Novel Treatment Concepts in Psoriatic Arthritis

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KEYWORDS

• Psoriatic arthritis • Treat-to-target • Tight control • Minimal disease activity criteria • Comorbidities • Anti-TNF drugs • DMARDs (biologic) • Dose reduction

KEY POINTS

- Early diagnosis and implementation of highly effective therapies provides the possibility of achieving better outcome in PsA.
- Tight control with frequent adjustments to medications and a treat-to-target approach to maintain low disease activity has shown clinical benefit.
- Refractory patients pose a challenge, but strategies to overcome treatment failure exist (eg, switching TNF inhibitors or implementing alternative therapies). Evidence for these strategies is accumulating in clinical trials.
- Patients well controlled on treatment may be able to taper or discontinue therapy, although the long-term outcome of such an approach remains unknown.
- New and potentially effective therapies are currently in advanced stages of clinical development.

INTRODUCTION

Psoriatic arthritis (PsA) is a chronic inflammatory condition that affects approximately 0.3% of the general population and 20% to 30% of patients with psoriasis.[1] It is a heterogeneous condition with diverse clinical manifestations or domains, including peripheral arthritis, axial arthritis, enthesitis, dactylitis, skin and nail psoriasis, and other manifestations.[2] The severity of involvement varies widely within domains and among individual patients, often making determination of disease activity challenging.

There have been numerous advances in the understanding of and treatment approach to PsA in the last decade. Among these, increased experience with highly effective therapies, particularly tumor necrosis factor-α inhibitors (TNFi), has altered

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expectations and revolutionized the approach to treatment. Several questions have been raised regarding the optimal use of these medications and other newer biologic therapies in PsA.

EARLY INTERVENTION

The importance of early intervention and initiation of therapy in PsA has become increasingly recognized (discussed elsewhere in this issue). This insight resulted mainly from the growing recognition that PsA is a more severe disease than previously thought, and the introduction of medications capable of altering the disease course in PsA. This section discusses early detection and diagnosis, early treatment, and highly effective therapy.

Early Detection and Diagnosis

The onset of skin disease precedes the onset of arthritis in greater than 80% of patients, often by more than a decade.[1] Consequently, there is a unique opportunity in PsA to identify patients with musculoskeletal manifestations early in the disease course (Fig. 1).[3] There are several challenges to the early detection and diagnosis of PsA, including who should be screened and how screening should be performed. In addition, patients may be asymptomatic or minimally symptomatic, and may fail to report symptoms. Time constraints may also hinder a comprehensive evaluation.

To overcome these obstacles, several screening tools have been devised to help identify musculoskeletal manifestations of PsA (Table 1).[4,5] These tools were developed to assist dermatologists and primary care physicians in making an appropriate referral to a rheumatologist when PsA is suspected to ultimately make the diagnosis.

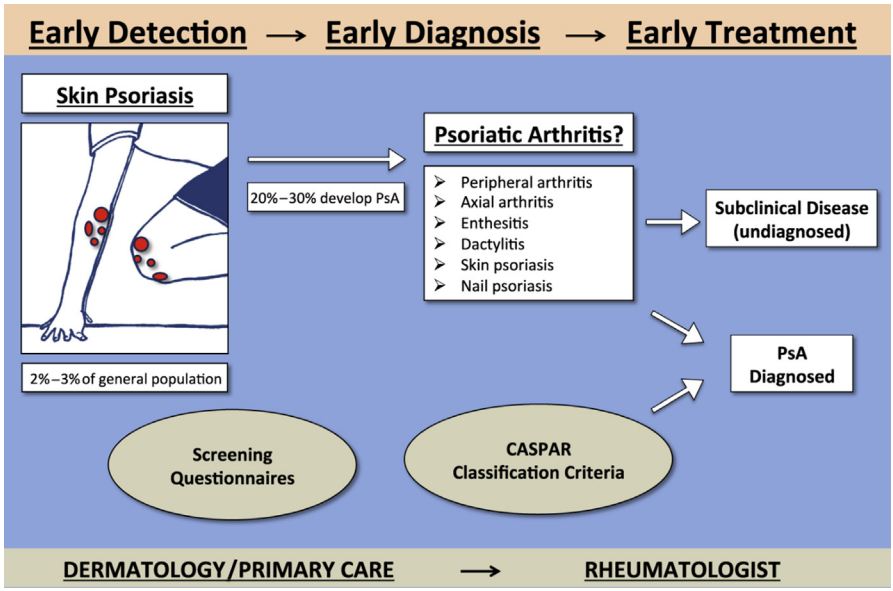

Fig. 1. Early intervention is recognized as the best strategy to achieve optimal outcome in PsA. Screening questionnaires help identify PsA in patients with skin psoriasis. The CASPAR classification criteria can be used to help make the diagnosis. Identifying subclinical disease remains a diagnostic challenge.