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Screening for Axial Involvement in Psoriatic Patients

Dr. Keller:
Welcome to *DermConsult* on ReachMD. I'm your host, Dr. Matthew Keller. And I'm very excited to have my fellow ReachMD host and rheumatologist, Dr. Monica Schwartzman, here with me today to discuss screening strategies for axial involvement in psoriatic patients during routine dermatology checkups.

Dr. Schwartzman, it's great to speak with you today.

Dr. Schwartzman:
Thanks for having me. I'm excited to be here.

Dr. Keller:
So let's just dive right in, Dr. Schwartzman. What are some of the signs of axial involvement that patients with psoriasis might be experiencing?

Dr. Schwartzman:
So I think first what I'd like to do is just take a step back and think about what these terms are because there's a couple of different terms that are used when we think about axial spondyloarthritis, and the big ones are what we know as radiographic axial spondyloarthritis, which is synonymous with ankylosing spondylitis, and that's where we see x-ray changes in the sacroiliac joints. That's in contrast to an entity known as nonradiographic axial spondyloarthritis, which is where we see changes on MRI. And it's important because we can see changes on MRI much earlier than we can see changes on x-ray, so that's allowing us to identify these patients earlier. So I think big picture, those are the more "classic" axial spondyloarthridities that we tend to see and think about.

The question then becomes where does axial psoriatic arthritis fit in? And psoriatic arthritis is under the umbrella of spondyloarthritis, and it's typically thought of more as a peripheral disease, but actually, up to 35 percent of patients with psoriatic arthritis can have axial disease. Most of these patients will also have peripheral arthritis, so things like your wrists, knees, elbows, small joints of the hands. But there are actually a small percentage of patients with psoriatic arthritis who have just axial involvement, and this represents about one to four percent of patients. So I think it's important for us to recognize that patients with psoriatic arthritis, which we typically think of as a more peripheral arthritis, meaning non-spine, joint involvement, actually does affect the spine.

And this is an active area of research where we're really getting better at identifying and defining these patients, and a big question that is being investigated is to whether axial psoriatic arthritis is distinct from the more traditional axial spondyloarthritis that I mentioned earlier, radiographic and nonradiographic axial spondyloarthritis, and there is some data that these conditions may be a little different and have some unique features. Axial psoriatic arthritis typically presents older, and patients will typically also have those peripheral joint symptoms more than the patients with the more traditional axial spondyloarthritis, and on imaging there are actually differences, as well where axial psoriatic arthritis tends to be more asymmetric and have more cervical spine involvement than the more traditional axial spondyloarthritis. And interestingly, there are actually some genetic differences, as well. HLA-B27 is typically thought of as the characteristic gene mutation among all spondyloarthridities. However, it's been shown that actually patients with axial psoriatic arthritis have an association with HLA-B8 in addition to HLA-B27, though a lower rate at HLA-B27 than the more classic axial spondyloarthritis.

So I think an important thing for us, certainly as rheumatologists and as well as dermatologists, is to recognize that axial psoriatic arthritis is an important entity for us to be aware of, and there are some differences with the more traditional or classic axial spondyloarthritis I think that we've all traditionally thought of when we think of spine involvement in these groups of diseases.

Dr. Keller:
You make a very great point about the fact that radiology certainly plays an important part but doesn't necessarily rule it out just on x-ray, which is I think, what a lot of dermatologists end up utilizing as their primary imaging. So what strategies would you recommend for dermatologists to use when they screen for axial involvement in patients with psoriasis?

Dr. Schwartzman:
So I think the most important question is to be aware to ask. You should be asking your patients with psoriasis, in addition to whether they have any sort of joint pain, to also ask about whether they have low back pain, and then from here there's a myriad of different causes of low back pain ranging from chronic mechanical type of syndromes, herniated discs, or spinal stenosis. All of those things are very common in the general population, and the key here is to differentiate what is more mechanical back pain from what represents a potential inflammatory back pain.

And there's been a new screening tool developed for use in dermatology clinics where it casts a really broad net, and basically addresses whether patients have back pain for greater than or equal to three months, which is a key feature. And the other key is these patients typically are younger, so usually less than 40 or 45 years old.

If you feel that those patients either have those two features, having them seen by a rheumatologist certainly I think is important to have us tease apart whether there is maybe more inflammatory type of features to their back pain, and classification criteria have been developed addressing this.

Of course, I think on the dermatology side in your clinics, focusing on identifying the presence of any sort of back pain, and then having them see a rheumatologist in a timely fashion to further tease apart, I think is the most important. And this gets into a little bit of what you said earlier in terms of imaging. And again, this is a little more on the rheumatology side than I think you would see in a dermatology clinic, but I typically don't stop at x-rays in my patients that I'm concerned about an inflammatory back pain in patients with psoriasis because I know that early disease is unlikely to show on x-ray, so I have a pretty low threshold for getting an MRI in these patients because I know that there's a possibility that x-ray could be missing early disease.

Dr. Keller:
Yeah, those are all very good points. We don't really want to wait for a patient to have x-ray changes. You know, we'd like to try to catch it a little earlier now that we have something to do. And the question that's on the top of a lot of people's mind is, Dr. Schwartzman, which patients do you think should be on biologics? Where does that line happen?

Dr. Schwartzman:
That's a great question, and this is an emerging concept. There's really not a ton of great data in axial psoriatic arthritis, so we borrow from the axial spondyloarthritis literature. I think the first step if patients can tolerate it from a GI or variety of other perspectives is a trial of nonsteroidal anti-inflammatory medications. Typically, I do this in a standing fashion as opposed to on demand, and that would be first-line for axial spondyloarthritis. Patients that don't respond or that doesn't adequately control their disease, that's really when I then reach for biologics. And again, borrowing from the axial spondyloarthritis literature, we know that the conventional synthetic DMARDs really don't work when there's axial involvement.

So then that brings us into the different biologics that work in axial disease. So, certainly, we have the TNF-alpha inhibitors, so those are potential options. The IL-17 agents ixekizumab and secukinumab, also are efficacious in axial spondyloarthritis, so borrowing from that would be nice options, and then lastly, the JAK inhibitors, like tofacitinib and upadacitinib. And again, given the current safety concerns with these agents, certainly making sure that we're choosing the right patient population if we're thinking about these agents from a comorbidity perspective.

Dr. Keller:

So for those of you just tuning in, you're listening to *DermConsult* on ReachMD. I'm Dr. Matthew Keller, and today I'm speaking with rheumatologist and my fellow ReachMD host, Dr. Monica Schwartzman, about screening strategies for axial involvement in psoriatic patients. Dr. Monica Schwartzman will now be taking over as host.

Dr. Schwartzman:
All right. So switching gears a little bit to you, Dr. Keller, how do you determine which medications to give your patients with psoriasis?

Dr. Keller:
Well that's a great question. If we just assume it's a new patient that comes in, I'm going to start with a discussion about psoriasis and to an extent psoriatic arthritis, and also all the different types of treatments from soup to nuts, from topical therapy through light therapy, pills, and on to shots, I think because the patient needs to understand what's out there. And then the most important thing, and it's sort of apropos of what we're talking about today, is I try to assess if they have arthritis. I think it's a really important thing. I think we underestimate in dermatology. More than 10 percent of psoriasis patients have arthritis. And it's not always cut and dry. It's one of those diagnoses we don't really have a lab test that's going to guide us definitively, but it certainly affects the way I think about therapy.

I also consider where their disease is. So do they have facial disease? Do they have significant scalp, palm, sole, or genital involvement? That immediately alone will make their psoriasis severe as far as classification criteria.

So with mild disease, I'm usually going to start with topicals. More severe disease, I'm going to have a discussion about light treatment, pills, and shots off the get-go. And then I'm going to work with the patient based on what prior therapies they have been on because I get a lot of referrals, their thoughts on systemic therapy, because there are some people that just don't want to do a systemic treatment, and then I design a treatment plan that kind of works well for them. Most patients are going to want to try topicals first if they haven't already but if they aren't working, I always provide the more severe patients with labs to check, and I usually do that at the first visit. So I give them their labs—I say, "Don't get these checked unless you don't feel like the therapy we're doing is working, and then go ahead and get it checked so when you come back to see me, we have everything we need in order to move to the next step." That allows us to assess what type of therapy is going to work best.

If they have arthritis, especially if it's affecting their daily activities, I also refer to rheumatology because often it can be a while for them to get in with rheumatology, so what I'd like to try to figure out is, do I have a suspicion? And if I do, I'm going to move to systemic therapy a little faster, especially if it's having a significant impact. Some of these patients come in and they're already having multiple years of worsening activity, they have that 45 minutes or an hour of joint stiffness in the morning that takes a long time to work out.

Dr. Schwartzman:
I think you raise a lot of really great points, and one of the most important things is that we address the co-manifestations of psoriatic disease.

So I'm always impressed in the office when I see patients referred from dermatologists and they are already on a biologic therapy. So my question for you is, from a biologic perspective, how do you think about treatment options for your patients?

Dr. Keller:
Yeah, so I've used biologics quite frequently for patients. The first thing I do is assess if I'm going to start a biologic in this patient, which one would be the most appropriate?

So if the patient has MS or lupus, either in their personal or family history, I'm going to avoid the TNF-alpha inhibitors unless they have really bad spondyloarthritis or something that I feel like, okay, they don't personally have it, maybe it's worth rolling the dice, and I do that along with a rheumatologist. For those with severe inflammatory bowel disease or people that have a strong family history, I'm going to avoid those IL-17 inhibitors. And finally, as I said before, I avoid the IL-23s in moderate-severe psoriatic arthritis. I know there's some data out there that shows that it's efficacious, but for my patients, I just haven't had as much luck with it.

If they have significant skin and joint disease, I typically go with adalimumab. One, it's a self-injectable, it's going to cover that spine disease at least from what I'm told a little bit better, and it's a little easier for most of my patient population to use than infliximab. The caveat there is if they're a Medicare patient, I'm going to use infliximab much more frequently just from an insurance cover standpoint. I find adalimumab to be a very effective drug for both. And if they make it past about a year to 18 months on therapy and they're doing

well, usually they do well for a long time. There is that certain percentage of patients that will develop neutralizing antibodies or have loss of efficacy on adalimumab, but that usually is one of my first-line therapies for people with skin and joint disease.

If they have significant skin disease and little to no joint disease, I'm typically going to use Risankizumab, and then I'll use ixekizumab as a second-line for people with arthritis and psoriasis or just really bad psoriasis. And certainly others in all of those classes can be used, but those are my preferred ones really based on my personal experience and insurance coverage in my area.

Dr. Schwartzman:
So before we wrap up our discussion today, Dr. Keller, any final thoughts you'd like to leave with our audience?

Dr. Keller:
I think the major thing I try to impress upon people is the safety and the tolerability of these medicines in almost all patients is really fantastic and appropriate treatment of psoriasis and psoriatic arthritis, it's life-changing for patients, and I encourage everyone to find comfort in at least some of these medicines and really take the time to treat the psoriasis the way you'd want to be treated.

Well this has been an informative discussion including how rheumatology and dermatology can work together in diagnosing and treating our patients with psoriasis. I'd like to thank Dr. Monica Schwartzman for joining me and sharing her insights. It was a pleasure.

Dr. Schwartzman:
Thanks for having me. This was a great time and a great session.

Dr. Keller:
For ReachMD, I'm Dr. Matthew Keller. To access this episode and others from this series, visit ReachMD.com/DermConsult where you can Be Part of the Knowledge. Thanks for listening.