



Key Features to Explore to Avoid Delaying the Diagnosis of Psoriatic Arthritis

Signs to examine for:	<ul style="list-style-type: none">• “Sausage digits” or dactylitis• Enthesitis• PIP and DIP involvement• Tender and/or swollen joints
Symptoms to ask about:	<ul style="list-style-type: none">• Morning stiffness• Morning back pain• Persistent joint pain or arthritic symptoms• Fluctuation of joint pain with psoriasis exacerbations• Family history of psoriatic arthritis

Key: DIP=distal interphalangeal; PIP=proximal interphalangeal.

Pocket Reference Cards

supported by an educational donation provided by Amgen and Wyeth Pharmaceuticals.

Clinical Challenges

Optimizing Patient Management in Psoriatic Disease

Traditional Systemic Agents for Treating Psoriasis: Dosing Summary

	Dosing	Most Common Serious Side Effects
Cyclosporine	Initial dose: 2.5 mg/kg/d in 2 divided oral doses Adjust dose after 4 weeks—may increase dose at 2-week intervals (0.5 mg/kg/d) Do not exceed 4 mg/kg/d Discontinue if no response in 6 weeks on 4 mg/kg/d	Hypertension, renal dysfunction, hirsutism, gum hyperplasia
Methotrexate	Initial dose: 10 to 25 mg/wk or 2.5 mg at 12-h intervals X 3 doses Gradually adjust either schedule to achieve optimal clinical response Do not exceed 30 mg/wk	Liver toxicity, bone marrow suppression, ulcerative stomatitis (inflammation of the mouth mucosa lining), nausea, abdominal distress
Acitretin	Initial dose: 25 to 50 mg/d with main meal Maintenance: 25 to 50 mg/d based on initial response	Hyperlipidemia, cheilitis (lip inflammation), liver toxicity

Neoral [package insert]. East Hanover, NJ: Novartis Pharmaceuticals; 2005.

Trexall [package insert]. Pomona, NY: Barr Laboratories; 2002.

Soriatane [package insert]. Palo Alto, Calif: Connetics Corporation; 2004.

Psoriatic Arthritis vs. Rheumatoid Arthritis and Osteoarthritis

Characteristic	Psoriatic Arthritis	Rheumatoid Arthritis	Osteoarthritis
Gender (M:F)	1:1	1:3	Depends on age and affected joint: eg, over 55 years, F>M; hip involvement, M>F
Joint distribution	Usually asymmetric	Symmetric	Often asymmetric in larger joints
Enthesopathy (disease at insertion of muscle tendon and ligament onto the bone)	Yes	No	No
Number of joints	Few – many	Many	Variable – can be many
Constitutional symptoms	Variable	Typical	No
Skin disease	Yes	Rare	No
Rheumatoid factor	Usually negative	Usually positive	Negative
Peripheral disease	Yes	Yes	Yes
Axial disease	20% – 30%	Cervical	Yes
Bowel inflammation	Genetic association with Crohn's disease	No	No

Gladman DD. Psoriatic arthritis. *Rheum Dis Clin North Am*. 1998;24:829-844.

Gupta K, Nicholas JJ. Rheumatoid arthritis. *eMedicine*. January 8, 2003.

Stacy G, Basa AP. Osteoarthritis, primary. *eMedicine*. June 21, 2002.

Biologic Administration: Quick Summary

	Etanercept (Enbrel)	Infliximab (Remicade)	Adalimumab (Humira)
Administration	Subcutaneous	Intravenous infusion	Subcutaneous
Frequency	Once or twice weekly	Week 0, 2, and 6, then every 8 weeks	Every other week
Dosage <ul style="list-style-type: none">• Psoriasis• Psoriatic arthritis	50 mg BIW X 3 mo, then 50 mg weekly	5 mg/kg	— 40 mg
Location of administration	At home	Office-based setting, hospital, or local infusion center	At home

Patterns of Psoriatic Arthritis

Subtype	Key Clinical Features	Approximate Incidence (%)	Additional Information
Asymmetric polyarthritis or oligoarthritis	Affects fewer than 5 joints, usually in an asymmetric pattern; commonly involves large joints with some DIP, MTP, or PIP involvements; pitting edema and sausage-like digits observed	Up to 66	Most common pattern of psoriatic arthritis; often the presentation pattern
Symmetric polyarthritis "RA-like"	Affects more than 5 joints, usually in a symmetric pattern; involves wrists, small joints of hands and feet, ankles, knees, and elbows	25	Difficult to distinguish from rheumatoid arthritis; rheumatoid factor negative; can be disabling in approximately 50% of cases
Spondylitis	Mild back pain; stiffness of neck, pelvic area, and spinal vertebrae; painful motion; hands, arms, legs, and feet may be involved	5	Iritis (inflammation of the eye that causes redness and sensitivity) has been associated with spondylitis
Distal interphalangeal joint disease	Involves joints closest to nails of fingers and toes; "classic" psoriatic arthritis pattern	12	Occasionally confused with osteoarthritis, but nail changes and erosive changes on xray differentiate it
Arthritis mutilans	Affects small joints of hands and feet; neck or lower back pain may be observed	1-5	Severe, deforming, destructive form; arthritic flares and remissions often correspond with skin flares and remissions

Key: DIP=distal interphalangeal; MTP=metatarsophalangeal; PIP=proximal interphalangeal.

Gladman DD. Psoriatic arthritis. *Rheum Dis Clin North Am*. 1998;24:829-844.

Heftler JM, Saulino M. Psoriatic arthritis. *eMedicine*. June 20, 2001.

Self-Injections: Managing Fears and Concerns

Determine the source of apprehension, such as physical limitations, fear of injections, aversion to pain

Stress rationale and benefits of self-injections

Break down emotional barriers:

- Build confidence through encouragement
- Empower patients to be active, not passive
- Involve caregivers and/or family members

Take time for demonstration or discussion

Confirm patient comfort level before completing demonstration or discussion

Stress ongoing support of the healthcare professional, pharmaceutical company, help lines/websites, family members

Explain injection site reactions

Recommend automatic injections, which remove needle from sight and are easier for patients with deformities

Differential Diagnoses for Psoriasis

Disorder	Description to Differentiate from Psoriasis
Atopic eczema	80% to 90% of cases begin before age 5 years. Lesions often are leathery, dry, and excoriated and involve the flexures of the elbow and knee. Trunk is also sometimes involved. Itching is the prominent feature and must be present to diagnose. Frequently associated with other atopic diseases such as asthma.
Discoid or numular eczema	Round, coin-shaped lesions are less well-defined and may ooze fluid or be encrusted. Extremely itchy. Lesions typically located on trunk and upper arms or legs.
Seborrheic dermatitis	Diffuse, greasy, yellowish scaling. Common in infancy (cradle cap), middle age, and the elderly. Scalp involvement typically diffuse.
Pityriasis rosea	Oval lesions tend to run along rib lines. Single herald plaque typically precedes rash. Lesions are usually confined to upper trunk.
Secondary syphilis	Generally a history of primary chancre. Generalized brownish scaly lesions that also frequently involve the palms and soles. Additional signs include oral changes, mild hair-thinning, malaise, headaches, and lymphadenopathy.
Cutaneous T cell lymphoma	Lesions may be ring-shaped or have strange outlines. Asymmetric and atypical locations. Thickness varies between lesions, which are usually resistant to topical therapy.
Tinea unguis (fungus of the fingernail or, more commonly, the toenail)	Often confused with nail psoriasis, but in this condition, there is no pitting. Also, nails are crumbly and discolored at their free edges.

Beers MH, Berkow R. Scaling papular diseases. In: *The Merck Manual of Diagnosis and Therapy*. 17th ed. Whitehouse Station, NJ: Merck Research Laboratories; 1999:816-820.

Hunter JAA, Savin JA, Dahl MV. *Clinical Dermatology*. 3rd ed. Malden, Mass: Blackwell Science; 2002:48-55.

Defining Quality-of-Life: Major Components Impacted by Psoriasis and Psoriatic Arthritis

Component	Examples
Physical factors	Itching, irritation, pain, difficulty using joints
Psychological impact	Self-consciousness, embarrassment, frustration, anger, depression, grief
Social impact	Fear of shaking hands, necessity of wearing certain clothing to hide lesions
Sexual impact	Feeling physically unattractive, pain in joints with sexual activity, fatigue
Occupational impact	Lost days due to flares; negative effect of skin disorder on customer relations (real or perceived)

Beyond psoriasis. The person behind the patient. Available at: <http://www.beyondpsoriasis.com/pdf/BPExecutiveSummary.pdf>. Accessed February 16, 2006.

Clinical Presentations of Psoriasis

Pattern	Lesions	Location	Additional Information
Plaque psoriasis	Well-demarcated, ranging from a few millimeters to several centimeters in diameter; pink or red with large, dry, silvery-white polygonal scales	Elbows, knees, lower back, scalp	Most common type of psoriasis
Guttate psoriasis	Numerous small (up to 1 cm in size), round, red macules that become scaly	Trunk; may also involve head and limbs	Often affects children and adolescents; may be the first sign of disease; rash clears in a few months, but plaque psoriasis may eventually develop
Localized pustular psoriasis (palmar-plantar pustulosis)	Numerous sterile pustules measuring 3 to 10 mm in diameter sit on a red base; pustules progress to brown macules or scales	Palms and soles	Intractable and often painful
Erythrodermic psoriasis	Uniform redness covering the skin with variable scaling	The entire body or nearly the entire body	Rare serious form; may be accompanied by fever, malaise, shivering, and hot, uncomfortable skin; serum and electrolyte abnormalities
Scalp psoriasis	Areas of scaling interspersed with normal skin	Scalp and just beyond the scalp margin	Significant hair loss is rare
Inverse psoriasis	Bright red, smooth patches; lesions are not scaly	In folds of skin; most common under the breasts, in the armpits, near the genitals, under the buttocks, in abdominal folds	Aggravated by sweat and skin rubbing together; psoriasis lesions may be triggered by yeast overgrowth
Nail psoriasis	Tiny white pits scattered in groups across the nail; yellowish or salmon-pink spots on nails; onycholysis (loosening of free edge of nail from nail bed)	Fingernails and toenails	Nail involvement is very common with any form of psoriasis; nail changes may precede skin involvement or be a marker for psoriatic arthritis

Hunter JAA, Savin JA, Dahl MV. Psoriasis. In: *Clinical Dermatology*. 3rd ed. Malden, Mass: Blackwell Science; 2002:48-55.

Langley RG, Krueger GG, Griffiths CE. Psoriasis: epidemiology, clinical features, and quality of life. *Ann Rheum Dis*. 2005;64:ii18-ii23.

Jones DL. Psoriasis. Available at: http://www.podiatry.curtin.edu.au/encyclopedia/pustulla_psoriasis/psoriasis.html. Accessed February 16, 2006.



How to Cope with Psoriasis and Psoriatic Arthritis: Recommendations for Patients

Learn the facts about psoriasis and psoriatic arthritis

Become comfortable talking about psoriasis and psoriatic arthritis

Be prepared; practice responses to questions people may ask about your condition

Become active; join activities/groups either with people who have or do not have psoriasis

Reassure and repeat to yourself, "I do not have anything weird or strange. I have a medical condition."

Expect that you will sometimes have negative experiences, but they will get easier to handle each time

Focus on the positive: your family, profession, hobbies, friends

Discuss exercise, sleep hygiene, proper nutrition

Address psychological consequences of chronic illness

Remind yourself that you are more than just your skin or joints—there is more to life than just psoriasis and psoriatic arthritis

Take advantage of support groups—meeting other people with the same conditions can give you further insight into living with psoriasis and psoriatic arthritis

Contact the National Psoriasis Foundation or the Arthritis Foundation, excellent sources of education and information as well as peer-to-peer support through meetings, publications, and website

Precipitating Environmental Factors Related to the Development of Psoriasis

Trauma	Lesions appear in skin damaged by a scratch or a surgical wound, known as the Koebner phenomenon
Infection	Acute bacterial and fungal skin infections aggravate psoriasis; tonsillitis with b -hemolytic streptococci associated with guttate psoriasis; AIDS exacerbates severe, explosive forms
Hormones	Improvement often observed with pregnancy; relapse occurs postpartum
Sunlight	Improvement of symptoms in 90% of patients; worsening of symptoms in 10%
Drugs	<ol style="list-style-type: none">1. Rebound following withdrawal of treatment with steroids (potent topical or systemic)2. Symptoms may flare following abrupt discontinuation of methotrexate3. Specific agents worsen psoriasis: antimalarials, b-blockers, interferon-a, lithium
Cigarette smoking and alcohol	Evidence accumulating in epidemiologic studies to demonstrate a precipitating and maintaining effect
Emotion	Exacerbations have been linked to emotional distress

Hunter JAA, Savin JA, Dahl MV. Psoriasis. In: *Clinical Dermatology*. 3rd ed. Malden, Mass: Blackwell Science; 2002:48-55.
Rosenberg WE, Noah PW. The Koebner phenomenon and the microbial basis of psoriasis. *JAAD*. 1998;18:151-158.

Psoriasis and Psoriatic Arthritis Support and Education: Organizations, Websites, Telephone Numbers

National Psoriasis Foundation (NPF) — Support groups listed by city and state are located on the NPF website	1-800-723-9166, www.psoriasis.org
Arthritis Foundation	http://www.arthritis.org/
PsoriasisNet — This is an educational site from the American Academy of Dermatology	http://www.skincarephysicians.com , American Academy of Dermatology 847-330-0230, www.aad.org
International Federation of Psoriasis Associations	http://www.ifpa-pso.org/
Psoriasis Connections	www.psoriasisconnect.com
Etanercept support and information	1-888-4ENBREL, www.enbrel.com
Infliximab support and information	1-888-799-9769, www.remicade.com
Adalimumab support and information	1-800-4HUMIRA, www.humira.com
Alefacept support and information	1-866-AMEVIVE, www.amevive.com
Efalizumab support and information	1-877-RAPTIVA, www.raptiva.com