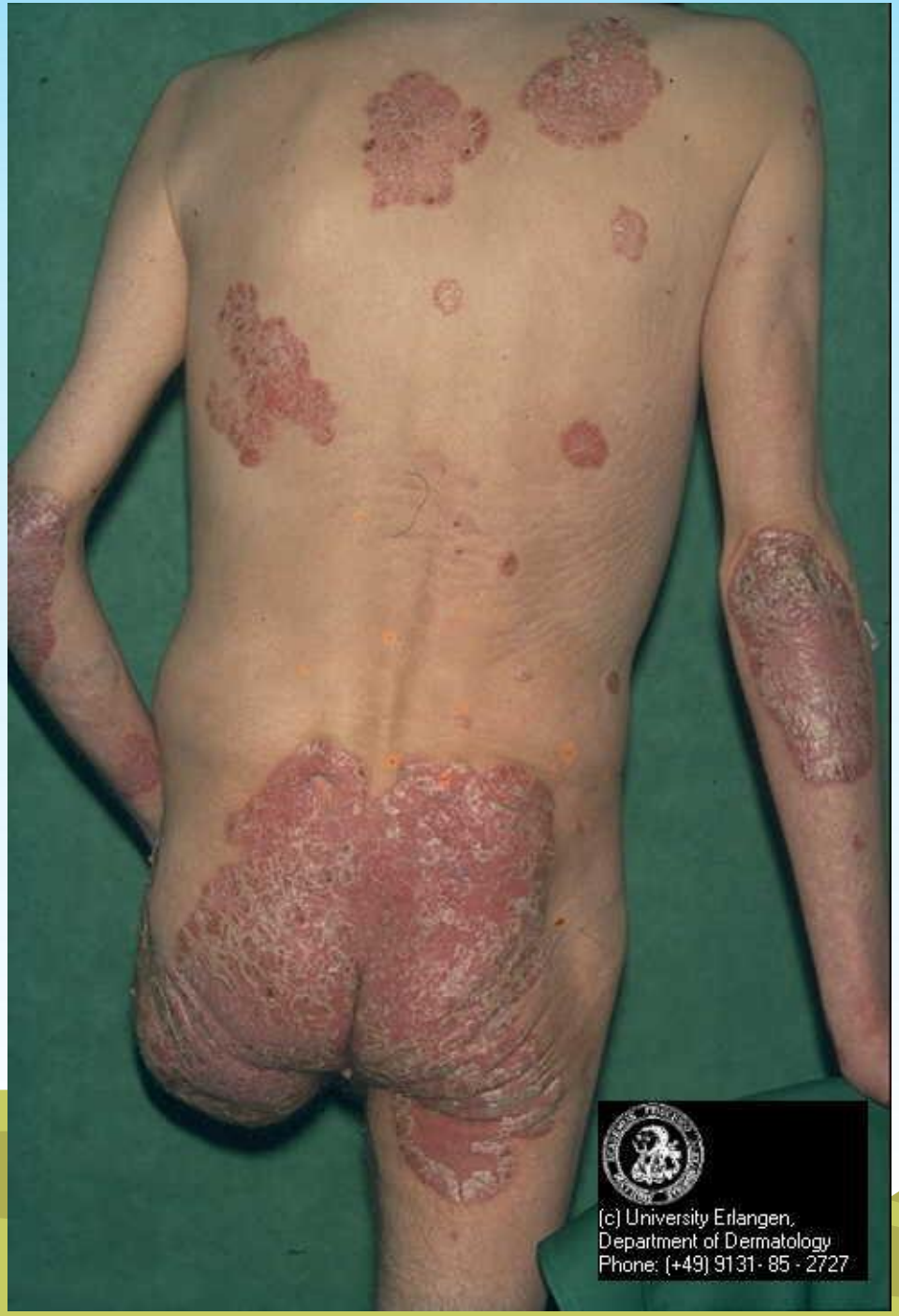
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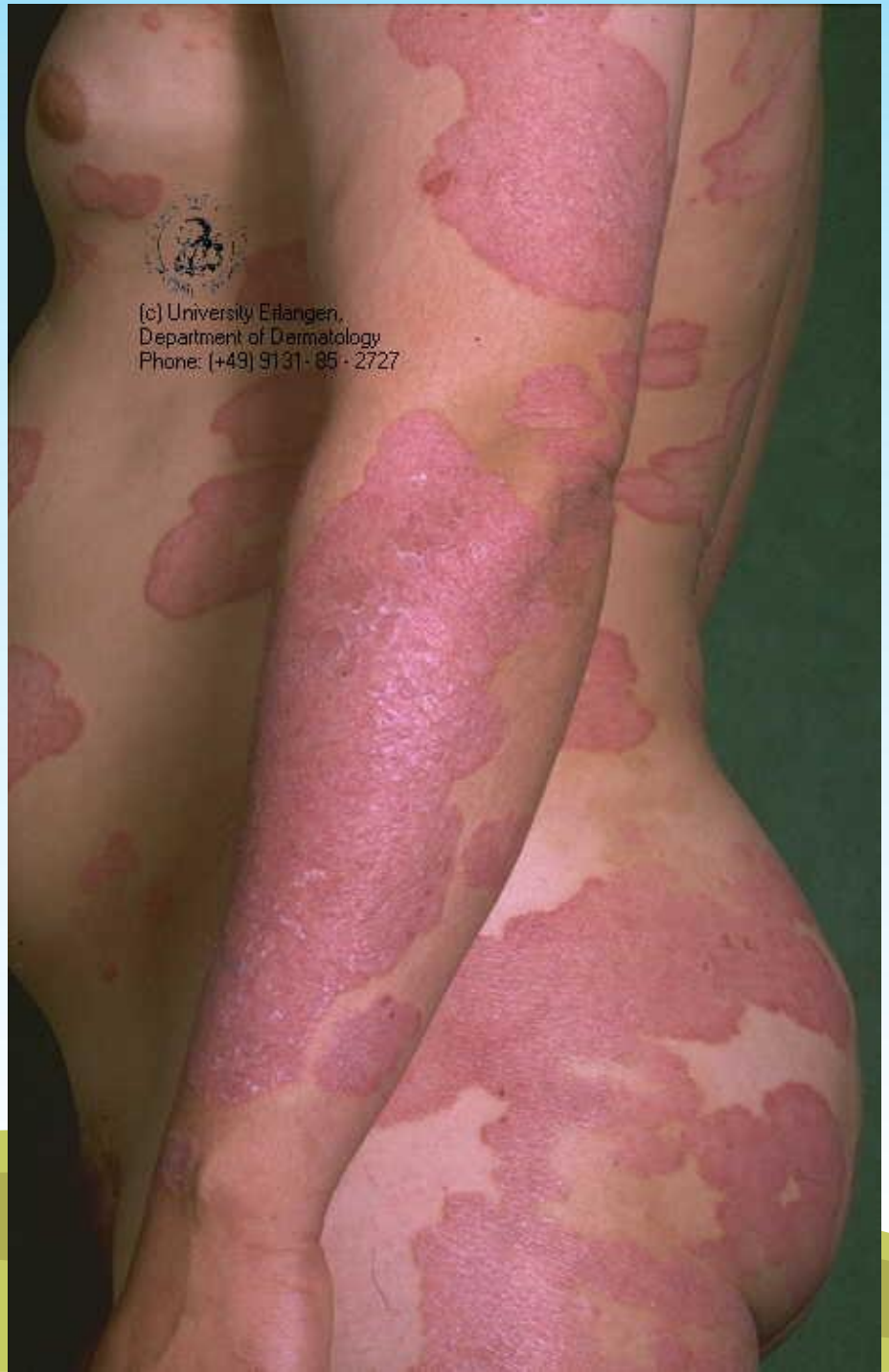
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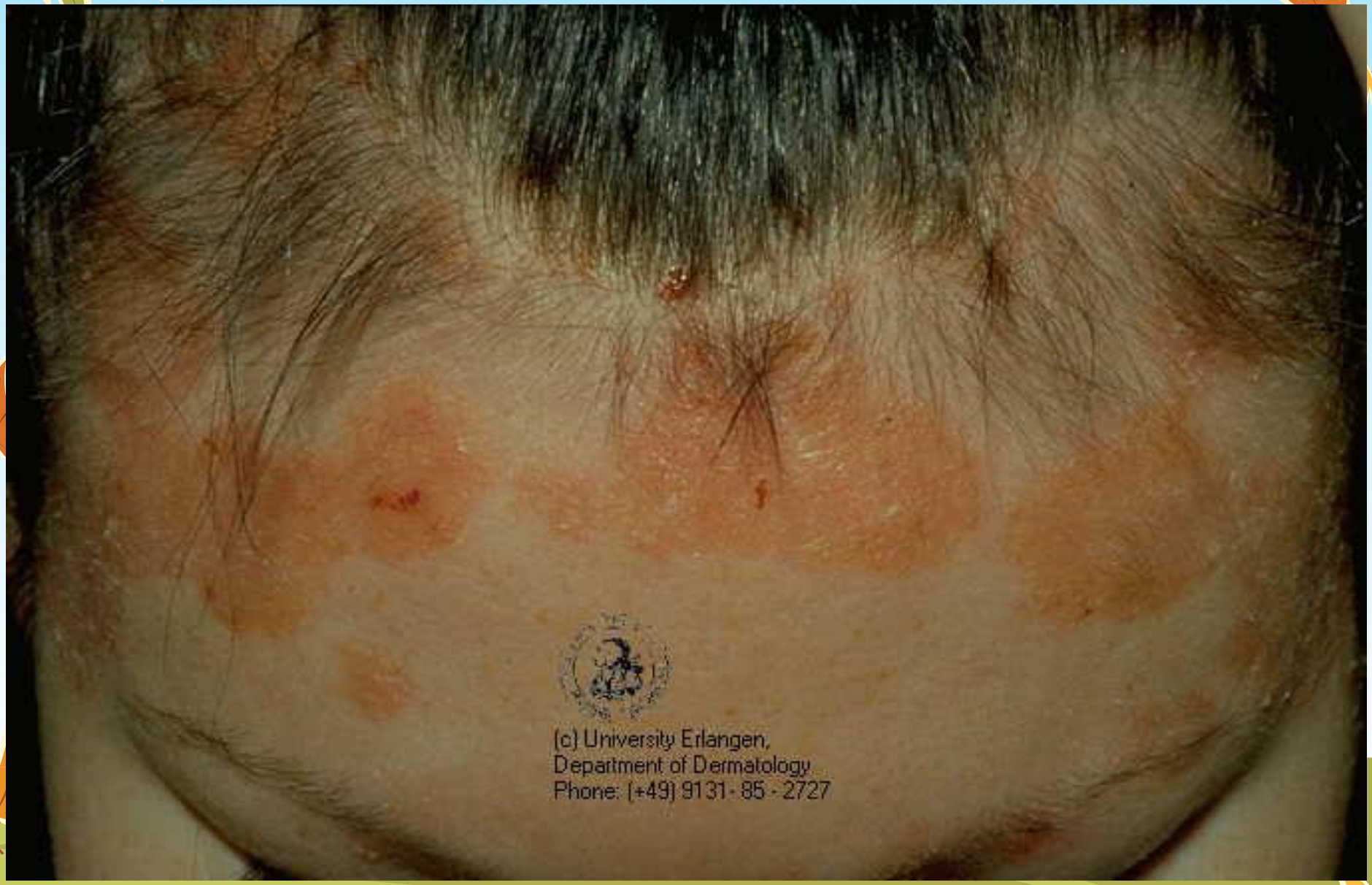
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PSORIATIC ARTHRITIS

PSORIATIC ARTHRITIS

Psoriatic arthritis refers to an inflammatory arthritis that characteristically occurs in individuals with Psorisis

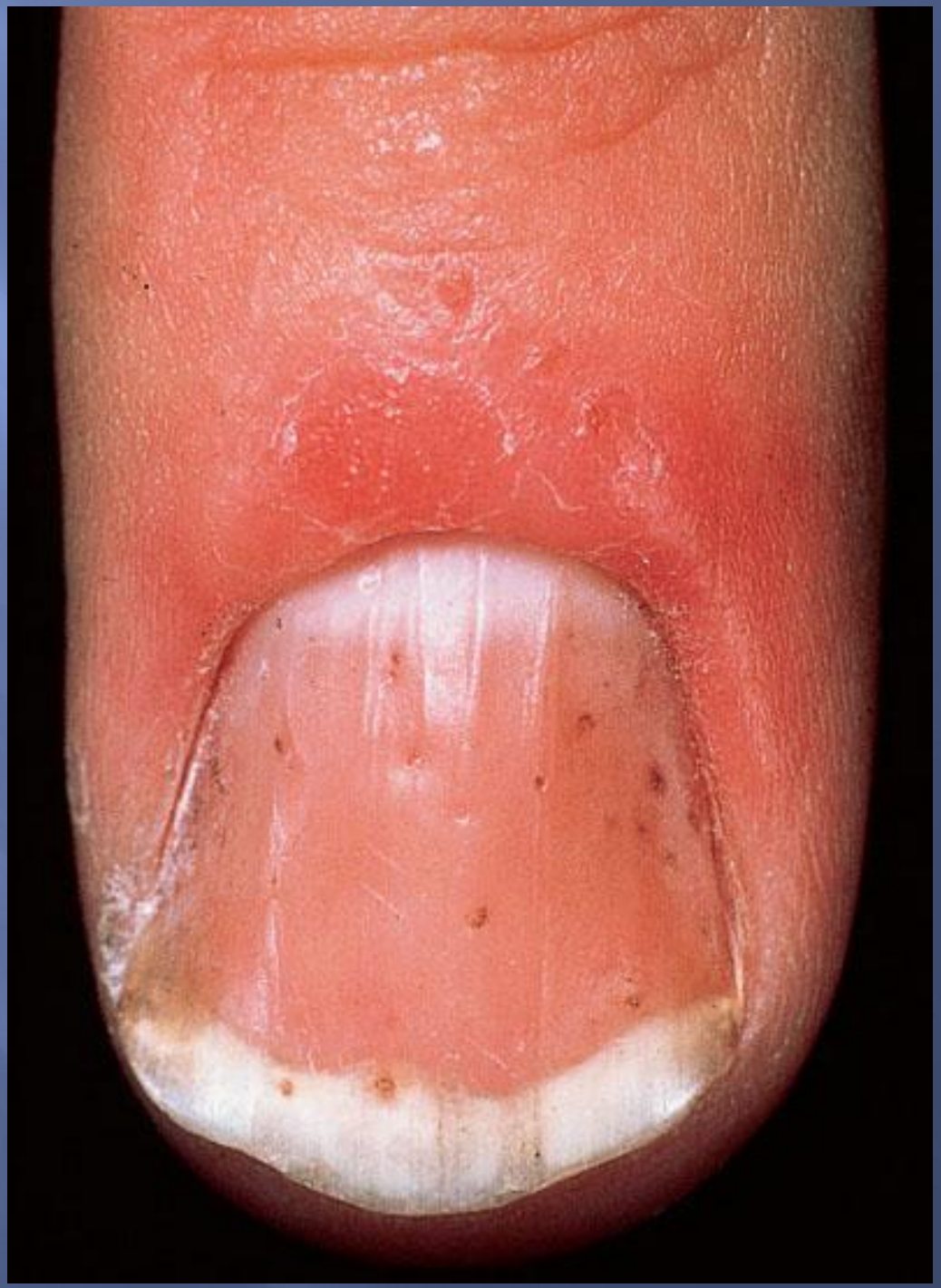
- Prevalence equal in males and females
- Peak age of onset between 30 and 55 years
- 4-30% of psoriasis patients will develop PsA
- More men present with axial disease and radiographic damage
- %60 of those with psoriatic spondylitis or sacroiliitis have HLA-B27

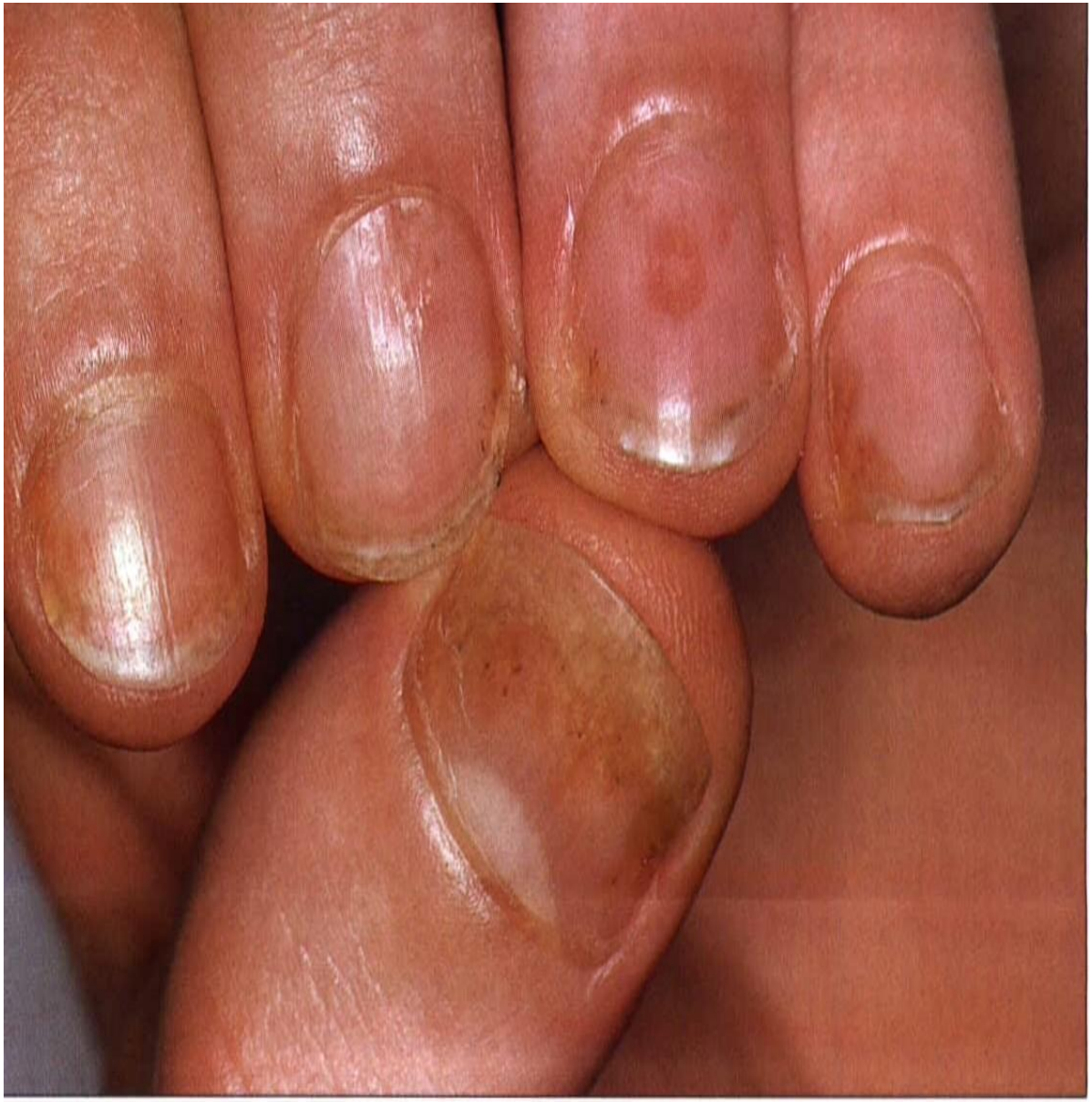
Relation between arthritis and skin lesions

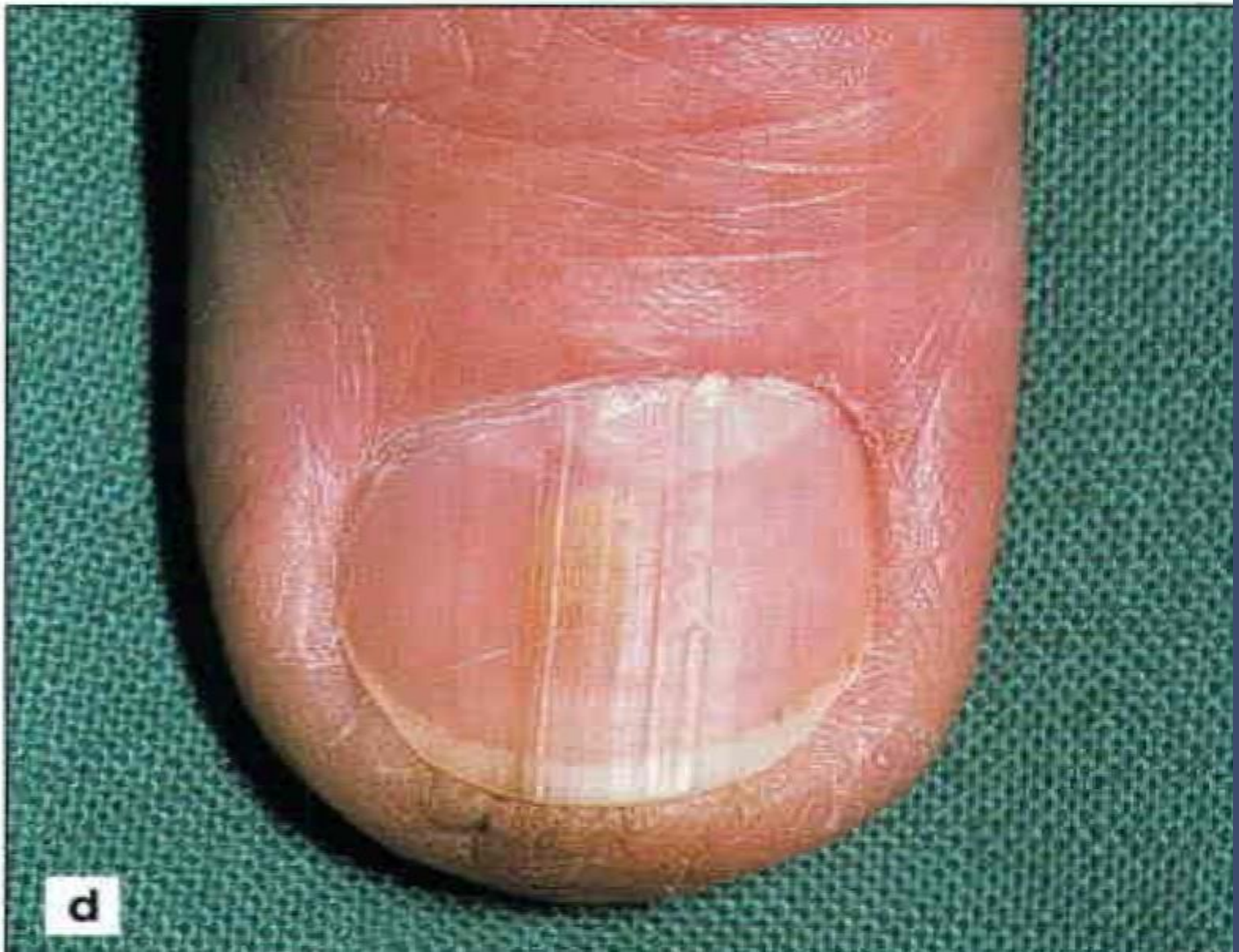
There is a weak relationship between the severity of skin disease and arthritic involvement

Only a minority of patients note a relationship between the activity of the skin and joint manifestations

The severity of nail involvement may correlate with the severity of both skin and joint disease and has been reported to be more common in those with DIP joint arthritis



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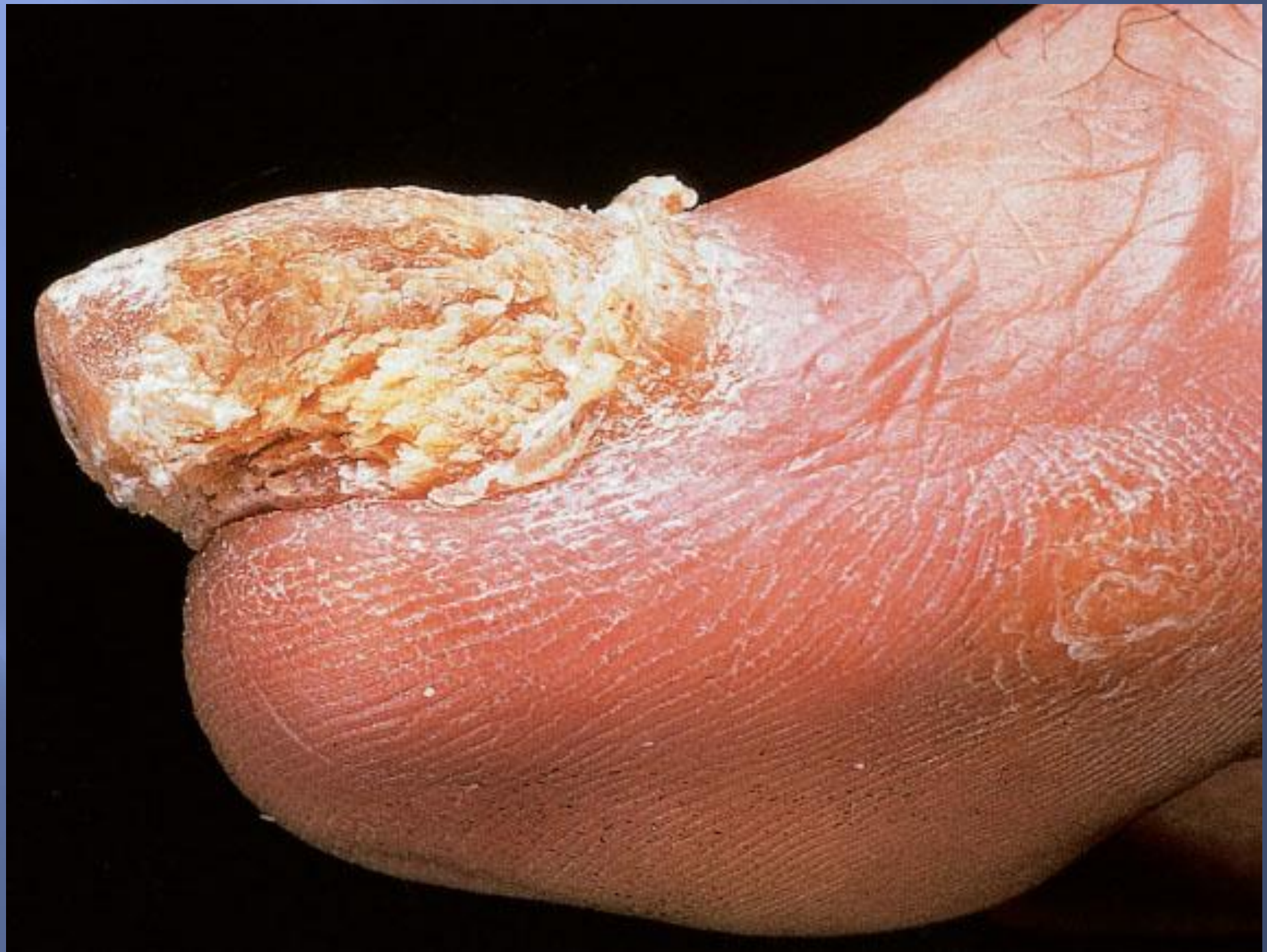

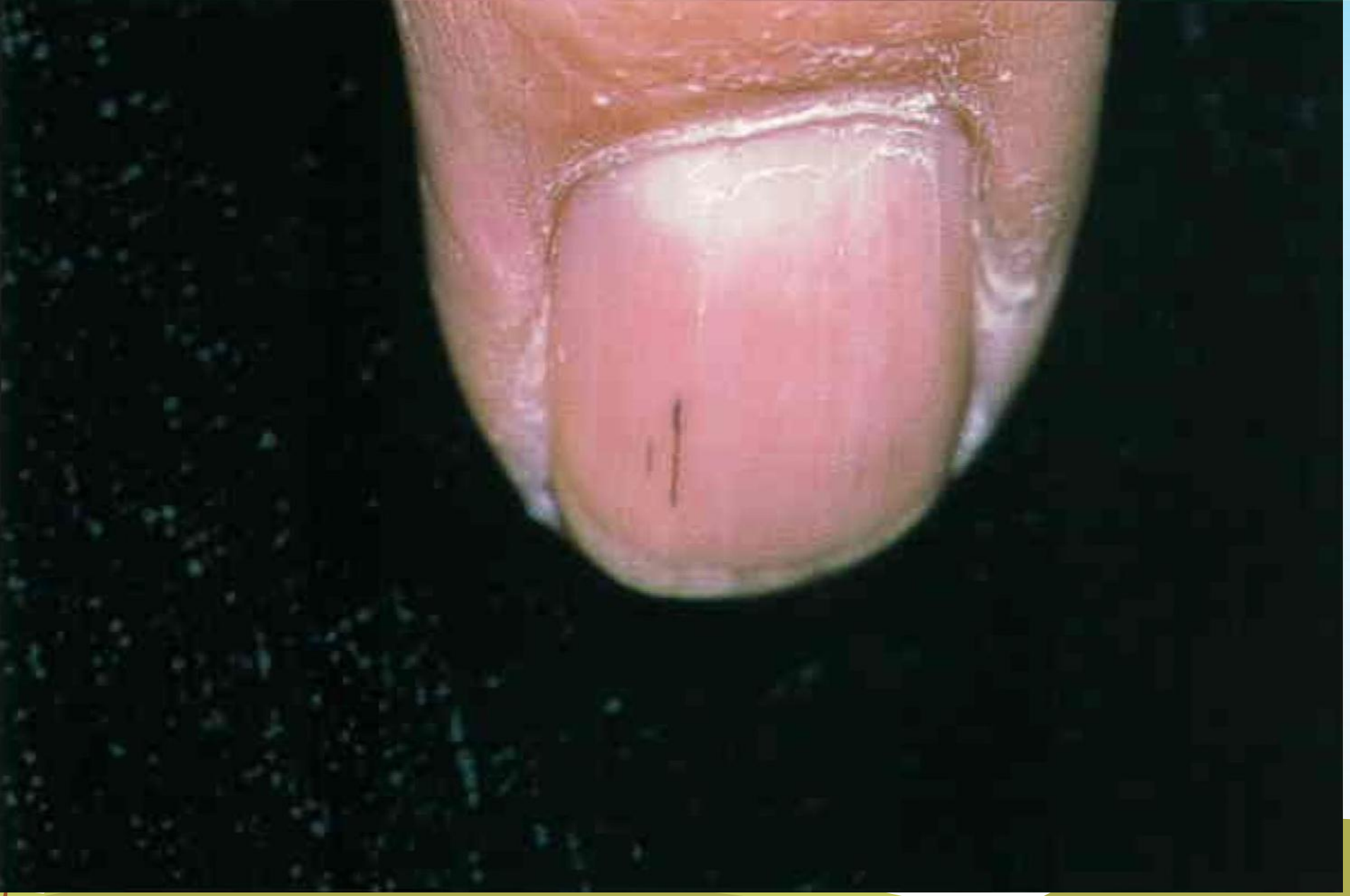


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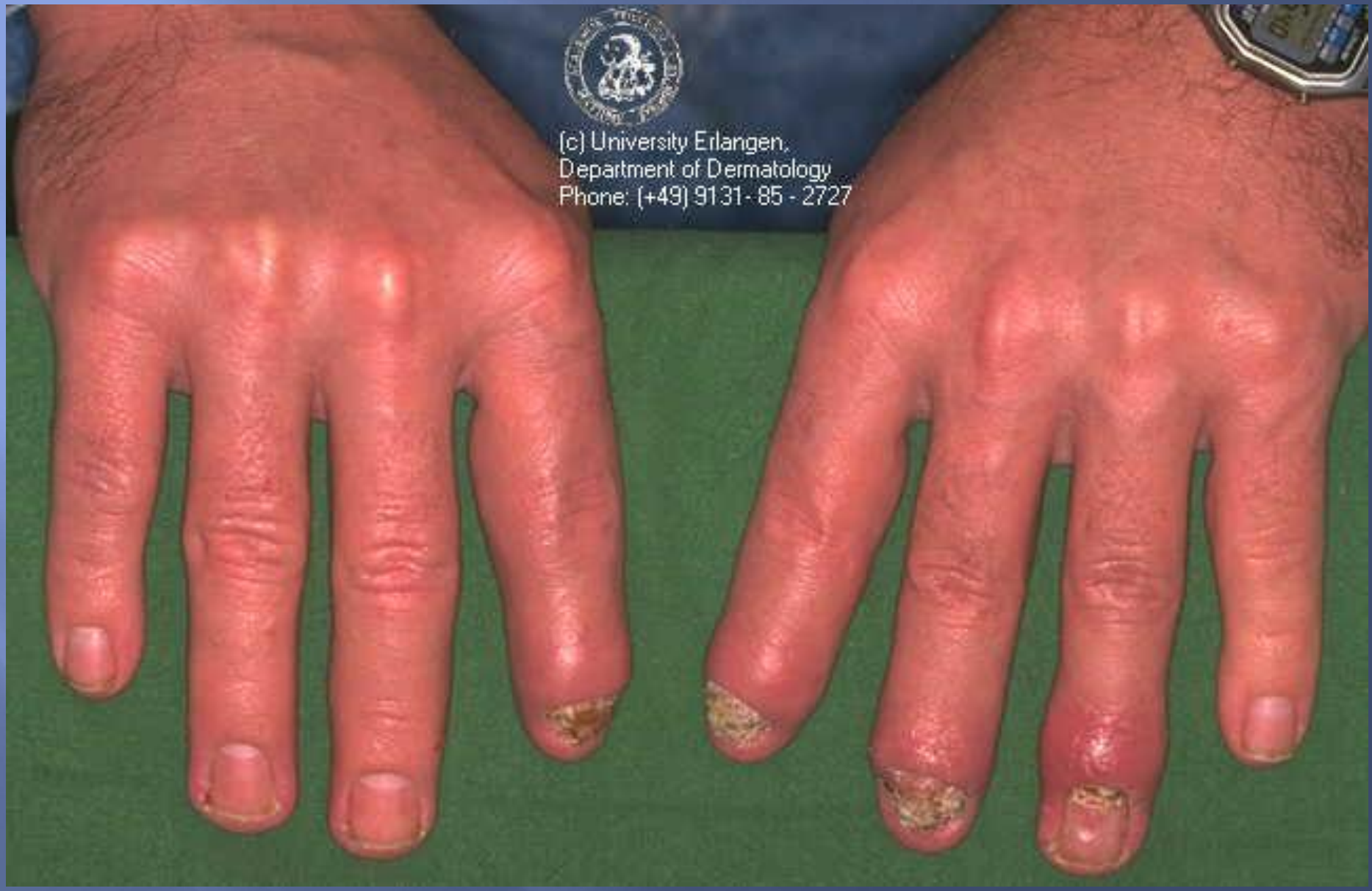
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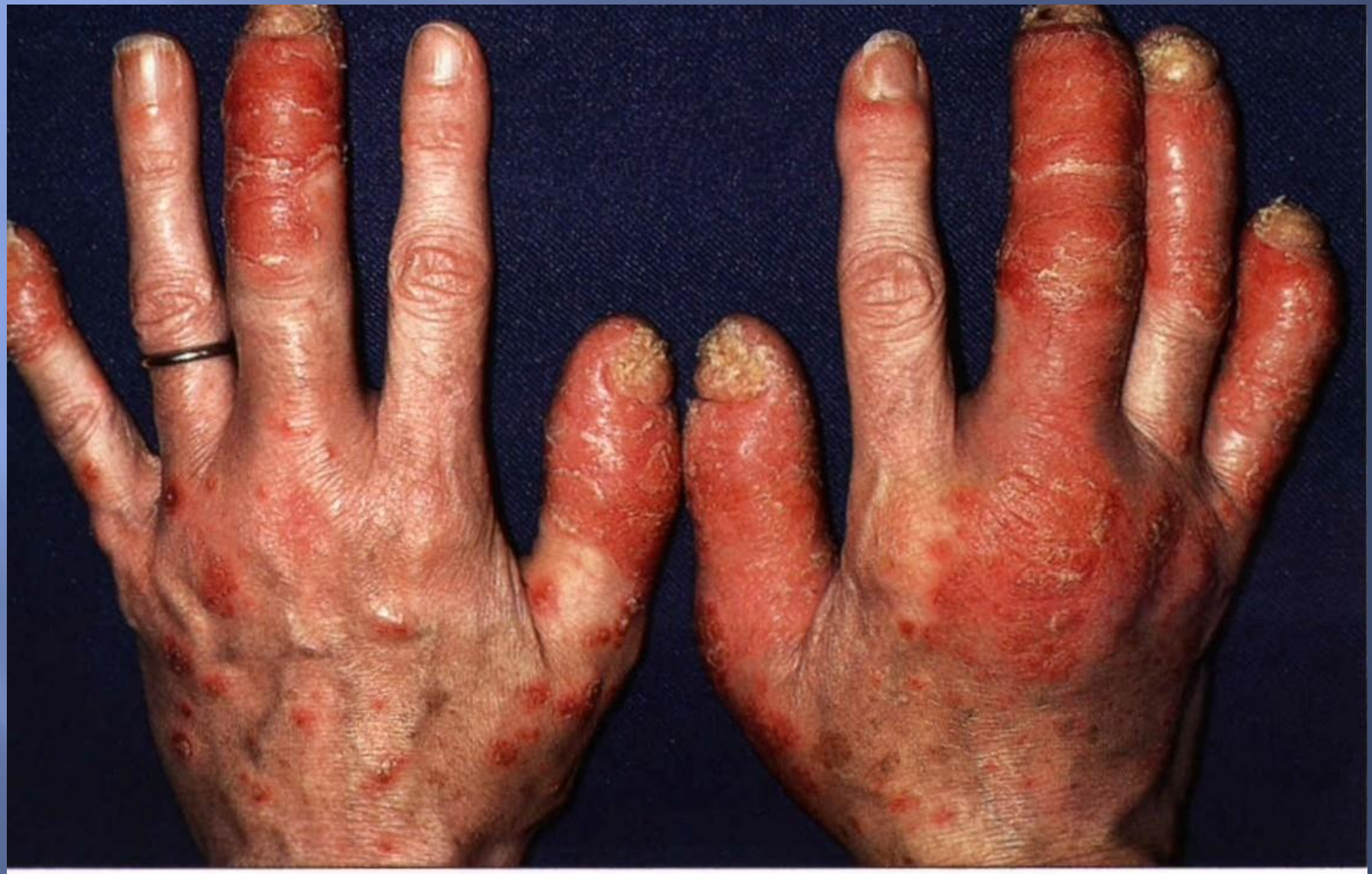
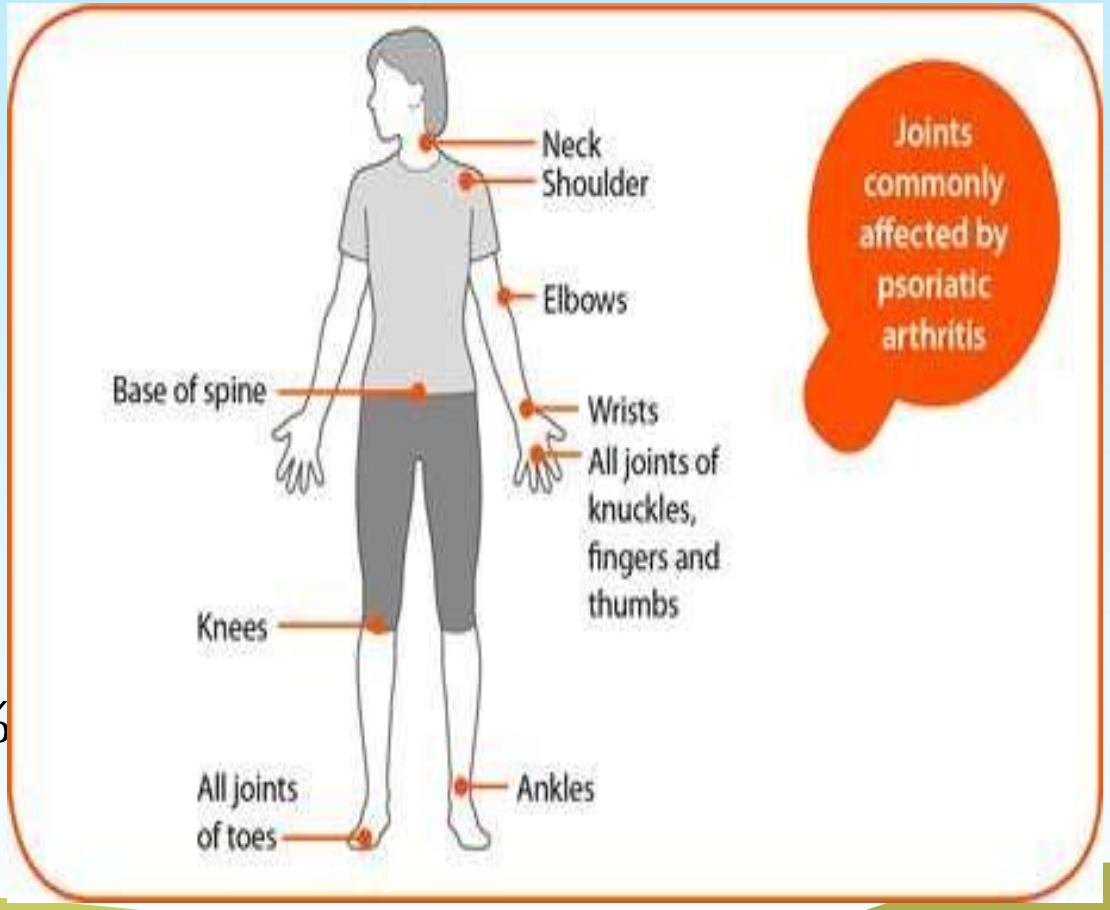


Clinical Features

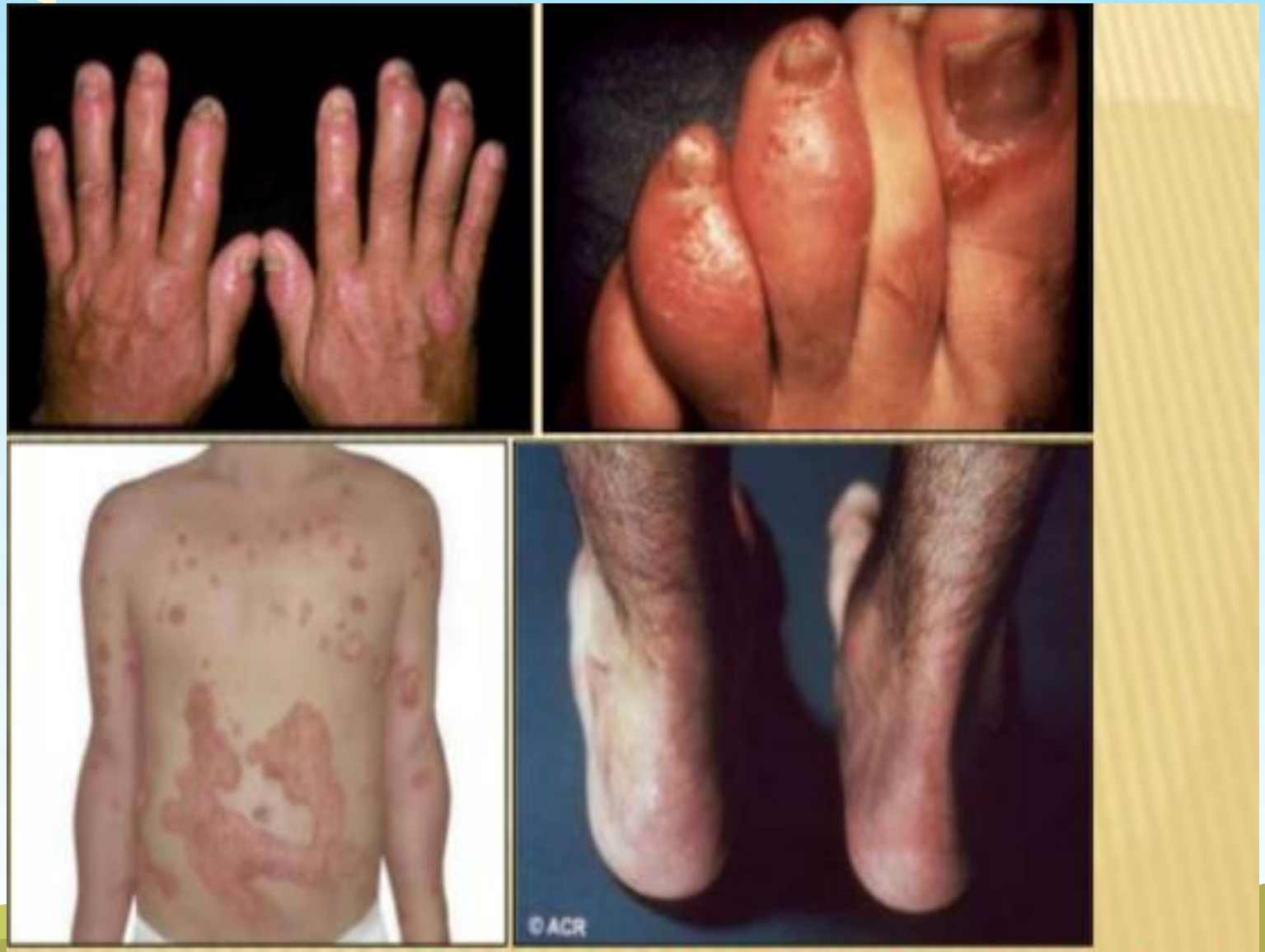
- In 60–70% of cases, psoriasis precedes joint disease.
- In 15–20% of cases,the two manifestations appear within 1 year of each other.
- In about of 15–20% cases, the arthritis precedes The onset of psoriasis.



Clinical Presentation of Psoriatic Arthritis

Clinical presentation of PsA is heterogeneous

- Peripheral arthritis
- Axial disease
- Enthesitis
- Dactylitis
- Skin and nail disease
- Pitting edema
- tenosynovitis
- Ocular involvement:(uveitis and conjunctivitis)

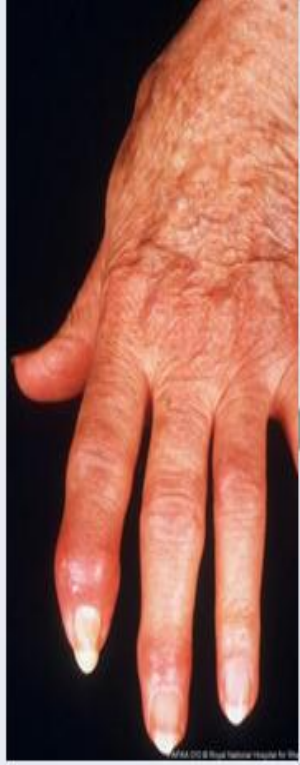


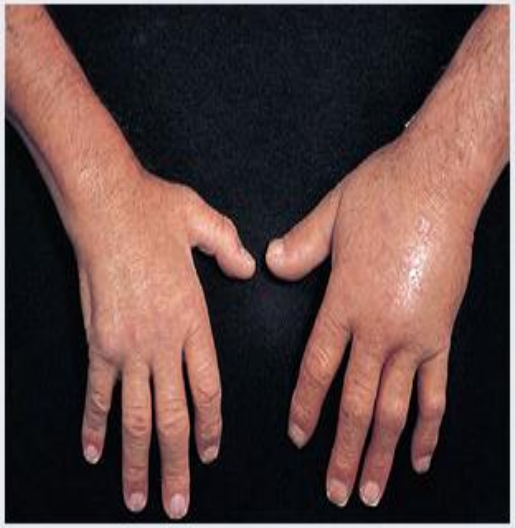
ACR Slide Collection on the Rheumatic Diseases; 3rd edition. 1994.

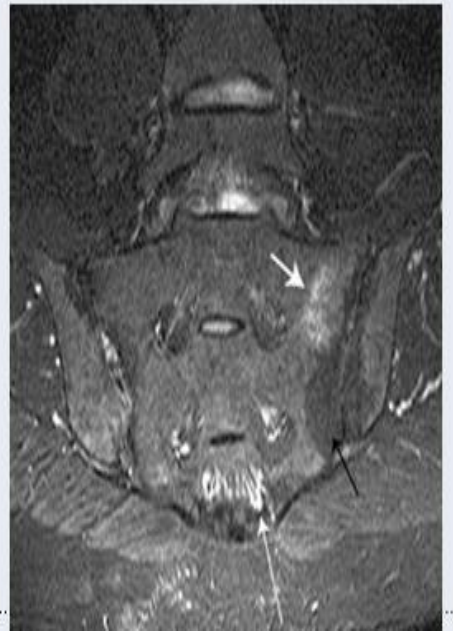
Clinical Presentation of PsA

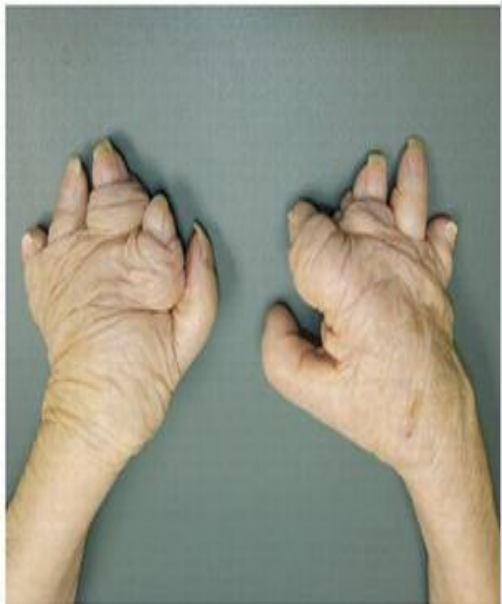
Clinical pattern on presentation	Percentage of patients
Asymmetrical oligoarthritis	50
Symmetrical polyarthritis	40
Distal interphalangeal arthritis	5
Arthritis mutilans	5
Spinal column involvement	40

Moll JM, Wright V. *Semin Arthritis Rheum.* 1973.[43]









Co-morbidities Associated with PsA

Cardiovascular disease	Inflammatory bowel disease
Depression/Anxiety	Kidney disease
Diabetes	Metabolic syndrome
Eye disease	Obesity
Fatty Liver disease	Osteoporosis
Gout	

- Nail changes-Pitting of the fingers or toes occur in 80% of patients with PsA.

Figure 2. A: Pitting of the fingernail. B: Onycholysis with an erythematous border.

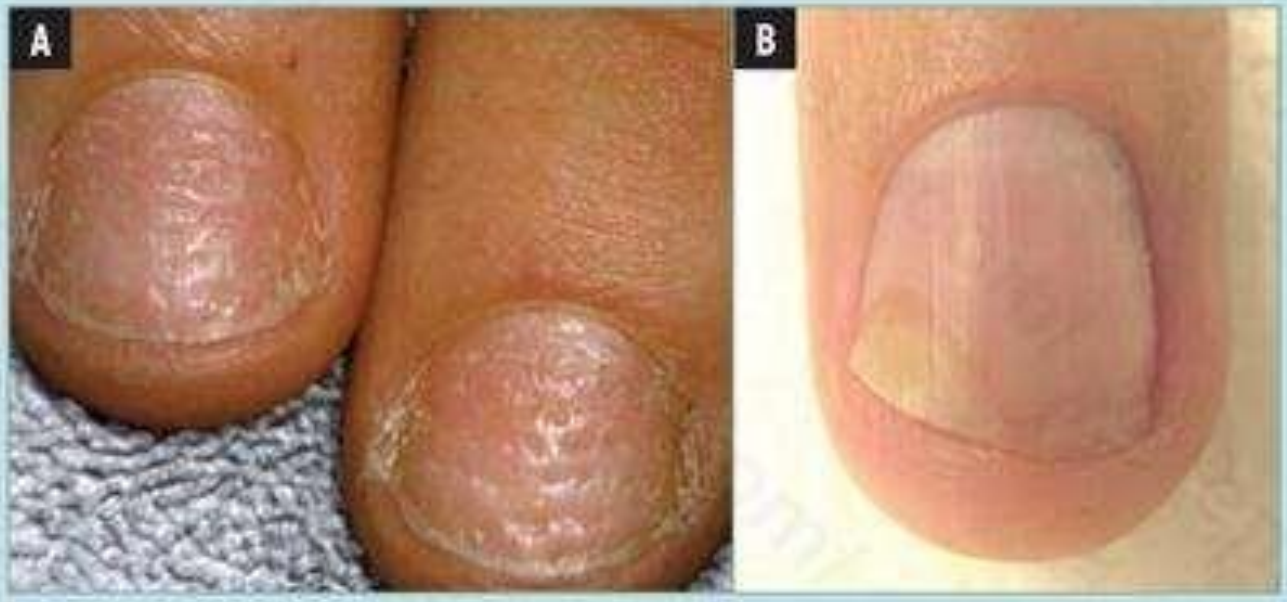
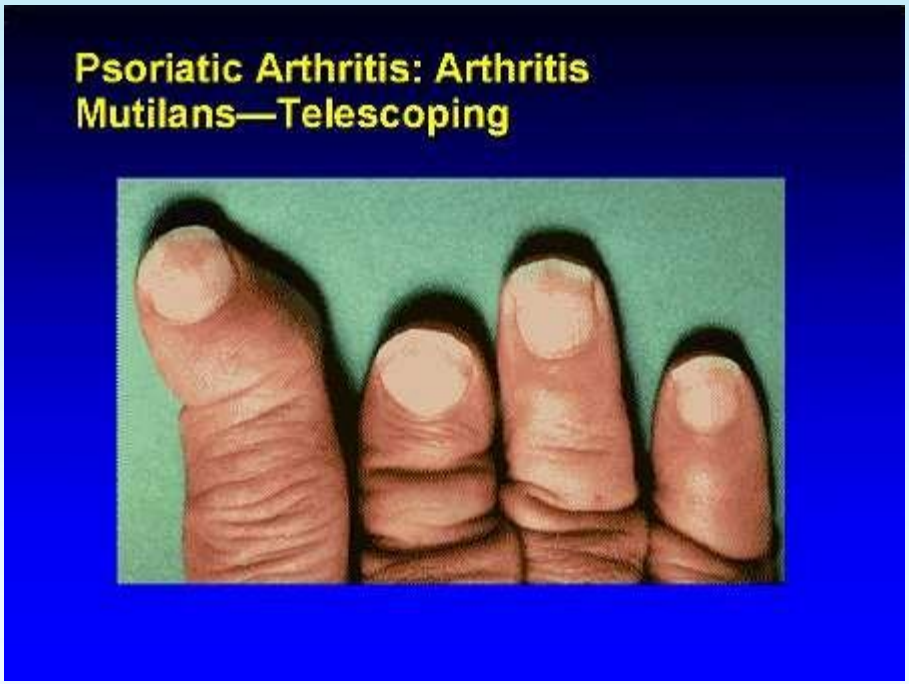


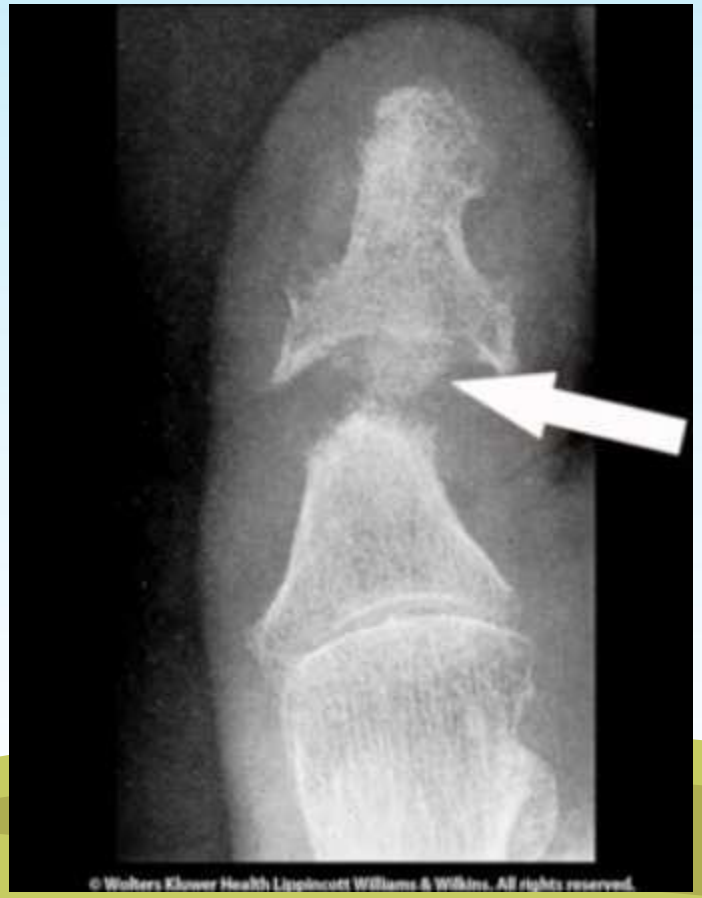
Image courtesy of International Journal of Clinical Reviews
http://www.remedicajournals.com/International-Journal-of-Clinical-Reviews/BrowseIssues/November-2010/Article-Nail-Psoriasis-topical-and-systemic-therapies

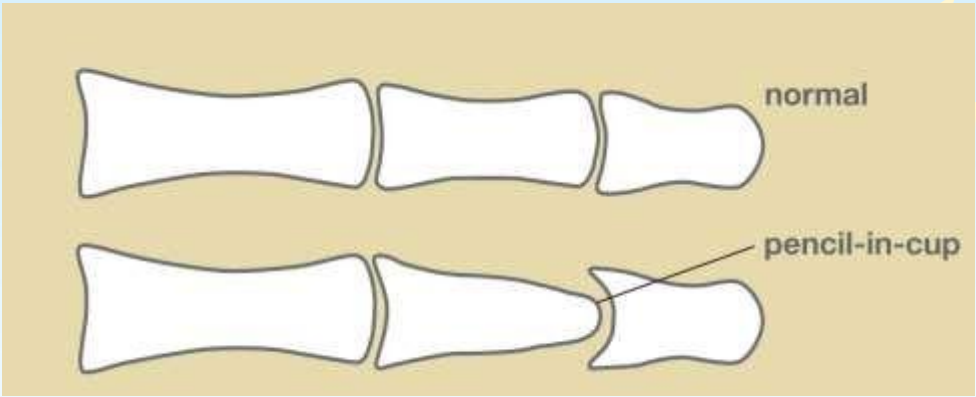
- Widespread shortening of digits (“Telescoping").
- Eye involvement, either conjunctivitis or uveitis,Episcleritis is reported in 7–33% of PsA patients.



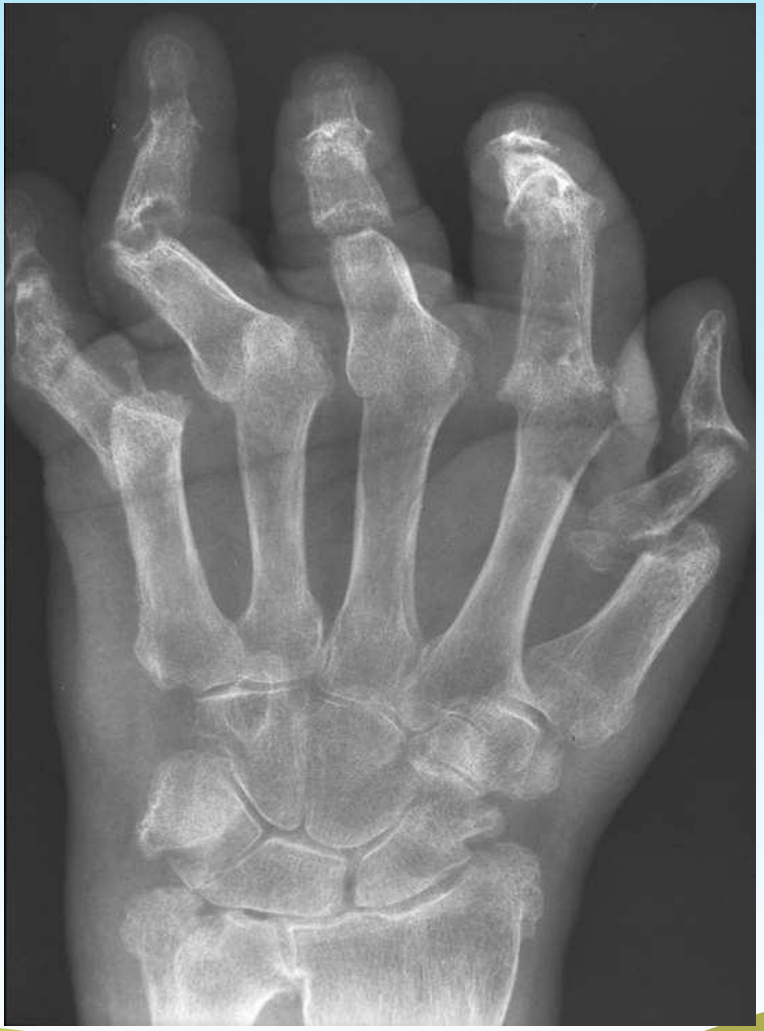
Radiographic Findings

- Characteristics of peripheral PsA include *DIP involvement*, including the classic .ytimrofed "***puc-ni-licnep***"



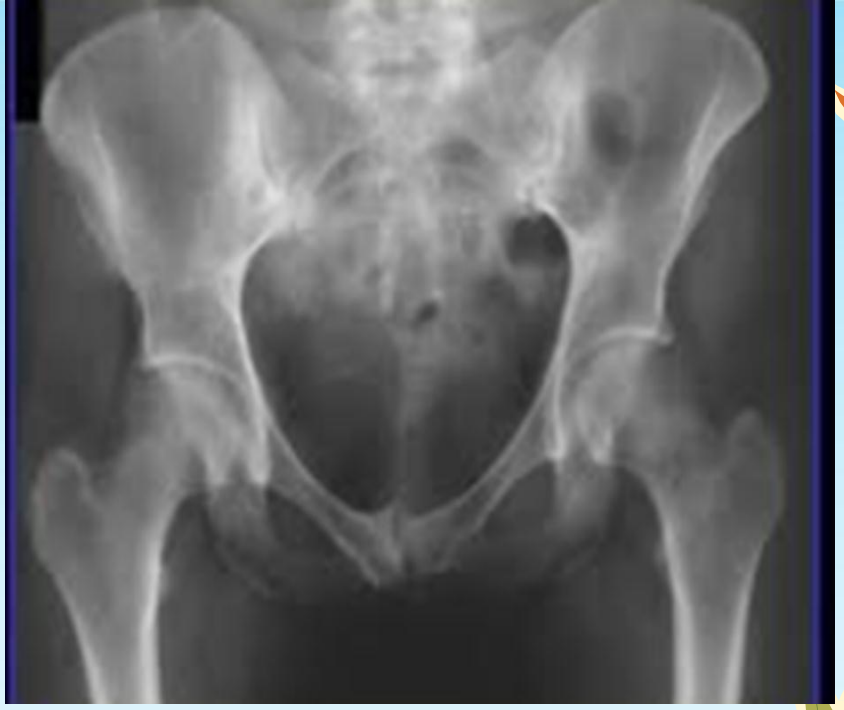


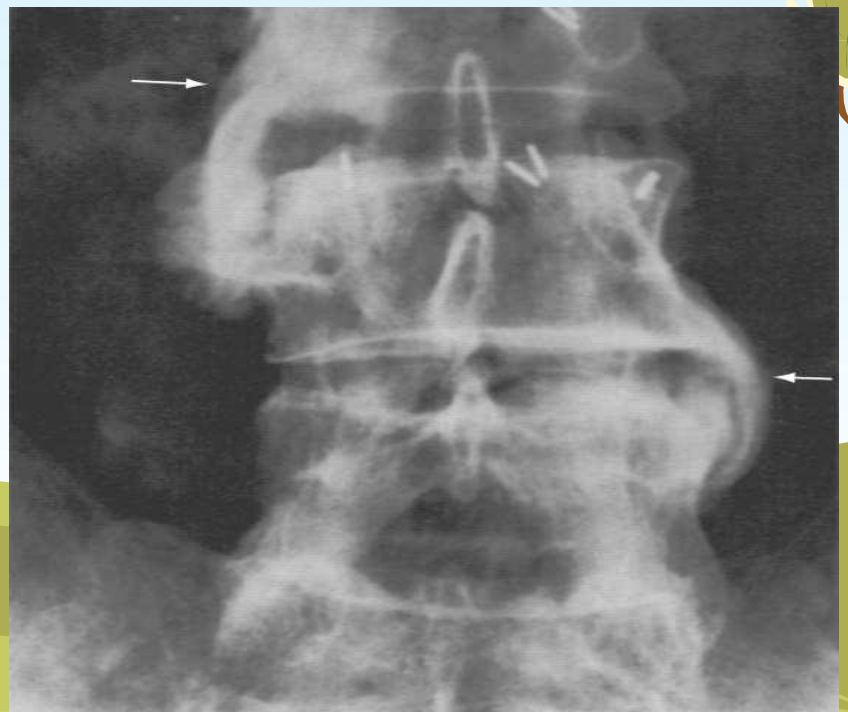
- Marginal proliferative erosions.
- Small-joint ankylosis.
- Osteolysis of phalangeal and metacarpal bone, with *telescoping* of digits.
- Periostitis and proliferative new bone at sites of enthesitis.



- Characteristics of axial PsA include ***asymmetric sacroiliitis***

- compared with idiopathic AS, less apophyseal joint arthritis, fewer and less symmetric and coarse syndesmophytes.





Laboratory Findings

- ESR and CRP are elevated(40%)
- RF, ANA, and anti-Anti ccp Abs are present in a minority of patients
- 8 - 16 % of patients have anti-CCP antibodies
- Uric acid may be elevated in the presence of extensive psoriasis
- HLA-B27 is found in 50–70% of patients with axial disease, but 20% in patients with only peripheral joint involvement.

Table 6 – Classification criteria for psoriatic arthritis[a]

Criterion	Points
1. Evidence of current psoriasis, a personal history of psoriasis, or a family history of psoriasis	
Evidence of current psoriasis on examination	2
Personal history	1
Family history	1
2. Typical psoriatic nail dystrophy (onycholysis, pitting, hyperkeratosis) on examination	1
3. Negative test for rheumatoid factor	1
4. Dactylitis (inflammatory swelling of an entire finger or toe)	
Current dactylitis on examination	1
Personal history	1
5. Radiographic evidence of juxta-articular new bone formation on plain radiographs of hands or feet	1

[a] To meet **CASPAR** (**C**l**AS**sification criteria for **P**soriatic **AR**thritis) criteria, a patient must have inflammatory articular disease (joint, spine, or entheseal) with ≥ 3 total points from any of the 5 categories.

Adapted from Taylor W et al; CASPAR Study Group. *Arthritis Rheum.* 2006.[47]

Treatment

- In mild disease no more than topical preparations to control the skin disease and NSAIDs for the arthritis are needed.
- In resistant forms of arthritis, immunosuppressive agents (methotrexate) and TNF inhibitors (infliximab, etanercept and adalimumab) have are effective.
- *Etanercept*- 50 mg SC once weekly or 25 mg SC twice weekly; if twice weekly, doses should be given on same day or 3-4 days apart.
- Adalimumab- 40 mg SC q2wk.
- Infliximab- 5 mg/kg IV at 0, 2, and 6 weeks, then every 8weeks.

Pretreatment

Screening for comorbidities and baseline testing :

Screening for cardiovascular risk factors (lipids, blood pressure, and smoking)

Weight loss counseling for patients with elevated BMI

Evaluation (eg, ultrasound) of the liver for patients with elevated LFTs

Screening for hepatitis in patients initiating methotrexate (MTX) therapy

Screening for latent tuberculosis (TB) in patients who may receive biologic agents.

RISK FACTORS FOR PROGRESSIVE JOINT DAMAGE

- Increased numbers of actively inflamed joint
- Elevated ESR or CRP
- Failure of previous medication trials
- The presence of joint damage (clinically or radiographically
- Loss of function (by Health Assessment Questionnaire [HAQ])
- Diminished quality of life
- patients who are HLA-B27-, -B39-, or -DQw3-positive are at a higher risk for progression of clinical damage
- Anti-CCP positivity

MILD PERIPHERAL ARTHRITIS

NSAIDS

There has been some concern that nsaids may aggravate the skin psoriasis in one randomized trial of a cox-2 selective inhibitor , there was no significant difference in an index of skin involvement between the two groups

comparative studies have not found any difference in efficacy between different nsaids

Apremilast (otezla) :an alternative agent for use in patients with mild PSA and multiple comorbidities , particularly in patients who wish to avoid dmard therapy, infusions, or injections, although only a portion of patients respond

joint aspiration and intraarticular glucocorticoid injection

avoid the use of oral glucocorticoids

Moderate to severe Peripheral arthritis or resistant to NSAID

- Conventional (Small Molecule) DMARD Rather Than A Biologic Agent
- Mtx (15 To 25 Mg Once Weekly) In Patients With Peripheral Arthritis Who Lack Axial Symptoms Or In Whom Axial Symptoms That May Be Present, Such As Back Pain, Are Well-controlled With Nsaids
- The Maximal Response To Mtx Is Usually Achieved Within Three Months Of Treatment With The Drug

Moderate to severe Peripheral arthritis or resistant to NSAID

- LEF (20 Mg Daily, Taken Orally) In Patients Who Have Persistent Joint Inflammation Despite Three Months Of Treatment With MTX (In Maximal Doses Up To 25 mg Weekly SQ) And In Patients Who Are Unable To Tolerate MTX Due To Adverse Effects

- Apremilast (30 Mg Twice Daily Following An Up-titration At A Rate Of 10 Mg Daily Over Six Days), A Novel, Orally Administered Phosphodiesterase-4 Inhibitor

- Apremilast Should Not Be Used In Patients With Erosive Diseas

SEVERE PERIPHERAL ARTHRITIS/ADVERSE PROGNOSIS

TNF inhibitor (etanercept, adalimumab, infliximab, certolizumab pegol, and golimumab) as first-line therapy, rather than a conventional nonbiologic DMARD

Other biologic DMARDs (eg, secukinumab or ustekinumab) are alternatives to a TNF inhibitor

in contrast to RA, MTX generally can be discontinued in PsA patients who respond to TNF-inhibitor therapy, with one important exception, which is infliximab

Choice of TNF inhibitor is based upon patient preferences for route (SQ versus IV) and frequency of administration

RESISTANT FORMS

- Resistant to one TNF inhibitor : switch to a second TNF inhibitor rather than trying a different class of biologic agent. Most patients achieve maximal benefit after about 3-4 months of therapy.

- Resistant to two TNF inhibitors : use an IL-17 inhibitor (ie, secukinumab or ixekizumab) or the IL-12/23 inhibitor ustekinumab.

- Resistant to multiple biologics : Abatacept, the costimulation blocker or Janus kinase inhibitors (Tofacitinib)

AXIAL DISEASE TREATMENT

Mild axial symptoms : NSAIDs

Moderate to severe axial disease: TNF inhibitors

Axial disease resistant to initial TNF inhibito: switching to a second TNF inhibitor and, if that is inadequate, to an alternative biologic agent such as secukinumab or ustekinumab

RESISTANT TO OR INTOLERANT OF STANDARD THERAPIE

- Alternative conventional disease-modifying antirheumatic drugs (DMARDs), such as sulfasalazine (SSZ), azathioprine, or cyclosporine
- Brodalumab: is an anti-IL-17 agent; concerns about suicidal ideation
- Guselkumab (Tremfya): is an anti-IL-23-specific monoclonal antibody
- Rituximab: variable results
- Filgotinib : selective Janus kinase 1 (JAK1) inhibitor under investigation for PsA
- Colchicine :Conflicting results

Thanks for your attention