Short Communication

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Acta Rheumatologica

2023
Vol.10 No.2:07

Psoriatic Arthritis: Therapeutic Strategies

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Received date: October 26, 2022, Manuscript No. IPAR-22-13141; **Editor assigned date:** October 31, 2022, PreQC No. IPAR-22-13141 (PQ); **Reviewed date:** November 15, 2022, QC No. IPAR-22-13141; **Revised date:** January 27, 2023, Manuscript No. IPAR-22-13141 (R); **Published date:** February 03, 2023, DOI: 10.36648/IPAR.23.10.2.07

Citation: Reddy A (2023) Psoriatic Arthritis: Therapeutic Strategies. Acta Rheuma Vol:10 No:2

Abstract

Our understanding of psoriatic arthritis has evolved as new knowledge of the disease has emerged. However, the exact prevalence of psoriatic arthritis is unknown, and its pathogenesis has not been fully elucidated. Genetic, environmental, and immunologic factors have all been implicated in disease development. Early diagnosis and treatment have become primary objectives in clinical rheumatology. Psoriatic arthritis not only causes functional impairment, but also increases mortality risk of patients. The advent of new therapeutic agents capable of arresting the progression of joint damage is expected. However, early psoriatic arthritis assessment remains limited. The objectives of this article are to outline the epidemiology, diagnosis, and treatment of psoriatic arthritis and to suggest a paradigm for identifying early psoriatic arthritis patients.

Keywords: Arthritis; Psoriasis; Psoriatic arthritis; Spondyloarthritis; Rheumatology

Introduction

Psoriatic Arthritis (PsA) is a chronic disease which involves the inflammation of synovial tissue, enthuses, skin and usually seronegative for rheumatoid factor. Spondyloarthritis complex includes enclosing spondylitis, reactive arthritis, arthritis associated with inflammatory bowel disease, undifferentiated spondyloarthritis, and PsA. PsA is belonged as one part of the spondyloarthritis complex. PsA patients have heterogeneous clinical presentations, with diverse articular and dermatological features and varied disease courses and outcomes. PsA was initially considered to be a mild disease, but in the past decade, 40%-60% of patients have developed erosive and deforming joint complications. PsA-induced joint damaging complications not only lead to lower articular function and higher mortality but also affect patients' ability to work and affect their social relationships. The remission of PsA symptoms has been attributed to early diagnosis and treatment in recent studies. However, PsA is underdiagnosed in psoriasis patients, which may be due to under recognition of PsA symptoms and a lack of effective screening tools. The aims of this article were to present the epidemiology, diagnosis, and treatment of PsA and to suggest a paradigm for use in standard clinical practice.

Description

Therapeutic Strategies

There is very little evidence to guide how these therapies should be used. The newest data for treatment strategy in PsA is from the Tight Control of PsA (TICOPA) trial; the study recruited 206 patients with early PsA who were randomised 1:1 to receive either tight control or standard care. The tight control patients were reviewed every 4 weeks and their treatment was escalated to achieve minimal disease activity. The standard care patients were seen every 12 weeks and were treated with no set protocol. The TICOPA study confirmed a significant benefit with tight control in terms of peripheral arthritis, skin disease and patient reported outcomes. As a result of this study, the first recommendation of the updated 2015 EULAR recommendations for the management of PsA is that 'treatment should be aimed at reaching the target of remission or, alternatively, minimal/low disease activity, by regular monitoring and appropriate adjustment of therapy'. The drugs used within the TICOPA study still followed a broadly 'step up' approach in keeping with current recommendations. This remains the default approach as it reduces costs associated with biologic therapies and because there is no evidence to date that a more aggressive treatment strategy improves outcome.

Treatment

New treatment recommendations for PsA were updated in 2015 by both the European League against Rheumatism (EULAR) and the group for research and assessment of psoriasis and psoriatic arthritis. Both of these recommendations are evidence based and both broadly suggest a similar 'step up' approach to therapy. This approach uses therapies sequentially starting with simple therapies such as non-steroidal anti-inflammatory drugs for pain or topical therapies for psoriasis, followed by Single Disease Modifying Drugs (DMARDs), then combinations of standard DMARDs, and finally biologic drugs if patients fail to respond to the previous treatment.

The majority of patients referred are already taking non-steroidal anti-inflammatory drugs and these are symptomatically

useful with appropriate cautions about side effects. In the initial stages, corticosteroids are used to settle inflammatory disease rapidly, often given as intra articular or intra-muscular injections. Expert opinion is that intra articular steroid injections may be used in persistent mono or oligoarthritis. Observational evidence showed that 41% of joints improved at 3 months following use of corticosteroids, although 33% of these relapsed subsequently. Oral steroids are not recommended, in part because of possible skin 'rebound' when they are withdrawn. Methotrexate remains the most common first-line DMARD therapy, despite controversies. The Methotrexate in PsA (MIPA) trial is the only powered placebo controlled trial to assess methotrexate in PsA and did not achieve the primary outcome. The only significant difference was seen in patient and physician global visual analogue scores. However, there were methodological flaws with this paper, including slow recruitment, low target doses of methotrexate and a high drop-out rate. Supplementary data suggest a marked reduction in disease activity in the polyarticular group (≥ 5 active joints) but this was not formally tested. Observational data from the Tight Control of PsA (TICOPA) study found an ACR20 (American College of Rheumatology 20% improvement criteria) score of 40.8% at 12 weeks with methotrexate, as well as some effect on enteritis and dactylitis. Sulfasalazine has been the subject of a number of studies. A Cochrane review confirmed a significant but small effect against placebo with no effect on enthesitis. Leflunomide is the most well researched of the DMARDs for PsA, with a placebo controlled randomized controlled trial of 190 patients. However, leflunomide is not commonly used in clinical practice.

Conclusion

The incidence and prevalence of PsA vary worldwide. The incidence and prevalence of PsA in Asia are lower than in North American and European countries. Early diagnosis and treatment for PsA improve patient's outcomes. PsA is underdiagnosed among psoriasis patients. Physicians should be alert the possibility of PsA when a patient with preexisting psoriasis has arthritis. If needed, counsel a rheumatologist for help. The treatment of PsA should be considered all aspects of the disease, including clinical manifestations, mental problems, and maintenance of articular function. PsA is a common, disabling and frequently undiagnosed arthropathy for which effective treatments are available. Early detection and treatment are likely to improve the outcome. For assessment and therapy, it should be appreciated that this is a heterogeneous disease best managed with a multispecialty and multidisciplinary team. The era of targeted biologic drugs has transformed the treatment landscape for this disease but more research is required on different treatment strategies.