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► To cite this version:

Aurélie Du Thanh, Céline Girard, Jacques Morel, Camille Roubille. Toward a holistic management of skin and joint disorders in PsA patients. *Rheumatology*, 2021, 10.1093/rheumatology/keab889 . hal-03470805

HAL Id: hal-03470805

<https://hal.science/hal-03470805>

Submitted on 3 Jun 2022

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Toward a holistic management of skin and joint disorders in PsA patients

PsA is a multifaceted disease with joint and skin involvement. Both cutaneous psoriasis (Pso) and PsA have an impact on the physical, social and psychological health-related quality of life (HRQoL) of patients. Pain and disability primarily influence the living conditions of PsA patients. However, the extent of skin lesions is also an important factor in the disease burden of PsA that should not be overlooked, as highlighted by Kasiem *et al.* [1] in this issue of *Rheumatology*. Pso can lead to stigmatization, negative self-image, impaired self-esteem and decreased social interactions [2]. In the Corrona PsA registry, patients with greater skin involvement (body surface area [BSA] >3% vs ≤3%) had greater patient-reported pain and fatigue, poorer functional status with higher HAQ scores, greater disease activity and greater work disability, illustrating the greater disease burden associated with greater skin involvement in patients with PsA. These data highlight the importance of assessing psoriasis skin symptoms in patients with PsA, as they may be a contributing factor to the severity of PsA [3].

Psoriatic disease is probably the disease that requires the closest holistic collaboration between rheumatologists and dermatologists, in terms of both diagnosis and management, especially for patients with both skin and rheumatological involvement, patients with comorbidities requiring coordinated management strategies, and patients with Pso with risk factors for progression to PsA [4]. Treatment options are discussed according to the predominant clinical manifestations, as not all available drugs have shown the same efficacy on skin and rheumatological lesions. Therefore, the key element in the management of psoriasis is to reach consensus on both the assessment of disease severity and the determination of treatment goals. Clinicians must consider both skin severity and joint activity in treatment decisions. In addition, HRQoL assists in making therapeutic decision in Pso/PsA patients and is increasingly being assessed in daily clinical practice. In the case of PsA, specific treatment goals have been established, based mainly on objective measures, namely 'Treat to target'. In Pso, French guidelines, for example, do not mention the concept of 'treat to target' but include the measurement of the psoriasis area and severity index (PASI) and the dermatology quality of life index (DLQI), as well as the management of comorbidities [5]. According to this expert opinion, the absolute PASI should be ≤3, the Physician Global Assessment at 0 or 1, the DLQI ≤5, or at least a PASI 90 should be achieved. However, the PASI measurement cannot be accurate when the skin lesions involve so-called 'sensitive' areas, such as the

face and scalp, hands or genitals. Instead, the European guidelines [6] define patients requiring systemic therapies based on an accurate assessment as follows: affected BSA >10%, special areas affected and failure of topical therapy. The lack of perfect consensus among these experts regarding precise scoring reflects the difficulty of assessing the severity of psoriasis in dermatology compared with rheumatology.

However, according to the International Psoriasis Council, BSA as well as DLQI and the involvement of so-called 'special areas' should be used to classify psoriasis as follows: mild psoriasis defined by a BSA of 0–5% and DLQI <5; moderate psoriasis by a BSA of 1–5% and DLQI 5–10, or a BSA of 5–10% or special areas involvement; severe psoriasis by BSA >10% or special areas involvement or a BSA of 5–10% and DLQI >10 [7]. Patient satisfaction is therefore a crucial point in the evaluation of therapeutic response, emphasizing the importance of quality-of-life scoring in Pso patients.

HRQoL is impaired in both Pso and PsA, but the impact of Pso in PsA is less well documented. In this issue, Kasiem *et al.* [1] assessed the progression of Pso in patients with early PsA over a 1-year period as well as the impact of Pso on HRQoL using a dermatology-specific questionnaire, the Skindex-17 questionnaire, which includes a symptomatic and a psychosocial subscale. Although the progression of Pso severity was most often mild (PASI < 7), it affected HRQoL with a significant association with the Skindex-17 score. As proposed by the authors, rheumatologists should be aware of the impact of Pso on the HRQoL of their PsA patients and assess skin burden in their daily practice using a specific dermatological HRQoL questionnaire, or at least ask their PsA patients about their skin. Although rarely used in daily practice, the Skindex-17 score seems to be interesting because it has a higher cross-cultural validation than the DLQI [8]. Of note, when assessing their psoriasis, patients may have objective and subjective scores that are not necessarily in the same direction. Thus, discordance between low PASI scores and high DLQI scores is not uncommon. On the other hand, when PASI improves, the DLQI also improves. In any case, it seems relevant not to focus only on joint involvement in the overall impact, and not to neglect the impact of skin involvement in PsA patients.

Assessment of disease severity using the PASI is another mainstay of management. In this study by Kasiem *et al.* [1], PASI was measured by trained research nurses, which highlights the question of who should assess skin lesions during a rheumatology consultation

and how, and whether this should be done separately by a corresponding dermatologist. Some rheumatologists may feel uncomfortable examining the skin and may not consider themselves experienced enough to perform the clinical dermatological evaluation. In an on-line survey, up to 35% of 153 rheumatologists acknowledged a lack of training in skin disease assessment [9]. Therefore, rheumatologists and dermatologists should jointly consider the respective roles of each specialist in assessing the overall disease severity prior to management and establish appropriate collaboration [4, 10].

Beyond these considerations, patients with Pso/PsA experience cardiovascular, metabolic and psychological comorbidities that also have a deleterious impact on HRQoL and morbi-mortality. Both rheumatologists and dermatologists are increasingly involved in the screening and management of these comorbidities. Evidence-based and practical recommendations have been developed [10]. A multidisciplinary model of care aimed at individualized and coordinated management of skin involvement, joint involvement and comorbidities should be encouraged in patients with Pso/PsA to reduce the burden of psoriasis [4].

Funding: No specific funding was received from any bodies in the public, commercial or not-for-profit sectors to carry out the work described in this article.

Disclosure statement: The authors have declared no conflicts of interest.

Data availability statement

No new data were generated or analysed in support of this work.

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