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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Psoriatic Arthritis Then and Now: Lessons From Dermatology

Announcer:
You're listening to *On the Frontlines of Psoriatic Arthritis* on ReachMD. Now, here's your host, Dr. Alexandria May.

Dr. May:
This is *On the Frontlines of Psoriatic Arthritis* on ReachMD, and I'm Dr. Alexandria May. Today, we're taking a look at the evolving treatment landscape for psoriatic arthritis with Dr. Jennifer Cather. She's the Medical Director at Mindful Dermatology and Modern Research Associates in Dallas, Texas. Dr. Cather, welcome to the program.

Dr. Cather:
So nice to talk to you again.

Dr. May:
I'd love to start with a little history, Dr. Cather. When you were first starting out, how did you think about psoriatic arthritis from the dermatology side, and what was the biggest challenge you faced in caring for those patients?

Dr. Cather:
So this is going to be difficult to tell you, but I was done with my training in 1999, to put that in perspective. So thinking about when my generation was training, our textbook said psoriatic arthritis is a benign arthropathy. So there wasn't a lot of interest in psoriatic arthritis. We didn't really address it in our general dermatology clinic, and we were actually treating psoriasis only with topicals, mainly. So we have come a really long way.

Dr. May:
Looking back, what do you see as the biggest turning point in how we treat psoriatic disease, and how did that change the conversations you have with patients who have joint involvement?

Dr. Cather:
So I will tell you, I have had the best life as a medical dermatologist, because I have touched every single new medicine for psoriasis before it's come into the marketplace. So, historically, let's all think back to 1998, 1997. What were we doing? We were doing rotational therapy with small molecules like methotrexate or cyclosporine, or we were putting people in light boxes. And I remember having conversations with people in my clinic and saying, "When is your best year? When do you want the best year of your life to be? Because I can actually get you clear with something like cyclosporine, but I can't keep you on it, because it has a one-year limitation of use." Or I can treat them with methotrexate, and we were spending so much time talking about the toxicity with it and pregnancy planning—things like that.

Then move into 2002, and the first biologic is approved for psoriasis, which was a TNF inhibitor. And we are now interested in long-term disease control, because we do not have things in the marketplace that have known toxicity, which is really exciting.

Dr. May:
Now, beyond having more options, our understanding of the immunology has evolved too. How does that influence the way you choose a therapy for a patient who has both skin and joint disease?

Dr. Cather:
We know there's a lot of immune-mediated inflammatory diseases that run together. And now we know a lot about the immunology

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behind things like psoriasis and psoriatic arthritis. We also know there's a lot of common pathways for things like inflammatory bowel disease, uveitis, and hidradenitis.

So every time I'm seeing somebody in clinic, I'm asking them about all their medical history, because I want to make sure that if I have medicines at my disposal that can actually address multiple disease states, I choose that.

Additionally, remember, we're not just into all medicines all the time. We really need to start educating people more about lifestyle choices, because we know things that drive psoriasis, like tobacco and alcohol, are probably the hardest things to actually elicit change from the patient's perspective. We also know trauma is important. So think about your patients with psoriasis that are construction workers. They need to wear knee pads, because every time they kneel on the ground or do some hammering and things like that, they can actually precipitate some arthritis. So it's actually a fascinating thing to be involved in as a dermatologist, because I might not be the most important person in the room, but I think I can add a lot of value to a person's life.

Dr. May:
For those just tuning in, you're listening to *On the Frontlines of Psoriatic Arthritis* on ReachMD. I'm Dr. Alexandria May, and I'm speaking with Dr. Jennifer Cather about advances in psoriatic arthritis management.

With all of that context in mind, Dr. Cather, let's talk about how this shift shows up in everyday practice. When a patient with psoriasis comes in today, what history or exam findings make you suspect early psoriatic arthritis, and what do you do next?

Dr. Cather:
I think one of the most important things to key in on and risk stratify in a person is when a person comes in with musculoskeletal complaints, and when they have any kind of psychiatric disorders. Those have actually tracked along with things like psoriatic arthritis.

When I think about things I can ask my medical assistants to help me with, that would be administering the PEST questionnaire, questioning about morning stiffness, if they've gotten swollen toes or fingers, if they have ever been told they have arthritis, or if they have had nail changes or any heel pain. On the exam, I'm specifically looking at the scalp and nails. We touch joints. I am not a rheumatologist, so I am not an expert in that.

And then I'm just keeping in the back of my mind that people are a work in progress. There is no correlation between body surface area involvement with psoriasis and psoriatic arthritis. And while the majority of people present in a dermatology office first and they have things like plaque psoriasis for years before they get arthritis, it can happen at any time. So question about pain. Why are you taking that MCED? Why are you taking these other medicines? That's actually really important, and that will help get them diagnosed earlier.

Dr. May:
Building on that, how has your working relationship with rheumatology changed over the years, and what does co-management look like now for a patient whose treatment needs to work for both skin and joints?

Dr. Cather:
We're really lucky, because the majority of our things that we use on a daily basis, which are biologics that target things like IL-17, TNF-alpha, and IL-23, do help skin and joints. I do not wait to treat. If they come in my office, I'm going to treat them as a dermatologist, and I will say, "Okay, I'm treating your psoriasis, but this medication also has an indication or maybe has data that it might help your arthritis." And I'm going to refer them to a rheumatologist.

I'm lucky, because I have rheumatology on my iPhone. So I will tell people, when a red hot joint comes into a dermatology clinic, it is as close to a medical emergency as I know of, because their joint destruction can be rapid and progressive. And so I think it's really important to start the therapy, but also make sure they know, hey, there's a whole other medical specialty in which all they care about is your joints. So make sure they get to an appropriate person.

Dr. May:
Finally, even with all of this progress, what gap in psoriatic arthritis care frustrates you most today, and what would you want the next decade of treatment to solve?

Dr. Cather:
I would really love to know who is going to progress with their joint disease. I would really love to know how clear we have to keep patients' skin and for how long before we stop a therapy, because every single person wants to bail out of therapy. And I really think we need to educate our patients, because people get clear and they assume they can just stop.

We know that about two-thirds of people that you see with psoriasis can have subclinical joint involvement. So I think that we really need to support and preserve our academic dermatologists and rheumatologists. There are dermatologists that are double-boarded, and I

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think that we need to make sure we preserve their time so they can actually answer some of these questions. We need to make sure we're intervening in patients' lives and making it so they can do all activities and really have a nice long life that is fruitful and prosperous.

Dr. May:
And with those insights in mind, we come to the end of our program. Dr. Cather, thanks so much for joining me to talk about the most important advances in psoriatic arthritis care. It's been a pleasure having you.

Dr. Cather:
Thank you so much.

Announcer:
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