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Catching Psoriatic Arthritis Early in the Dermatology Clinic

Announcer:
This is *On the Frontlines of Psoriatic Arthritis* on ReachMD. Your host today is Dr. Mary Leuchars.

Dr. Leuchars:
Welcome to *On the Frontlines of Psoriatic Arthritis* on ReachMD. I'm Dr. Mary Leuchars, and joining me to discuss why early diagnosis and intervention matter in psoriatic arthritis is Andrew Mastro. He's a board-certified physician assistant at Illinois Dermatology Institute in Chicago. Andrew, thanks so much for being here today.

Andrew Mastro:
Thank you for having me.

Dr. Leuchars:
So let's jump right in, Andrew. In your role, I imagine you often see patients with psoriasis before they have any joint problems. Why does that put you in such an important position when it comes to psoriatic arthritis? And why does timing matter so much for these patients?

Andrew Mastro:
Timing is of the essence with these patients. And as dermatology providers, we have to approach them with a sense of urgency that we can confidently and calmly express to patients, right? We don't want to freak anyone out.

At the same time, we want them to level set with us so we can all be on the same page. Many of these patients with psoriasis are unaware of their risk of developing psoriatic arthritis, or they may not even understand what that means. So the downstream effect is that they don't know how or why they need to report the symptoms that they're experiencing

I read an interesting stat that states that 15% of patients that we see in our clinics have undiagnosed psoriatic arthritis. I think a stat like that should make us pause and think, why is that the case? How can we better inform the patients? How can we better communicate with other providers that we collaborate with in other specialties? And then, how can we better inform ourselves?

In terms of timing, I also tell psoriasis patients that we can always fix the skin, but when the joint damage occurs, we can't reverse that. So timing matters. It's of the essence. Even a six-month delay to diagnosis and starting therapy can severely impact outcomes. And as dermatology providers and potentially even PCPs, we see these patients over a long period of time, likely with an increased frequency in comparison to other providers, so it offers us the opportunity to diagnose and treat these musculoskeletal symptoms early.

There's this prodromal storm of symptoms before it becomes obvious, prior to many of these patients even being diagnosed, and that can be fatigue or just general stiffness. So, in this phase, we may not be seeing the enthesitis, dactylitis, targeted axial pain, et cetera. This is also a window to treat. However, most patients don't know enough to recognize that window, so we need to do a better job in informing our patients what to look out for and how to communicate those findings to us, as well as making sure that we're asking the right questions to the patient.

Dr. Leuchars:
So when a patient with psoriasis is in your exam room, what do you pay attention to the most? Are there things other than those you've already discussed on the skin or nails that make you think a person might be at risk for psoriatic arthritis or that it's already developing?

Andrew Mastro:

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Yes. Let's call these patients high-risk patients. So I express that to my patient as well, so they understand the relative and perceived risk. So, with that in mind, I'm looking at the nails closely, especially for pitting and onycholysis, but I'm making sure to recognize psoriasis versus onychomycosis—a fungus on the nails—and those other nail signs like splinter hemorrhages or oil spots. There's a lot going on there. The pitting and onycholysis are present in 80 percent or more of these psoriatic arthritis patients in terms of the nails. So this shows a really high level of predictive measurement. Nail involvement is also closely linked to enthesitis at the DIP joints, and the longer and more indurated these lesions become, the higher the risk of the greater severity of disease. So if a patient comes in with polish on, we have to make sure that we see that patient back and it's removed to evaluate the nails.

Outside of the nails, there are other things that we look for as well, like scalp disease, pustular psoriasis, and inverse psoriasis. Some of these are in areas that a patient may not want to show us, like the groin or the buttocks, especially if we're not doing a full body skin check. So asking if they have psoriasis in these areas is really critical to then unmask this potentially undiagnosed psoriatic arthritis, or potentially even those with the Koebnerization phenomenon.

So these are just potential things that we want to take a look for outside of just the nails. But when we think of some of the questions we're asking in clinic to uncover, we can talk about the PEST scores that we're doing in clinic. That's a quick, five-question thing that we can do with our patients. Even our MAs can do this. We're asking about a swollen joint or a digit. We're talking about enthesitis, Achilles tendonitis, dactylitis, a sausage digit, a diagnosis of arthritis, nails with pits, and heel pain. So these are quick questions that we can use to really get us in the right direction. Do we have to do more digging.

Most of these patients—over 80 percent of them—are dominant peripheral disease symptoms, usually presenting as an isolated joint. They also potentially have synovitis of the DIPs and symptoms that are worse in the morning. So questions of how the pain is onsetting are really critical.

We also need to think to the screen for axial involvement. Axial pain is such a critical point for these patients and one that can be really confused with other types of arthritises. So for axial pain, we're looking for inflammatory back pain that's worse with rest and better with movement, usually onset in the fourth decade of life. We can ask about shooting back pain or butt pain upon waking up. The thought behind what drives that is that these pro-inflammatory cytokines also have their circadian rhythm, kind of peaking through the night, so patients are waking up with that pain.

To make the picture even more muddied to some extent and to further add to this, patients can also have concurrent RA, and they can also have psoriatic arthritis without psoriasis. About 15 percent of patients will have that. And risk factors for those patients would be family history, some axial symptoms, enthesitis, and dactylitis. There's a lot that can muddy these pictures, so a lot of targeted questions for specific psoriasis phenotypes can be really, really, really helpful.

Dr. Leuchars:
Now, even with those clues, we know a lot of patients go a long time before getting a diagnosis. From where you sit, what gets in the way? Is it the visit time, the way care is divided up, or something else?

Andrew Mastro:
This is such a major issue and one that has a multitude of implications. One factor is on the patient end, right? They have some responsibility here. They likely do not have the knowledge of what they need to be looking out for in terms of symptoms. So that's how we differentiate those symptoms from just an old sports injury, which I hear all the time, or that the risk is even present. So if they're unaware, their push to be seen will be low, and their push to bring something up that's not part of their primary complaint will be low as well.

That point also bleeds into the second, which is the ability for these symptoms to be recognized by, potentially, their primary care physician. A lot of times, they are the first line of defense. And in fact, there's a large amount of patients that receive their psoriasis care strictly through their PCP.

So if the diagnosis doesn't happen through them, it connects into the third point, which is that a referral pathway into a rheum or derm is delayed. And in terms of derm providers, there are a few things that contribute: a general lack of musculoskeletal knowledge—just the basics in our training—being in practice and not keeping up on how to actually screen, or not having proper training on how to perform a quick psoriatic arthritis exam. There's potentially a lack of connection between derm and rheum providers that leads to treatment first from the derm and hopefully, eventually, a visit to the rheum, but there could be a time lapse which potentially puts that patient at risk.

Then lastly, time. We have busy clinics. We're seeing 50-plus patients a day, and we're always trying to gain back lost time when we can. So this can lead to not screening at all or to not screening well enough.

Dr. Leuchars:

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For those just joining us, you're listening to *On the Frontlines of Psoriatic Arthritis* on ReachMD. I'm Dr. Mary Leuchars, and I'm speaking with Andrew Mastro about recognizing psoriatic arthritis early to guide timely treatment.

So, Andrew, with those challenges in mind, let's talk about how we can ensure timely care for our patients. In your experience, what practical strategies have helped the most in overcoming those barriers, even in time-constrained visits?

Andrew Mastro:
I think there's some really good solutions here, and I think that it can apply broadly. So, obviously, if you have derm and rheum combined in one clinic under one roof, that would be fantastic. But that likely remains just a dream for most of us. So with that said, we need to establish the derm/rheum connections in our area and our regional network and expand that network. This could be done through grassroots campaigning around our area. This can also be done with the help of our partners in the pharmaceutical industry, who can help form those connections. We can potentially even hold joint meetings together across specialties. So there are different ways that we can formulate these connections.

We need to incorporate risk stratification so we can catch those high-risk patients that we discussed earlier. And we really need to establish those screening protocols within the office that can then be expressed to all the providers and medical staff in that office. The frequency that the AAD and the AAFP lets us know that we should be screening for psoriatic arthritis is every visit that we're seeing our psoriasis patients. So we need to make this a habit, not just for the providers, but for the medical assistants to ask these questions.

And we can do this through various models. One is the PEST score, which I mentioned previously in terms of those five questions. The other is one called EARP, which is Early Arthritis for Psoriatic Patients. Both of those are very sensitive and specific, so they can have a good sensitization specification for what we're looking for, but they also have high negative predictive values that leads us to the right place. GRAPPA, G-R-A-P-P-A, stands for Group for Research and Assessment of Psoriasis and Psoriatic Arthritis. That's a really cool questionnaire for rapid assessment, and it also has an app that can be used by both the provider and the patient. There's also a quick mnemonic. We love our mnemonics in derm. I just rattled off a million of them. There is the PSA mnemonic: pain, stiffness lasting for greater than 30 minutes, and axial disease.

So there are different things that we can use to quickly deliberate and say, "Do we have a problem going on?" We spoke before about some targeted questions that we can ask, whether it's morning stiffness lasting longer than 30 minutes that gets better with movement, swelling of fingers or toes, heel pain, and Achilles tendonitis or tightness. We can have our medical staff ask those questions before we walk into a room, so we can have multiple opportunities to collect this data. And of course, we can also palpate those really imperative digits or areas of the body on exam. But ultimately, we're going back to establishing the referral pathways for these patients so we can make sure that they're being treated from all aspects.

Dr. Leuchars:
Now, once you suspect psoriatic arthritis, how do you work with rheumatology and primary care to make that handoff as smooth as possible, and what does your role typically look like once the referral happens?

Andrew Mastro:
So when we can refer—when we can't exclude psoriatic arthritis—the referral should include documentation of characteristics, all screenings, whatever tools that we're using, the musculoskeletal symptoms, and any relevant treatments and medical history. All of that is going to my referral. Whether that's connecting with rheum or getting information back to a primary care physician just to let them know what we're doing, I want all that information to go back to my referral source.

The role that I take on is dependent on the order, sometimes, in which that patient is seen or who is potentially prescribing the medication. I typically don't hand over my psoriatic arthritis patients to rheumatology blindly. I continue as the main point of management, but rheumatology will follow with images and potentially labs and make recs of certain treatments.

But with the therapies that we have currently as derm providers, we should feel confidence in managing these patients and starting therapy early. We can potentially make an incredible impact for these patients before they have the potential to get into rheum, which, in my area, can take three to six months. And then we should be referring back to our primary care physician to let them know what is going on with that patient's therapy.

Dr. Leuchars:
Before we let you go, Andrew, if you had one final takeaway you'd like our listeners to remember from our conversation, what would it be?

Andrew Mastro:
Let's not think of ourselves as just a derm provider or a provider in a silo. While we are not working in this rheumatology space, it's our

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responsibility to educate ourselves in how we can moonlight appropriately in that realm to ensure our patients are receiving the most optimal outcomes. And if we have that mindset, ensure our patients are well-informed, and establish referral networks, we can provide the type of comprehensive care that these psoriatic arthritis patients desperately need.

Dr. Leuchars:
That's a very helpful reminder for us all. I want to thank my guest, Andrew Mastro, for joining me to discuss how we can improve outcomes in psoriatic arthritis through early diagnosis and treatment. Andrew, it was really great having you on the program.

Andrew Mastro:
Thank you so much for having me.

Announcer:
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