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SPECIAL ARTICLE

Recommendations for the Coordinated Management of Psoriatic Arthritis by Rheumatologists and Dermatologists: A Delphi Study☆

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Abstract Psoriatic arthritis, a chronic inflammatory musculoskeletal disease that is associated with psoriasis, causes joint erosions, accompanied by loss of function and quality-of-life. The clinical presentation is variable, with extreme phenotypes that can mimic rheumatoid arthritis or ankylosing spondylitis. Because psoriasis usually presents before psoriatic arthritis, the dermatologist plays a key role in early detection of the latter. As many treatments used in psoriasis are also used in psoriatic arthritis, treatment recommendations should take into consideration the type and severity of both conditions. This consensus paper presents guidelines for the coordinated management of psoriatic arthritis by rheumatologists and dermatologists. The paper was drafted by a multidisciplinary group (6 rheumatologists, 6 dermatologists, and 2 epidemiologists) using the Delphi method and contains recommendations, tables, and algorithms for the diagnosis, referral, and treatment of patients with psoriatic arthritis.

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PALABRAS CLAVE
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Elaboración mediante el método Delphi de recomendaciones para el manejo coordinado

Resumen La artritis psoriásica es una enfermedad inflamatoria crónica que afecta al sistema musculoesquelético, se asocia a psoriasis y suele producir destrucción articular con pérdida de función y calidad de vida. Su presentación clínica es heterogénea, con extremos fenotípicos que pueden solaparse con la artritis reumatoide o la espondilitis anquilosante. La psoriasis suele preceder a la artritis psoriásica, y la consulta de dermatología es el lugar clave para su detección precoz. Muchos tratamientos utilizados en psoriasis también se utilizan en artritis psoriásica, por tanto las recomendaciones terapéuticas para la psoriasis deben realizarse teniendo en cuenta el tipo y la gravedad de la artritis psoriásica, y viceversa. El objetivo de este documento es establecer pautas para el manejo coordinado (reumatólogo/dermatólogo) de la artritis psoriásica. Ha sido elaborado mediante la técnica Delphi por un grupo multidisciplinar (6 reumatólogos, 6 dermatólogos y 2 epidemiólogos) y contiene recomendaciones, tablas y algoritmos para diagnóstico, criterios de derivación y tratamiento de la artritis psoriásica.

Introduction

Psoriatic arthritis (PsA) is a chronic inflammatory musculoskeletal disorder associated with psoriasis. The prevalence of psoriasis in the general population ranges from 0.1% to 2.8%[1] and between 6% and 42% of these patients also have arthritis.[2] In approximately 70% of cases, cutaneous symptoms precede the onset of joint disease, musculoskeletal symptoms precede skin disease in only 15% of cases, and both occur simultaneously in 15%.[3] The risk of PsA remains constant following initial diagnosis of psoriasis, and the prevalence reaches 20.5% after 30 years.[4] It has been estimated that the mean (SD) interval between the diagnosis of psoriasis and the onset of PsA is 17 (11)years.[5]

PsA was initially considered to be a milder disorder than rheumatoid arthritis, but its progressive course was subsequently shown to cause joint damage and loss of function comparable to that of rheumatoid arthritis.[6] Its clinical expression is very variable, and the disease can manifest as spondyloarthritis, peripheral arthritis, dactylitis, and enthesitis.[7] The most common presentation is oligoarticular peripheral arthritis, followed by the symmetric polyarticular variant, which is similar to the typical presentation of rheumatoid arthritis. The pure axial form, similar to ankylosing spondylitis, is much less common. Between 20% and 30% of patients develop both axial (sacroiliitis, spondylitis) and peripheral (arthritis) symptoms.[8] During the course of the disease, involvement may progress from oligoarticular to polyarticular disease and vice versa.

Moll and Wright[9] in 1973 were the first authors to consider PsA to be a separate clinical entity distinct from other rheumatologic diseases. They defined it as a rheumatoid-factor negative inflammatory arthritis associated with psoriasis. In 2006, the Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA) developed the CASPAR criteria (ClASsification criteria for Psoriatic ARthritis).[10] One of the main advantages of this instrument is that it can be used to diagnose PsA in patients who do not have psoriasis and in patients with a positive rheumatoid factor. This characteristic, and the fact that it is quick and simple to apply, has made CASPAR the most widely used criteria for establishing a diagnosis of PsA.[11]

Owing to the association of PsA with psoriasis and the fact that, in most cases, joint involvement is preceded by skin disease, the dermatology consultation plays a key role in the early detection of PsA. However, the statistics reveal a somewhat depressing picture. A recent study showed that almost 30% of patients with psoriasis receiving dermatological treatment had undiagnosed PsA.[12] Thus, early diagnosis of PsA and prompt referral to a rheumatologist for treatment still represent a real challenge for dermatologists and there is evidence that prompt treatment of PsA can slow the progression of joint damage and the number of joints affected.[13]

Psoriatic onychopathy is a clinical predictor of PsA which has classically been associated with arthritis (80%-90% in PsA compared to 40%-50% in patients without arthritis).[14] Furthermore, although no correlation has been observed between the severity of psoriasis and PsA, an association has been found between the severity of psoriasis and the possibility of developing PsA.[12] The scalp, the retroauricular area, and the intergluteal cleft are the sites of psoriasis most often associated with PsA. An association has also been reported between obesity and the development of PsA.[15–17]

The diagnosis of PsA can be difficult in the dermatological consultation since, in addition to requiring close examination of the entheses, joints, and spine, it also requires imaging studies that are difficult to evaluate in this setting. However, assessment by a rheumatologist of all patients with psoriasis is not a viable option. The solution, therefore, is for the dermatologist to suspect a diagnosis of joint disease on the basis of a physical examination and the patient's medical history. A number of screening questionnaires have been developed to aid the clinician in establishing a suspected diagnosis of PsA in patients with psoriasis: the Psoriatic Arthritis Screening Evaluation (PASE),[18] the Psoriasis Epidemiology Screening Tool (PEST),[19] the Toronto Psoriatic Arthritis Screen (ToPAS),[20] the Psoriatic Arthritis Screening Questionnaire (PASQ),[21] and the Early ARthritis for Psoriatic patients (EARP) questionnaire.[22] However, the sensitivity and specificity of these instruments is well under 50% when the polyarticular forms of arthritis are excluded,[12] and no Spanish versions of these tools have yet been validated. Recent practical guidelines on the management of