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Quality of Life in Patients with PsA: Disease Domain Impacts

Announcer:

Welcome to CME on ReachMD. This activity, entitled "Quality of Life in Patients with PsA: Disease Domain Impacts" is provided by National Psoriasis Foundation with educational partner Rockpointe and is supported by an independent educational grant from Lilly.

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Dr. Birnholz:

Affecting up to one million Americans, psoriatic arthritis is a debilitating disease that exacts heavy physical and psychological tolls on patients. For this reason, improving quality of life is critically important to any treatment plan for psoriatic arthritis. And on today's program, we'll explore strategies toward earlier recognition and screening to help improve long-term outcomes for our patients. This is CME on ReachMD, and I'm Dr. Matt Birnholz. Joining me to discuss the impacts of psoriatic arthritis disease domains on quality of life is Dr. Marina Magrey. Dr. Magrey, thanks for being here today.

Dr. Magrey:

Thank you for inviting me

Dr. Birnholz:

I'm very much looking forward to speaking with you. So, to start, what can you tell us about the prevalence of psoriatic arthritis, and what risk factors we should be on the lookout for in our patients?

Dr. Magrey:

The estimated prevalence of psoriatic arthritis is usually between the 0.1 to 1% of the population, and it may affect about one million U.S. adults. And about one in three people who have psoriasis can develop psoriatic arthritis. And the most common age of onset is between 30 and 50 years, and affects men and women equally. There are multiple risk factors that have been identified to cause psoriatic arthritis in patients who have psoriasis, those could be anybody who has severe psoriasis, which is defined as affecting about 5% of their body surface area. The patients with psoriasis who are markedly obese or have other comorbidities like uveitis, nail involvement from psoriasis corticosteroid family history of psoriatic arthritis, and in certain patterns of the psoriasis. Scalp psoriasis or intergluteal psoriasis patients with one of the genes, HLA-B27 positivity, increases the risk to have axial involvement.

Dr. Birnholz:

That's an excellent primer to help us explore some of the ways that psoriatic arthritis impacts our patient's quality of life. So, with that said, what can you tell us about that, Dr. Magrey?

Dr. Magrey:

Psoriatic arthritis is a very heterogeneous disease; meaning that it is present in multiple forms it also has many clinical domains. It can cause enthesitis, where the tendons get attached to the bones, it can cause dactylitis, which is like a involvement of the tendon sheath and inflammation. It can cause axial disease or spondylitis. So with so many areas of the body involved, the patient has not only limitations in their physical activity, but they also cause fatigue impaired sleep, and may have difficulty coping. Based on a survey of

patients with psoriatic arthritis regarding their function and work productivity, and when those patients were asked if they had missed work in the past 12 months, about 31.5% said they had missed work. About 25.5% of these patients with psoriatic arthritis said that it prevented them from getting a job. And a similar number of 25.6% said it prevented them from keeping a job or, had impacted their choice of career, and impacted their career advancement, and 31.6% said psoriatic arthritis had impacted their ability to work full time. It does definitely not only impact the physical health, it also impacts the social and psychological functioning of these patients.

Dr. Birnholz:

Well, clearly, these are very sobering statistics and accounts for just how wide-reaching the impacts of this disease are. How do those impacts compare to the burden of other rheumatic diseases such as rheumatoid arthritis and axial spondyloarthritis?

Dr. Magrey:

Compared the impact of psoriatic arthritis, axial spondyloarthritis, and rheumatoid arthritis, and there was a retrospective study that was based on a Corona database, which collects information from all patients with inflammatory arthritis based on the data collected between March 2013 and March 2018, 11,000 patients were in the study of rheumatoid arthritis, about 2,000 patients with psoriatic arthritis, and 500 patients had axial spondyloarthritis. Patients with RA actually said they had shortened symptoms and disease duration than compared to those with psoriatic arthritis. Psoriatic arthritis patients had longer disease duration, and the patients with axial SpA had even longer duration of the disease. Even before they actually saw the doctor, they actually were suffering for many, many years. That is one thing one has to remember in these diseases, that they may not get diagnosed in a timely manner, and the patient may be, suffering for many years before they seek medical attention. Patients in this same study, when they were asked about the assessment of their disease activity, they said how bad is your disease? How would you grade your disease? And all three groups were comparable in pain. Psoriatic patients had higher assessment of the grading of how bad the disease is compared to the other two. Patients with psoriasis also had lower fatigue scores compared to rheumatoid arthritis patients, and patients with axial spondyloarthritis had comparable pain to rheumatoid arthritis. So all this suggested that patients with axial SpA had higher disease burden, if not equal or more than rheumatoid arthritis, and also psoriatic arthritis patients similarly may have higher disease burden than rheumatoid arthritis. The reason we are comparing this disease to rheumatoid arthritis here, is because rheumatoid arthritis is a well-known inflammatory arthritis, and it's much earlier diagnosed compared to these two diseases. When patients were asked to compare their pain and the pain scores were comparable in both diseases. The take-home message from this study was that these chronic rheumatic disease have heavy disease burden, patients suffer from a lot of pain and a lot of fatigue.

Dr. Birnholz:

For those just joining us, this is CME on ReachMD, and I'm Dr. Matt Birnholz. On this episode today, I'm speaking with Dr. Marina Magrey about the impact of psoriatic arthritis disease domains on quality of life. So, Dr. Magrey, we spoke a little bit earlier about the disease process itself and its impacts, but I want to come back to the comorbidities that you alluded to earlier. What are some of the most common ones associated with psoriatic arthritis?

Dr. Magrey:

Psoriatic arthritis patients can – besides the arthritis and the extraarticular manifestations, can also have other comorbidities associated with them. These patients can develop uveitis. They could have acute anterior or posterior uveitis. They may have inflammatory bowel disease, which in Layman's terms, we call colitis. And they are at increased risk of cardiovascular disease. A lot of these patients are obese, and suffer from metabolic syndrome, meaning they have impaired, glucose tolerance tests, they may have high uric acid levels, they may have diabetes. So, patients with psoriasis can have, nonalcoholic fatty liver. As I had mentioned earlier, there is a lot of psychological comorbidities associated in this disease. Patients may suffer from depression with suicidal ideation. They may also have secondary fibromyalgia, which is a chronic diffuse pain, and these patients are also at risk for developing low bone mass or osteoporosis.

Dr. Birnholz:

So this then brings us to the next logical question for our audience members, which would be: What are the best practices we should be incorporating when it comes to actually screening for these comorbidities? What can you tell us?

Dr. Magrey:

GRAPPA, which is an international organization of experts of psoriatic arthritis in 2015, they published guidelines looking at what should be done to prevent these comorbidities in these patients. They provide a framework, and in that, they mention that a comprehensive assessment of relevant comorbidities should be done in these patients. Patients should be assessed for obesity, metabolic syndrome, gout, diabetes, cardiovascular disease, liver damage, depression and mild anxiety. When they asked healthcare professionals how agreeable they were in assessing for these comorbidities, about 85% said they were in agreement with that. When they asked patients, would you like your rheumatologist be, looking for these comorbidities in you? And 100% of patients agreed. We should definitely screen them for diabetes. We should screen them for high cholesterol, liver problems, cardiovascular disease, and definitely

then refer them accordingly if we see any risks for heart disease or diabetes or obesity. In 2018, the American College of Rheumatology and the National Psoriasis Foundation also validated some of this. They said healthcare providers and patients must take into consideration all active disease domains in these patients. That means we should be assessing their skin. We should be assessing the joints, the entheses and then also for comorbidities in patient's functional status. And we should take into consideration all the comorbidities, the disease status, the functional status of the patient and then decide what would be the optimal therapy for them at any given point in time. The goal of a physician is to make the patient feel better we want to improve the quality of life of these patients. In order for them to feel good, we just cannot limit the treatment to one area. We want to provide the treatment that's going to cover all domains of the disease. For prevention of cardiovascular disease is they should have periodically have their blood pressure checked, their lipid panel. We definitely encourage them to quit smoking. Smoking is a risk factor not only for heart disease, but it also is a risk factor for these patients to have worse disease activity and a poor response to treatment. So definitely, if anything the patients can do to help themselves, that would be to quit smoking. We should be doing screening tests to rule out diabetes. Their weight and body mass index should be checked regularly whenever they visit their doctors. They should be asked if they have any symptoms of diarrhea, blood in the stools. They should also get once a year an eye exam, and consider periodical skin checkups for cutaneous malignancies like skin cancers. Ask them if they have any history of ultraviolet light therapy because these are the patients who get that for treatment of psoriatic disease. Periodically, we should be checking their liver and kidney function to rule out any chronic infections like hepatitis B or hepatitis C before starting any disease-modifying agents or biologic therapies in these patients. Also it's very critical and important that these patients should be screened for depression and anxiety. There are questionnaires if there is any suspicion that these patients may be suffering from underlying depression or anxiety.

Dr. Birnholz:

Dr. Magrey, those were excellent insights into the comorbidities and screening considerations that we need to keep in mind. But before we close today, are there any main takeaways that you want to leave with our audience today?

Dr. Magrey:

As I mentioned earlier, that we want to improve the quality of life of these patients. Quality of life may be a better indicator of treatment efficacy than just assessing disease activity alone. I want to make sure that all the rheumatologists who are taking care of patients with psoriatic disease are aware that in addition to causing pain and impairment in functional capacity and sleep disturbances, these patients can also have multiple comorbidities. I would like to stress they not only take care of the rheumatological manifestations, but also the comorbidities of these patients.

Dr. Birnholz:

Dr. Magrey, it was great having you on the program today.

Dr. Magrey:

And it was great speaking with you today.

Announcer:

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