Psoriatic Arthritis

Disclaimer

See also:

- Ankylosing Spondylitis
- Inflammatory Arthritis
- *Psoriasis*
- Rheumatoid Arthritis

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Red Flags

- Giant-cell arteritis (GCA)

Background – About Psoriatic Arthritis

- Psoriatic arthritis:
  - is an inflammatory musculoskeletal disease associated with psoriasis.
  - occurs in approximately 7.5% of patients with psoriasis, according to in community-based studies.
  - is one of a group of related inflammatory arthropathies known collectively as spondyloarthritides.
  - is progressive and over time can progress from mild synovitis to severe erosive arthropathy. 47% of patients will develop radiological detectable joint damage within 2 years of diagnosis.

- Occasionally psoriatic arthritis may occur in the absence of skin disease or there may be only subtle skin findings which are not noticed.
- Non-steroidal anti-inflammatory drugs (NSAIDs) are usually sufficient to treat limited disease, but patients with

Assessment

1. Take a history:

   ➢ ***Symptoms***

   Symptoms
   - *Inflammatory joint symptoms:*
     - *Prolonged morning stiffness > 30 minutes*
     - *Improvement with use*
     - *Recurrence with prolonged rest*

   - *Distribution of joint symptoms – asymmetric, monoarticular or oligoarticular:*
     - *Psoriatic arthritis frequently presents with mono- or oligo-articular joint involvement.*
     - *Polyarticular joint involvement or dactylitis is a high-risk presentation and is associated with significant progression.*
   - ***Inflammatory back pain***

     Inflammatory back pain
     - *Insidious onset*
     - *Improvement with exercise*
     - *No improvement with rest*
     - *Pain at night with improvement upon getting up*

- *Dactylitis (fusiform swelling of an entire digit)*
- *Symptoms of enthesitis (heel pain, elbow pain or lateral hip pain related to entheseal inflammation) at bony tendon or ligament attachments.*
- *Spinal stiffness*
- *Sacroiliitis*

➢ Previous symptoms, diagnosis and treatment of psoriasis
➢ Family history of psoriasis or spondyloarthritis
➢ History or symptoms of inflammatory bowel disease
➢ Current medications, particularly use of DMARDs, biologics, and over-the-counter and herbal medications

2. Examine the patient for:
   - Skin and nail changes consistent with psoriasis
   - Peripheral joints for swelling and tenderness (synovitis)
   - Tenderness of plantar fascia, Achilles tendon, epicondyles of elbows indicating enthesitis
   - Spinal stiffness
   - Features that may help distinguish from rheumatoid arthritis:
     - Oligoarticular or monoarticular initial pattern of joint involvement
     - Distal interphalangeal (DIP) joint involvement
     - Dactylitis (fusiform swelling of an entire digit) – see images
     - Sacroiliitis

3. Arrange investigations:
   - FBC, ESR, CRP (inflammatory markers may be normal or elevated)
   - Consider electrolytes, urea, and creatinine, LFT
   - Rheumatoid factor (RF) and anticyclic citrullinated peptide antibody (anti-CCP) if polyarthritis. Usually negative and therefore may be useful in distinguishing from rheumatoid arthritis however RF and anti-CCP are positive in a small percentage of patients with psoriatic arthritis, with anti-CCP associated with more severe disease.
   - Consider X-rays of hands and feet. Erosion in the DIP joint and ill-defined ossification near joint margins (periostitis) is suggestive of psoriatic arthritis but early disease may not have any radiological signs.
   - Consider investigations to rule out differential diagnoses including other inflammatory arthritides.

Management

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1. Refer for immediate rheumatology assessment if:
   - fever and an acutely, hot, swollen joint – for exclusion of septic arthritis.
   - fever or unexplained illness in a patient on biologic or immunosuppressant medications.

2. Refer for urgent or routine rheumatology referral if psoriatic arthritis suspected, **and** at least one of:
   - Inflammatory back pain
   - Heel pain (enthesitis)

- Uveitis
- Dactylitis
- Psoriasis
- Inflammatory bowel disease
- Positive family history of spondyloarthritis
- HLA-B27

3. Prescribe ***non-steroidal anti-inflammatory drugs (NSAIDs),*** as first-line treatment for symptom relief, unless contraindicated. Inflammatory arthritis usually responds well to NSAIDs.

Nonsteroidal anti-inflammatory drugs (NSAIDs)

- *If co-prescribed angiotensin-converting-enzyme (ACE) inhibitors and diuretics, use with caution and check renal function within 10 to 14 days.*
- *Discuss harm versus benefits and the recommendation against long-term use in chronic pain.*
- *If higher risk of gastrointestinal bleeding, consider prescribing a gastro-protective drug.*
- *Be aware that multiple side-effects may occur in the elderly and those with asthma, gastrointestinal, cardiac, or renal disease.*

Contraindications:

- *Gastrointestinal (GI) ulcers*
- *Renal impairment*
- *Other nephrotoxic medications*
- *Bleeding risk*
- *Aspirin-sensitive asthma*
- *Warfarin is a relative contraindication*

Dosage:

- *Ibuprofen 200 mg to 400 mg every 6 to 8 hours*
- *Naproxen 250 mg to 500 mg every 12 hours*
- *Celecoxib 200 mg daily*

Maximum dosage:

- *Ibuprofen maximum 1600 mg per day*
- *Naproxen maximum 1000 mg per day*
- *Celecoxib maximum 400 mg per day*

4. If inadequate response to NSAIDs, consider intra-articular corticosteroid injection (in consultation with rheumatologist). Avoid systemic corticosteroids, as there is a risk of post-steroid psoriasis flare.

5. Refer for physiotherapy assessment to assist in reducing pain, improve range of motion and strengthen muscles of joints with associated periarticular muscle atrophy.

6. Consider a chronic disease management plan to facilitate allied health referrals.

7. Ensure screening and management of cardiovascular risk factors as psoriatic disease is a risk factor for metabolic syndrome.

8. If known psoriatic arthritis and concern about progressive or refractory disease, refer for urgent or routine rheumatology referral as treatment with a disease-modifying antirheumatic drugs (DMARDs) or biologic medications is required to arrest or modify the disease process.

9. If the patient is taking methotrexate, see Methotrexate Shared Care.

10. If the patient is pregnant or planning a pregnancy, arrange urgent or routine rheumatology referral. If unplanned pregnancy while taking DMARDs or biologics, seek urgent rheumatology advice.

11. Arrange follow-up appointment to monitor response to treatment.

Referral

- Refer for immediate rheumatology assessment if:
  - fever and an acutely, hot, swollen joint – for exclusion of septic arthritis.
  - fever or unexplained illness in a patient on biologic or immunosuppressant medications.

- Refer for urgent or routine rheumatology referral if psoriatic arthritis suspected, **and** at least one of:
  - Inflammatory back pain
  - Heel pain (enthesitis)
  - Uveitis
  - Dactylitis
  - Psoriasis
  - Inflammatory bowel disease
  - Positive family history of spondyloarthritis
  - HLA-B27

- Refer for physiotherapy assessment to assist in reducing pain, improve range of motion and strengthen muscles of joints with associated periarticular muscle atrophy.
- If known psoriatic arthritis and concern about progressive disease, refer for urgent or routine rheumatology referral.
- If the patient is pregnant or planning a pregnancy, arrange urgent or routine rheumatology referral. If unplanned pregnancy while taking DMARDs or biologics, seek urgent rheumatology advice.

Information

For health professionals

Further information

British Journal of General Practice – Diagnosis and Management of Psoriatic Arthropathy in Primary Care

For patients

Arthritis Australia – Taking Control of your Psoriatic Arthritis

References

1. Wilson, F.C., Icen, M, Crowson, C.S. Incidence and clinical predictors of psoriatic arthritis in patients with psoriasis: a population-based study. Arthritis and Rheumatism. 2009;15;61(2):233-9.
2. Kane, D. A prospective, clinical and radiological study of early psoriatic arthritis: an early synovitis clinic experience. Rheumatology. 2003;42: 1460-8.

Disclaimer

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