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Unmet Needs and New Horizons in Psoriatic Arthritis

Announcer:
This is *On the Frontlines of Psoriatic Arthritis* on ReachMD. Here's your host, Dr. Mary Leuchars.

Dr. Leuchars:
You're listening to *On the Frontlines of Psoriatic Arthritis* on ReachMD. I'm Dr. Mary Leuchars, and joining me to explore what's on the horizon for psoriatic arthritis is Dr. Erin Boh. She is the Joseph Chastain Endowed Chair of Clinical Dermatology at Tulane University School of Medicine in New Orleans. Dr. Boh, welcome to the program.

Dr. Boh:
Thank you for having me today. I look forward to our conversation.

Dr. Leuchars:
Before we start talking about the future, Dr. Boh, let's take a look at where we stand today. From your perspective, what are the biggest unmet needs we're still grappling with in psoriatic arthritis care?

Dr. Boh:
You know, we've come a long way in our treatment of psoriasis, certainly, and actually, we're getting there with psoriatic arthritis. I think one of the unmet needs in this arena though is actually having physicians and healthcare providers feel comfortable with making the diagnosis and then being able to pick the right medicine that can treat both the arthritis and the psoriasis.

Dr. Leuchars:
Looking ahead now, what new research, therapies, or ways of working with other specialties are you most excited about in terms of addressing these unmet needs?

Dr. Boh:
I think what we need to think about doing is feeling comfortable with reaching out to the rheumatologist when we have a patient who may not fit exactly into that little niche of psoriatic arthritis. Now, I recognize, though, that it's difficult sometimes to reach out to rheumatologists, because there are not a lot of them around. So I think the first thing I tell many providers to do is make friends with your closest rheumatologist so that you can get these patients in.

But I think we need to start feeling comfortable with recognizing the signs and symptoms of psoriatic arthritis so that we can detect that disease state earlier in patients with psoriasis. Also, we need to start thinking about recognizing patients who are at risk for developing psoriatic arthritis later. And there's a few things that we look at. We might look at people who have other comorbidities. We look at people whose psoriasis started at a very young age. Maybe they have recalcitrant disease, difficult-to-treat disease, or a family history. Those three entities are very important in setting, in my mind, patients who are at risk for psoriatic arthritis. Or they may already have it. So then we start gearing our questions into getting those patients to recognize that they may have psoriatic arthritis.

But the most difficult thing, I find, is to separate out psoriatic arthritis from osteoarthritis and to recognize that some patients with arthritis may have a component of both. So we have to figure out what's the part of that arthritis picture that we need to focus on when we pick our treatments.

Dr. Leuchars:
One thing we hear a lot about is matching the right treatment to the right patient, especially when skin and joints are both involved. How

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do you see that getting better, whether through new tools, biomarkers, or smarter strategies?

Dr. Boh:
Well, one of the things that I think is very important for us to start looking at, and I think many providers don't think about this, are those biomarkers. And there are tools and tests out there available now that can help us to detect which inflammatory cytokines our patients with psoriasis are overexpressing. There are several tests that are out on the market that allow us to do genetic profiling.

And when we do that, it's helpful because we can look at the patient and see what the skin is overexpressing. So if we have a patient, for instance, who overexpresses TNF and IL-23, a combination of TNF and a 17, or any combination thereof, then we can pick the best drug to treat both the arthritis as well as the psoriasis.

So these tools are available to us in the clinic. They're easy to do. You can send off the results to the company and get the results of that genetic profiling or overexpression back within a week to 10 days. And I think that will help us in determining what the best choices are for our patients who have psoriasis. In addition, it'll help us in picking the right medicine that would attack the psoriatic arthritis component as well as the psoriasis component.

Dr. Leuchars:
For those just tuning in, you're listening to *On the Frontlines of Psoriatic Arthritis* on ReachMD. I'm Dr. Mary Leuchars, and I'm speaking with Dr. Erin Boh about emerging opportunities in psoriatic arthritis care.

So, Dr. Boh, we know that dermatologists often see psoriasis patients years before any joint symptoms appear. Are there any opportunities on the horizon to better identify those at risk of psoriatic arthritis or even intervene earlier? And if so, how would that change day-to-day practice?

Dr. Boh:
You're right. We see patients sometimes very early in their disease course. So patients with psoriasis may develop psoriasis in adolescence or early adulthood, and that's often years before the arthritis symptoms appear. So if we get attuned to asking our young patients about family history—which is important, because patients who have a family history of psoriasis, arthritis, or even other inflammatory diseases like rheumatoid arthritis or HS—that may help us to set the stage, because we know patients who have a family history of psoriasis are more at risk for developing arthritis later.

We want to be concerned about patients who have an early onset of disease, maybe have a family history of disease, have a BSA greater than 10 percent, or their disease has been recalcitrant or hard to respond to other therapies in the past. Those three components I think are super important in helping me to determine which of these patients may be at risk for developing psoriatic arthritis later.

When I go to pick my medicine or my treatment choice for these patients, I want to get the patients on treatment early enough. And I want to get them on effective treatment, because there's a lot of data now being published that shows if we get our moderate-to-severe psoriatic patients on treatment early, we see that these comorbidities, which take years to pronounce or become more apparent, may be delayed in their onset, or they may not appear at all.

We're poised as dermatologists to be at the first or front line to get patients on therapy. And it's adequate therapy, like our new biologics and our small molecular weight agents, which have the potential to defray or inhibit the progression of joint disease in these patients. So I think about, early on, getting patients on therapy. And that's regardless of the age. If you have a kid or adolescent and they have 10 percent psoriasis or they've got just scalp psoriasis, get them on a biologic early.

Dr. Leuchars:
We've talked a lot about what's coming, but I also want to highlight what's already working. What are the strengths of how we currently treat psoriatic disease, and what do you hope never changes, no matter how many new options come along?

Dr. Boh:
Now, when I look at a patient who has psoriasis and I look at their age, their comorbidities, and the extent of disease that they have, I like to think of three little buckets. We have patients who are skin forward, no arthritis. We have patients who have a mix of some arthritis along with psoriasis. And then we have some patients who have predominantly arthritis with just a little bit of psoriasis.

So I question my patients every time they come in about their joint status to see if I'm having them on the right medicine. I think getting the skin under control very quickly is super important, because then we can ferret out where the joint disease may truly lie. I tend to revisit this on every visit to make sure that they're not having ongoing joint pain or progression.

And I do like to get patients on biologics early on in the course of their disease journey, because almost all of our newer biologics halt

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progression of skin disease. They halt progression of joint disease, and that is the key, because once we get irreparable damage from the inflammatory joint disease, you cannot undo that. So we want to prevent its onset.

If we're unsure of what's going on, I think, as dermatologists, you should feel free and comfortable consulting with your rheumatology colleagues, because they can separate these out better sometimes. You can also get imaging. Now, X-rays are a little bit difficult sometimes to get a true inflammatory arthritis diagnosis, but it oftentimes does help me in determining how much osteoarthritis is present. And sometimes, if I tell my radiologist what to look for, I can have them pick up inflammatory changes that occur in psoriatic arthritis. If you don't feel comfortable doing the X-rays or imaging, send them to the rheumatologist and get a firm confirmation of joint involvement early on, so we get the patients on the right medicines so that their joint disease does not progress.

Dr. Leuchars:
Before we come to the end of our conversation, Dr. Boh, let's think big picture. Ideally, what would success look like for a patient with psoriatic disease in five or 10 years from now?

Dr. Boh:
If we look at our history, we've seen an incredible acceleration of investigation into new drug therapies, looking at different mechanisms of actions and improvement in the drugs that we've already got. So I think, as we look forward to the next ten years, we're going to find that we can tease out even better the molecular defects that are going on and the permutations that occur because of genetic makeups. And if we start looking at genetic testing as a tool that we can use to tell us what cytokines are being produced by the individual patient, we will get to a point where we are ahead of the game in diagnosing and managing our psoriatic disease, as well as our arthritis component. So I think we should embrace this genetic testing. It personalizes the treatment options that our patients have, and it truly becomes a targeted type of therapy. So we can pick the best therapy, the therapy that's most likely to improve and maintain improvement in those patients, by looking at the genetics and the overproduction as a consequence of the genetic makeup of that patient.

And we can hit a home run the first time we get our patient on drug. And what does it do for us as a whole healthcare system? It will minimize waste. It's very cost-effective. It saves the patient a lot of duress, because if they usually have to try multiple different therapies before they get to the one that's going to work for them, this will then allow us, by personalizing their treatments, to get to the best treatment the first time. And so that minimizes the ups and downs and the flares that patients with psoriasis get. And that may actually help us in preventing or staving off the arthritis that comes as a consequence of poor control of skin disease.

I think the most important takeaways here are talk to your patient and evaluate your patients at intervals that are reasonable, so you don't miss the onset of new symptoms or signs. Oftentimes, our patients are the real tools that we can use to get to the bottom line of what the best treatment is. And remember that the patient with psoriasis has, potentially, other comorbidities that can also help us in figuring out which patients are going to be at more risk for developing comorbidities such as psoriatic arthritis.

Dr. Leuchars:
Well, it seems like we have a lot to look forward to. I want to thank my guest, Dr. Erin Boh, for joining me to discuss the future of psoriatic arthritis management. Dr. Boh, it was great having you on the program.

Dr. Boh:
Thank you for having me on the program.

Announcer:
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